Evaluation of the Future of Global Health Initiatives (FGHI) process

External report

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ACT-A	Access to COVID-19 Tools Accelerator
Africa CDC	Africa Centres for Disease Control and Prevention
AFRO	Africa Regional Office
AI	artificial intelligence
Amref	African Medical and Research Foundation
APCASO	Asia Pacific Council of AIDS Service Organisations
AU	African Union
CCM	Country Coordinating Mechanisms
CEO	Chief Executive Officer
CEPI	Centre for Epidemic and Pandemic Innovations
CS	civil society
CSO	civil society organisation
COVID-19	coronavirus disease 2019
CPHIA	Conference on Public Health in Africa
CTT	Commitments Task Team
DRC	Democratic Republic of the Congo
FCDO	Foreign, Commonwealth and Development Office
FGHI	Future of Global Health Initiatives
FIND	Foundation for Innovative New Diagnostics
GFAN	Global Fund Advocacy Network
GFF	Global Financing Facility
GH	global health
GHA	Global Health Architecture
GHI	Global Health Initiatives
GRSP	Government Relations and Strategic Partnerships Team
HIC	high-income country
HLM	High Level Meeting
HSS	Health System Strengthening
IDA	International Development Association
IFI	international financial institutions
IHP+	International Health Partnership
JCWG	Joint Committee Working Group
KII	key informant interview
LAC	Latin America and the Caribbean
LAWG	Lusaka Agenda Working Group
LMIC	low- and middle-income countries

M&E	monitoring and evaluation
MDB	Multilateral Development Bank
MoH	Ministry of Health
NGO	non-governmental organisation
ODA	Overseas Development Assistance
PEA	Political economy analysis
PHC	primary health care
R&D	research and development
RfP	Request for Proposals
RLTT	Research and Learning Task Team
SDG3 GAP	Global Action Plan for Healthy Lives and Well-being for All
SG	Steering Group
TB	tuberculosis
ToC	Theory of Change
UHC	universal health coverage
UHC2030	Universal Health Coverage 2030
UK	United Kingdom
UN	United Nations
UNF	United Nations Foundation
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
SWAp	sector-wide approach
WHO	World Health Organization

1. Executive summary

1.1. Background, purpose and approach

The Future of Global Health Initiatives (FGHI) process aimed to improve how the global health financing ecosystem and Global Health Initiatives (GHIs) support countries to advance universal health coverage (UHC). It took place between March 2022 and December 2023 and its objectives were:

1. GHIs are more efficient, effective and equitable in complementing and strengthening health system capacities and delivering health impacts.
2. Financing streams across GHIs – and between GHIs and the broader health architecture at national, regional and global levels – are better balanced and coordinated, with stronger mutual accountability for meeting current and future global health needs.
3. GHIs incentivise increased and sustained domestic investments in health that are more efficiently, effectively and equitably allocated, implemented and accounted for to achieve UHC.

This evaluation, commissioned by the Wellcome Trust, aims to provide an independent assessment of what happened during the FGHI timeline, generating forward-facing insights on what worked well and less well, and lessons for future global exercises such as this. The evaluation covers two phases: the conception/initiation of FGHI (March 2022 – Sept 2022); and the core FGHI process (Sept 2022 – Dec 2023). The aim is to examine the effectiveness of the working methods and tactics employed and evaluate the extent to which planned objectives were achieved in an equitable way. This report provides a record of what happened, and the successes and challenges encountered, to support learning and reflection by the global health community and to inform future collaborative efforts.

The evaluation team gathered and triangulated data across multiple sources. We interviewed 43 key informants from across 13 stakeholder groups involved in FGHI, reviewed 134 documents, and received 45 responses to an online feedback survey. Through systematic collation and analysis of divergent views, the evaluation hopes to facilitate an understanding of whether and how the FGHI process contributed to meaningful change in the way domestic and international resources support country primary health care (PHC), health systems and UHC needs.

1.2. Findings

The evaluation findings answered seven evaluation questions, agreed with the Wellcome Trust, with findings structured around three overarching questions: did FGHI set out to do the 'right things'; did it implement them in the 'right way'; and did this approach deliver the 'right results'?

Did FGHI set out 'to do the right things'?

In terms of its relevance and coherence, FGHI was a timely, relevant and bold initiative, catalysed by the aftermath of and politics around the response to the COVID-19 pandemic. There was consensus on the relevance of the FGHI agenda but divergence on specific problem definition. This lack of shared understanding of the problem to be solved by FGHI was reflected in uncertainty over the scale and ambition of the reforms FGHI should pursue. The selection and relevance of certain GHIs included in FGHI were unclear. FGHI's design sought to differentiate itself from existing mechanisms by establishing stronger links to GHI Boards but, while an

important ambition, this was more difficult politically and operationally than anticipated. Greater political economy analysis (PEA) could have strengthened FGHI's design and approach.

In terms of governance and legitimacy, the structure of FGHI was appropriately designed to reflect best practices in global health governance. The Steering Group leadership was viewed as a credible and balanced partnership between high-income country (HIC) and low- and middle-income country (LMIC) co-chairs. The selection process for other Steering Group members could have been more structured, to strengthen legitimacy and inclusivity. The Steering Group made efforts to achieve broad representation but geographic and civil society differences highlighted the complexities of managing inclusivity, legitimacy and efficiency. Balancing inclusivity and independence in the FGHI process overall proved challenging, with trade-offs in both LMIC engagement and GHI involvement. Task Teams were established as focused technical platforms, with varying levels of integration with the Steering Group.

Were FGHI activities implemented in the 'right way'?

In terms of implementation efficiency, FGHI's structured and relatively tight timeline facilitated progress but also led to trade-offs, particularly around research quality and endorsement, and advocacy for the Lusaka Agenda. FGHI implementation was marked by a series of key moments and strategic steps that drove progress forward. These included: Wellcome-commissioned research study that incorporated a research consultation in Addis Ababa in July 2023, a Wilton Park Dialogue hosted in the UK by the Foreign, Commonwealth and Development Office (FCDO) in October 2023, and a final meeting in Lusaka in November 2023, at which the conclusions of the FGHI process were agreed. Between these meetings, multiple processes took place to build consensus around the Lusaka Agenda Five Shifts, priorities, next steps and actions, including Task Teams, side events at intergovernmental and/or Board meetings and drafting committees for the Commitments Paper.

In terms of equity, collaboration, voice and inclusivity during the FGHI process, informal selection processes enabled diverse participation but power imbalances hampered meaningful engagement of some LMIC stakeholders. Amongst HICs, there was varied engagement, which weakened their ability to push for change. In addition, during implementation, FGHI partners missed several opportunities to address specific problems in the global health architecture. Throughout, the FGHI Secretariat played a strong operational role, though with some limitations.

Did FGHI deliver the 'right results'?

FGHI culminated in the publication of the Lusaka Agenda in December 2023. This set out the conclusions of the process as summarised by the co-chairs, including Five Shifts for the long-term evolution of the GHI ecosystem, near-term priorities, next steps and a call to action:

1. Make a stronger contribution to 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 (R&D) and regional manufacturing to address market and policy failures in global health.

The original FGHI objectives were regarded as controversially bold in their reform proposals but over time they became less ambitious, due to variable engagement and time constraints to reach

agreement. The Lusaka Agenda serves as a reconfirmation of existing commitments but missed opportunities to advance the debate, in the face of changing donor priorities and GHI competition for resources. FGHI achieved partial success in building consensus on key challenges and potential solutions.

Detailed analysis of the implementation of the Lusaka Agenda was outside the scope of this evaluation. However, it is clear that one year on, post-Lusaka, agreement has superficially been achieved on key shifts needed but deeper consensus on the feasibility of and accountability for next steps has yet to be resolved. The AU's commitment to establish a Lusaka Secretariat at Africa CDC may have the potential to stimulate sustained impact in Africa. Other follow-on processes include the Joint Committee Working Group (JCWG) between the Global Financing Facility (GFF), Global Fund and Gavi, the Vaccine Alliance (Gavi) Secretariats, and their work alongside 'champion countries'.

1.3. Key lessons to guide future work in this area

Lesson 1: Reform to the global health ecosystem remains a priority issue

The first lesson from this evaluation of the FGHI is that there was, and remains, a strong appetite for reform within the global health ecosystem. Stakeholders from all groups agree that health systems in many LMICs are under-resourced although the role of GHIs specifically within this is more contested. Wellcome and its partners involved in conceptualising FGHI correctly identified that the global health ecosystem is neither fit for purpose nor sustainable, either for supporting and strengthening health systems or for delivering disease impact. These issues were highlighted during the COVID-19 response and FGHI emerged during a period of consensus on the wider need for reform.

Lesson 2: Define the problem clearly from the outset and leverage the work of previous efforts

FGHI's lack of consensus among stakeholders on problem definition highlighted the importance of achieving clarity early in the process. FGHI allocated insufficient time to agreeing the problem up front and, as a result, while it disrupted the status quo, it is not clear that it laid the foundation for lasting institutional change, grounded in the realities of Board and grant business models and domestic health financing systems. Future work should invest time and resources to develop a shared understanding that is first, sufficiently grounded in evidence of what worked well/less well from prior efforts (IHP+, UHC2030, SDG3 GAP, etc), and second, supported by a broad coalition. Any future efforts by Wellcome and/or others to build consensus around reform should not start from scratch but instead closely examine the strengths and weaknesses of prior initiatives and identify specific problems to target.

Lesson 3: Establish inclusive and transparent governance structures

The FGHI governance structure aimed to be inclusive but fell short due to inconsistent and informal selection processes. Effective governance requires transparent, structured mechanisms for selecting participants and ensuring all relevant voices are heard. Balancing efficiency, inclusivity and legitimacy is crucial to foster credibility and trust. The informal nature of FGHI had subsequent implications for the legitimacy of the whole process, including the outcome – the Lusaka Agenda – which was more of a declaration of intent lacking binding commitments. Future efforts should mobilise effective stakeholder engagement via clear strategies that go beyond invitations to participate. Ensuring institutional backing for LMIC representatives and CSOs, as well as including and resourcing them meaningfully in decision-making processes, is essential for achieving balanced representation and fostering ownership of outcomes.

Lesson 4: Sophisticated, multi-layered political economy analysis of GHI Boards is essential to drive change

Integrating political economy analysis early in the process can enhance the understanding of power dynamics, competing interests and institutional constraints. Such analysis is vital for designing strategies that effectively engage diverse stakeholders and navigate political complexities. The political economy of FGHI was dominated by existing, complex power dynamics – that play out across GHI Boards and other health-related inter-governmental bodies. This went beyond simple HIC-LMIC or government-non-government dichotomies, since each of the GHIs has its own micro-political economy and Boards have little bandwidth for cooperation amongst themselves, despite having significant overlap in member constituencies. Future initiatives, including those involving Wellcome, should consider designing governance structures that include formal mechanisms for GHI Board engagement from the outset, to secure buy-in, align institutional interests with reform objectives and enhance the feasibility of proposed solutions.

Lesson 5: Capitalise on windows of opportunity – in 2025 as much as 2022 – to address fundamental issues in sustainable health financing

FGHI emerged during a window of opportunity in the late COVID-19 era. A new opportunity is now arising in 2025, spurred by major shifts in international funding. Despite challenges, growing momentum across the Africa region, exemplified by the prominence of the 'Lusaka Agenda', reflects ongoing appetite for reform. The AU's championing of this agenda needs to be balanced by identifying mechanisms to support the agenda in other regions, where some LMICs remain heavily dependent on GHIs for important parts of their health budgets.

At the global level, GHIs are collaborating to refine business models, mainly on operational alignment rather than systemic transformation. Most GHIs profess to follow a 'country-led' model yet maintain discretionary controls behind the scenes. As a result, despite aspirations 'one plan, one budget and one monitoring and evaluation (M&E) plan', GHIs remain driven by a need to demonstrate disbursement, impact and minimized fiduciary risk to their Boards.

Future reform will require joint accountability mechanisms to improve coordination between global and regional or national stakeholders aligned with the Lusaka Agenda. Efforts must go beyond surface-level changes, to promote actionable frameworks that strengthen domestic funding, and integrate with other international mechanisms. Declining international aid budgets underscore the urgency for innovative global and regional financing strategies, within a framework that facilitates cross-GHI cooperation, and for which there is potentially a role for relative newcomers like the Wellcome Trust.

2. Introduction and background

2.1. An evolving global health architecture

FGHI aimed to improve how the global health financing ecosystem and GHIs support countries to advance UHC. The FGHI process took place between March 2022 and December 2023. Its initial three objectives were:

1. GHIs are more efficient, effective and equitable in complementing and strengthening health system capacities and delivering health impacts.
2. Financing streams across GHIs – and between GHIs and the broader health architecture at national, regional and global levels – are better balanced and coordinated, with stronger mutual accountability for meeting current and future global health needs.
3. GHIs incentivise increased and sustained domestic investments in health that are more efficiently, effectively and equitably allocated, implemented and accounted for to achieve UHC.

Over the last 20 years, a large number of initiatives have emerged in the global health space, which is widely acknowledged to have become increasingly fragmented. For the FGHI process, early participants initially identified a set of six GHIs for focus: three are the largest GHIs distributing funds to support health sector programmes in low and middle-income countries (LMICs) – the Global Fund, Gavi, the Vaccine Alliance (Gavi) and the Global Financing Facility (GFF); and three focus more on product research and development (R&D) – the Centre for Epidemic and Pandemic Innovations (CEPI), Unitaid and the Foundation for Innovative New Diagnostics (FIND). A number of other important global health actors (e.g. the World Bank, the World Health Organisation [WHO] and the United Nations Children's Fund [UNICEF]) were invited to be observers to the process but were not its primary focus.

Previous efforts to address fragmentation in global health included the International Health Partnership (IHP+), established in 2007, and its successor UHC2030 (2016 – ongoing), as well as the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), established in 2019. All are grounded in Paris and Busan development effectiveness principles and sought to improve domestic and international resource allocation for PHC and health systems.[1,2] A number of issues have faced all efforts to reform the global health ecosystem including (amongst others): how to reach meaningful global commitments, given dramatically different GHI business models; how to hold signatories/members accountable for translating global commitments into action at global and country levels; how to strengthen national coordination mechanisms and ensure they are owned and used effectively; that secretariats' efforts to coordinate may be hindered by Boards' mixed interests and influence over change; and how to develop common monitoring systems that provide useful information while not overburdening countries with gathering data to service global information needs. In addition, during the past two months, prior evidence of 'donor fatigue' alongside competition for public resources has materialised into almost complete withdrawal from the international aid system by the United States of America (USA) and further cuts to the United Kingdom (UK) aid programme, previously two of its largest funders.

[1] OECD (2009), *Aid Effectiveness: A Progress Report on Implementing the Paris Declaration*, Better Aid, OECD Publishing, Paris, https://doi.org/10.1787/9789264050877-en. Accessed 11/03/2025.

[2] OECD (2023), The Busan Partnership for Effective Development Co-operation. Available online at: https://web-archive.oecd.org/temp/2023-10-09/57958-busanpartnership.htm. Accessed 11/03/2025.

Between mid-2022 and late 2023, a new window of opportunity emerged for global actors to focus on health financing in LMICs and the strengths and weaknesses of GHIs in complementing domestic health resources. The policy context within which the FGHI process took place was during the transition of Coronavirus Disease 2019 (COVID-19) from pandemic to endemic status. Setbacks in several key areas of the COVID-19 response highlighted failures in the system and contributed to renewed analysis of the pressure on and competition for international resources for health, changes in the eligibility criteria and transition models of key GHIs, and the increased concentration in their business models of countries suffering from conflict, instability and fragility.

During FGHI, different sets of stakeholders attended a series of consultative meetings, with some having the opportunity to join the Steering Group (SG) and Task Teams. Wellcome also commissioned a research consortium to undertake background analysis.[3] The process culminated in the publication of the Lusaka Agenda in December 2023,[4] in which the conclusions of the process were summarised by the co-chairs, including Five Shifts for the long-term evolution of the GHI ecosystem (Box 1). Stakeholders further identified near-term priorities, and next steps to catalyse short-term action, including improvements to GHI governance and alignment with government systems, coordination around impact metrics, greater transparency of GHI financial support, improved sustainability and transition policies, simplified grant application and disbursement processes, and more collaborative R&D business models. Development of roadmaps for change to take the work forward was also proposed by stakeholders.

Box 1. Five long-term shifts in the Lusaka Agenda

1. Make a stronger contribution to PHC care 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, R&D and regional manufacturing to address market and policy failures in global health.

3. Evaluation purpose and key questions

3.1. Purpose, audience and approach

This evaluation will examine the question of whether and how the FGHI process met its objectives and in so doing contributed to meaningful change in the way domestic and international resources support country primary health care (PHC), health systems and UHC needs. By systematically collating and analysing divergent opinions, the evaluation will shed light on the interests and influence of the multiple stakeholders involved (both positive and negative), and their views on both the FGHI process and its outcomes. In so doing, the evaluation

[3] Witter, S. et al. (2023) Reimagining the Future of Global Health Initiatives. Research Report, Queen Margaret University, Geneva Centre of Humanitarian Studies, Aga Khan University, Cheikh Anta Diop University, Institut de Recherche pour le Développement, Stellenbosch University.

[4] The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process. Available online at: https://d2nhv1us8wflpq.cloudfront.net/prod/uploads/2023/12/Lusaka-Agenda.pdf. Accessed 11/03/2025.

aims to balance independent assessment of what happened with generating forward-facing insights for Wellcome and the broader global health community on what worked well, less well and lessons for future global policy-oriented exercises like FGHI.

The objective of this report is to present the results of this FGHI evaluation, providing a record of what happened, and the successes and challenges encountered, to support learning and reflection by the global health community and to inform future collaborative efforts. The evaluation covers two phases: the conception/initiation of FGHI (March 2022 – Sept 2022); and the core FGHI process (Sept 2022 – Dec 2023). The report includes a focus on documenting what occurred, examining the effectiveness of the working methods and tactics employed and evaluating the extent to which planned objectives were achieved in an equitable way.

4. Methods

This section sets out a brief summary of our methodological approach, with more detailed information available in the annexes.

4.1. Analytical framework

Our theory-based evaluation was grounded in the widely used Kingdon theory of agenda-setting.[5] The Kingdon framework centres on the idea that multiple streams influence how policy agendas are shaped, including the way that social conditions come to be defined as a problem (the problem stream); the solutions generated to address problems (the policy stream) and political factors (the politics stream). The Kingdon stream also acknowledges the crucial role played by policy entrepreneurs in driving these streams.

The evaluation was structured around a Theory of Change (ToC) and accompanying set of assumptions, developed during the evaluation inception phase (see Annex 1). The evaluation team developed, refined and mapped seven evaluation questions (EQs) onto the ToC. For each EQ, the team also developed a set of sub-questions to deepen understanding of what occurred, and whether/how the FGHI process (and Wellcome's role within it) was implemented as planned, to achieve the expected outcomes and objectives (see Annex 2). The findings section of the report summarises the extent to which these assumptions did (or did not) hold.

In addition to our ToC, the evaluation was structured around three central evaluation modules. Module 1 (To what extent did FGHI set out to do the 'right things'?) focuses primarily on the conception and initiation of the FGHI process between November 2021 and September 2022. Module 2 (To what extent did FGHI implement its activities in the 'right ways'?) is focused on the overall FGHI process, tactics and activities that took place between September 2022 and December 2023. Module 3 (Did FGHI deliver the 'right results'?) focuses on the effectiveness and sustainability of outputs and outcomes of the FGHI process up to December 2023.

Our methodology also included political economy analysis (PEA) to understand the positions, power, interests and incentives of different stakeholders. PEA tools are useful to analyse the political context of policy development, by addressing three main questions: (1) what is the underlying issue or problem being addressed; (2) why does this situation persist in this form; and (3) how can change come about? PEA can be easily overlayed with the Kingdon theory of agenda-setting by focusing on the role of interest groups, the distribution of power, practical

[5] Kingdon, J.W. (2003) *Agendas, Alternatives and Public Policies*: 2nd edition. New York: Addison-Wesley Educational Publishers Inc. pp.90–208.

constraints upon the use of that power, formal and informal norms that influence decisions, and stakeholders' different incentives and ability to change.

During the inception phase, the evaluation team undertook comprehensive stakeholder mapping, including attendance at and membership of FGHI governance and related structures, participation in key FGHI events, and membership of the Secretariats and Boards of the main GHIs in question. This process resulted in approximately 150 individuals being identified. These were categorised into 13 stakeholder categories (see Box 2). We did this to understand stakeholder involvement (and exclusion); to understand the diversity, inclusivity and equity of the FGHI process; and to provide insights into how the process performed, the obstacles it faced, and the feasibility of achieving its intended objectives.

Box 2. Stakeholder groups

- FGHI Secretariat
- Wellcome Trust
- GHI Secretariat staff
- UN agencies and wider IFIs
- LMIC governments
- HIC governments
- LMIC CSOs/networks
- HIC CSOs/networks
- Other LMIC and/or regional organisations
- Global health (GH) experts and independent consultants
- Philanthropic foundations
- 'Reimagining the Future of GHIs' Research Consortium

Finally, a strength of evidence framework was used to classify the strength of evidence available in support of each finding. See Table 1 below for a description of each evidence rating.

Table 1. Strength of evidence approach

Rating	Description
Strong (1)	Evidence comprises multiple data sources (which enables triangulation from at least two different sources) that are of good quality and/or evidence is repeated by multiple key informant interviews (KIIs) from a range of stakeholder categories.
Moderate (2)	Evidence comprises multiple data sources (which enables triangulation from data sources) of acceptable quality, and/or the finding is supported by fewer data sources of good quality.
Limited (3)	Evidence comprises few data sources across limited stakeholder groups (limited triangulation) or is generally based on data sources that are viewed as being of lower quality.

4.2. Data collection

During data collection, we gathered evidence from multiple data sources and then analysed and triangulated findings to determine whether the ToC assumptions were met or not and to answer the EQs. This provided a picture of how the tactics, activities and stages of the FGHI process or ways of working contributed individually and collectively to the ToC streams, and overall FGHI objectives and outcomes.

The evaluation team interviewed 43 key informants during January and February 2025 (see Annex 3 for full list). Key informants were purposively selected from the stakeholders mapped during inception (see process described above). Our intention was to maximise inclusivity and breadth of voices. Participants included membership of FGHI governance and related structures, stakeholders who participated in key FGHI events, Secretariats and Boards of the six GHIs, and additional stakeholders that did not participate as closely in the FGHI process, including representatives of other multilateral health agencies, LMIC governments, civil society organisations (CSOs) and non-governmental organisations (NGOs). A breakdown of key informants by stakeholder category is available in Annex 3.

The team undertook a desk review of 134 documents (see Annex 4 for full list). This focused on examining the quantity and categories of FGHI documentation (e.g., process planning-related documents, meeting reports, outreach/socialisation briefings, research reports and responses etc.) and other external reports and secondary data available to inform the evaluation findings.

The evaluation designed an online survey to expand the reach of respondents and gain insight from a broader group than those who were consulted through KIIs. The survey was circulated in January 2025 in three ways:

- To the full 150+ individuals identified in the FGHI stakeholder list, with tailored requests to: (i) the interviewees (to forward within their organisations); (ii) the remaining 100+ individuals on the stakeholder list; and (iii) specific individuals with membership/working groups for onward distribution. All were asked to distribute the survey more widely.
- To a further 1,000+ individuals registered in the FGHI Secretariat database.
- Via LinkedIn connections of Wellcome and evaluation team members.

The survey remained open for three weeks and received 45 responses from a diverse range of stakeholders. Details of the survey respondents and findings can be found in Annex 5.

4.3. Data analysis

We undertook analysis and triangulation of data from the KIIs, document review and survey using a clear framework with pre-determined codes to structure information against specific EQs, sub-questions and ToC assumptions. We then coded the data using tools designed to allow systematic extraction of evidence against the EQs, and we collated the data in Word and Excel templates mapped against Modules 1–3. The team also used the *Claude* artificial intelligence (AI) package as a supplementary analytical tool to support analysis of KII transcripts and key documents. AI was used to support human analysis, with all AI-generated insights critically reviewed by the team against the raw data to verify emergent patterns or themes identified and to check for potential biases or misinterpretations. Please see Annex 7 for more detail on our use of AI in the KII and document analysis.

The team conducted a primary analysis of the survey responses, followed by a disaggregated analysis based on stakeholder type, level of engagement and geographical region. We also

examined open-ended survey questions using qualitative thematic coding to identify key insights from respondents. We then triangulated the insights with the KII and document review findings.

5. Findings

This section summarises the key findings across each of the three evaluation modules.

5.1. To what extent did FGHI set out to do the 'right things'?

In this section, we examine the extent to which FGHI set out to undertake the 'right things' (Module 1). In this section we answer EQ1, EQ2 and EQ5. Section 5.1.1 presents findings in relation to the relevance and coherence of the problem and policy definition while Section 5.1.2 examines the governance and legitimacy of the process. At the end of the section we reflect on implications for the assumptions underpinning the ToC (Box 4).

Box 3. Relevant EQs addressed in this section

EQ1: Were the FGHI objectives relevant and coherent?

EQ2: Were the FGHI project governance structures designed to maximise outcomes?

EQ5: How well did the FGHI governance and related structures work in practice?

5.1.1. Relevance and coherence of the problem and policy definition

Table 2. Key findings on relevance and coherence of problem and policy definition

#	Findings	Strength of evidence
1.01	FGHI was a timely, relevant and bold initiative, catalysed by the aftermath of and politics around the COVID-19 pandemic.	1
1.02	A broad consensus emerged among global and country stakeholders on the relevance of the FGHI agenda although with significant variation in how stakeholders specified the problem FGHI sought to address.	1
1.03	This lack of shared understanding of the problem to be solved by FGHI was reflected in uncertainty over the scale and ambition of reforms that FGHI should pursue.	1
1.04	The selection and relevance of certain GHIs included in the process was unclear.	1
1.05	FGHI's design sought to differentiate itself from existing mechanisms by establishing stronger links to GHI Boards. While an important ambition, there was limited evidence of its political and operational feasibility.	2
1.06	Greater political economy analysis could have strengthened FGHI's design and approach.	1

Finding 1.01. FGHI was a timely, relevant and bold initiative, catalysed by the aftermath of and politics around the COVID-19 pandemic. The COVID-19 pandemic exposed critical dysfunctions, power imbalances and inequities in the global health system, particularly affecting LMICs, which

experienced significant challenges accessing COVID-19 vaccines.[6] Against this backdrop, FGHI emerged from discussions initiated in March 2022[7] at a pivotal moment when global debates centred on the lessons of the pandemic and long-standing issues of complexity, fragmentation and sustainability of the global health ecosystem, including with GHIs. The experiences from the pandemic provided political space and momentum to push for ambitious reforms to the system. Key actors – John-Arne Røttingen (Global Health Ambassador for the Government of Norway), Jeremy Farrar and Alex Harris (Wellcome Trust) and a small group of other of HIC governments (initially the UK and Canada) – leveraged this opportunity to start to rethink the global health ecosystem. Additionally, John-Arne Røttingen's involvement in the Access to COVID-19 Tools Accelerator (ACT-A) provided critical insights into the appetite across partners for a more coherent, system-wide approach to financing and health systems based on PHC, which influenced the timing and approach of FGHI's approach.

KIIs consistently highlighted FGHI's bold, potentially disruptive agenda which aimed to challenge the status quo and reinvigorate conversations on how to make the global health ecosystem more relevant for the future. Few recent initiatives since the IHP+ had addressed systemic weaknesses through grant operations and thus FGHI was potentially filling an important gap to realign financing and governance structures with country ownership and priorities. The perceived neutrality of John-Arne Røttingen and the Wellcome Trust was influential in enabling FGHI to set ambitious objectives without being constrained by institutional interests.

Finding 1.02. A broad consensus emerged among global and country stakeholders on the relevance of the FGHI agenda, although with significant variation in how stakeholders specified the problem FGHI sought to address. During the conceptualisation phase (March–September 2022), FGHI's objectives evolved from an initial focus on GHI financing, efficiency and sustainability to a broader focus on health system strengthening (HSS) and universal health coverage (UHC).[8,9] While discussion on alignment of global health funding with country priorities was widely welcomed – particularly by LMIC stakeholders – others held diverging views on what the problem was that FGHI was hoping to solve.

'On the relevance of the FGHI objectives, the idea of coordinating and making sure that everyone aligns to the country's plan and works from the same budget, and then we pursue the same goals and objectives – that was a major priority for us. So that's why we fully engaged in the process, and we find it very useful.' **(KII, LMIC government)**

FGHI intentionally opted for an iterative approach, allowing the problem definition to emerge through the process rather than being pre-determined. Perspectives on the problem varied significantly both within and between stakeholder groups, reflecting different ideas, institutions and interests. LMICs emphasised issues of control, authority and alignment of resources with national health agendas, as well as the operational challenges posed by multiple GHI

[6] KIIs (International financing partners, UN, CSOs, LMIC) and internal and external documents provided by Wellcome Trust e.g., FGHI Concept Note; Future of GHIs Consultation in Lusaka; Is global health financing fit for purpose; How is the global health landscape evolving?

[7] Early discussions on FGHI started in March 2022. The period March–September 2022 was defined as the FGHI conceptualisation period. The core FGHI process started from September 2022 to December 2023. See the report's timeline for further information.

[8] KIIs with different stakeholder groups (LMIC, GHI Secretariat, international financing partners, Southern based CSOs); survey responses, which indicated 54% agreed or strongly agreed that the FGHI process was effectively designed to inform reform efforts addressing key challenges in the global health ecosystem.

[9] The scope was finalised in October 2022 at the World Health Summit meeting in Berlin with the two co-chairs of the FGHI Steering Group, John-Arne Røttingen and Dr Mercy Mwangangi (Former Chief Administrative Secretary of the Kenyan Ministry of Health).

requirements. Amongst HIC funders with long-term investments in GHIs, some focused on financial sustainability and efficiency of GHIs and the need for greater investment in health systems rather than on disease-specific approaches, while others remained committed to supporting GHI disease- or issue-specific approaches. GHIs themselves also had differing perspectives: the Global Fund did not accept that GHIs were the main problem; Gavi and GFF appeared to acknowledge the need for better alignment with country systems and reduced fragmentation. Some CSOs brought distinct concerns regarding the potential impact of reforms on vulnerable populations, while others wanted to ensure GHIs were more responsive to governments.

Finding 1.03. This lack of shared understanding of the problem to be solved by FGHI was reflected in uncertainty over the scale and ambition of the reforms that FGHI should pursue. Perspectives ranged from bold structural reforms, aimed at fundamentally redefining the role of GHIs and shifting power and resources to national governments, to incremental adjustments, aimed at improving efficiency while maintaining funding flows and replenishments.

'There was no unity of purpose; within bilaterals, philanthropists, CSOs there was consensus something needed to change but how much, how fast, what should change look like, understanding the risks, was not set out.' **(KII, FGHI Secretariat)**

*'The main agreement was that we needed to change things and couldn't continue business as usual. But there were disagreements about how, which issues to focus on and how to approach [reform].' (**KII, LMIC government)***

While Wellcome took steps to clarify the problem – such as in the FGHI Concept Note (June 2022)[10] – lack of clarity on the problem definition persisted beyond the conceptualisation phase. The FGHI SG meeting in February 2023 and the Starting Statement[11] both underscored the need for a shared problem statement to provide a solid and inclusive starting point for the process.

'There was a call for the Steering Group to align around a statement articulating the problem the FGHI process is aiming to solve for, to facilitate clear, consistent and compelling communication by members…. Of note, what is being sought at this time is an informal consensus about how to speak about the problem, not a negotiated statement of how the Steering Group agrees to solve it.' **(Steering Group Meeting Report, February 2023)**.[12]

The decision to adopt an iterative approach to the GHI problem to be solved aimed to capitalise on the window of opportunity for reform and the FGHI timeline to ensure broad stakeholder participation and perspectives. A more structured approach was considered risky by narrowing the agenda too soon, potentially excluding key voices or limiting the scope of discussion. However, it is unclear whether this concern was justified. The window of opportunity remained open and broad stakeholder engagement would have been necessary regardless of whether an early problem statement had been agreed. What is clearer is that the absence of a more clearly defined problem had consequences for the process. It complicated FGHI's ability to manage diverging opinions, requiring FGHI to adapt its framing strategies and stakeholder engagement strategies through the course of the process. The lack of clarity also influenced the range of

[10] FGHI Concept Note, June 2022.

[11] Starting Statement for FGHI, Brunswick, March 2023.

[12] Steering Group Meeting Report, February 2023.

policy solutions considered (or not considered) and, at times, left stakeholders uncertain about what FGHI ultimately aimed to achieve.

Finding 1.04. The selection and relevance of certain GHIs included in the process was unclear. Six GHIs were chosen for inclusion in FGHI – the Global Fund, Gavi, GFF, Unitaid, CEPI and FIND. An internal Wellcome document provides criteria for inclusion, stating FGHI as *'focusing on GHIs operating outside the UN and Multilateral Development Bank (MDB) system with multi-stakeholder boards, replenishment models and providing grant funding to low- and middle-income countries, as well as those that do market shaping for products that are procured/financed by them'*.[13] The six GHIs varied in their alignment with FGHI's criteria, and indeed not all of them have replenishment models: the Global Fund and Gavi met the criteria most closely; CEPI and Unitaid aligned based on their roles, governance structures and funding mechanisms; GFF partially aligned with the criteria; and FIND diverged the most, with few criteria met, and functioning as a technical organisation rather than a funder or GHI. During the conceptualisation phase (March–September 2022), outreach efforts were made to all six GHI leadership teams, though the timing varied. Gavi, the Global Fund, Unitaid and CEPI were first informed in May 2022, GFF in July 2022 and FIND in September 2022.[14] Some GHI informants reported that they were unaware of their inclusion and had to actively push for involvement in discussions about their future. As FGHI progressed, the focus on the six GHIs shifted. This group had limited participation in FGHI governance, with Unitaid, CEPI and FIND absent from the extended Commitments Task Team (CTT) while Global Fund, Gavi and GFF were actively involved.

KIIs, including those with the GHIs, frequently highlighted the lack of clarity around GHI selection and the relevance of some GHIs included in the initiative, especially given the differences in business models.[15] Some stakeholders – including the Global Fund, the Gates Foundation, CSOs and some representatives from LMICs – advocated for a more holistic approach to addressing systemic challenges in the global health ecosystem, arguing that key players such as the World Bank, regional development banks and WHO should have been included, given the emphasis on financing and HSS. Others viewed the exclusion of the Pandemic Fund as a missed opportunity given this was a new fund operating in the financing and HSS space.

'The process surfaced valid challenges with the whole global health ecosystem but channelled them narrowly onto few institutions without examining broader system roles.' **(KII, HIC CSO)**

Finding 1.05. FGHI's design sought to differentiate itself from existing mechanisms by establishing stronger links to GHI Boards. While an important ambition, there was limited evidence of its political and operational feasibility. Rather than replacing existing mechanisms, FGHI positioned itself as building on initiatives such as UHC2030, IHP+, SDG3 GAP and the GFF Alignment Working Group. While the FGHI Concept Note emphasised that its design process would be informed by past successes and challenges of such initiatives, it was less clear how exactly these lessons were discussed and leveraged.[16] Discussions with key informants on this issue tended to focus on the SDG3 GAP and its shortcomings, notably the lesson learned that

[13] Internal slide sets provided by Wellcome Trust (e.g., Slides for ID Heads, Sept 2022).

[14] Evidenced by relevant emails shared by the Wellcome Trust and documentation: Wellcome Trust, GHI Reform Engagement plan: June–Sept 2022; GHI Slides, Wellcome/Norway, 24 June 2002.

[15] KIIs from multiple stakeholder groups including research consortia, global south CSOs, UN, Wellcome Trust.

[16] For example, available documentation was limited in discussing how FGHI had considered the learnings from existing alignment and coordination mechanisms; the first SG meeting in October 2022 also raised the importance of linking to/learning from related networks and processes.

coordination alone is necessary but not sufficient to drive action at country level, which also needs clear accountability mechanisms and enforceable commitments.

FGHI attempted to engage directly with GHI leadership and governance, to seek clearer direction from Boards and to facilitate buy-in and take-up of policy solutions. For example, an analysis of GHI Board members participating in FGHI processes indicated the involvement of a total of 14 Board members, split between Gavi and the Global Fund.[17] While this strategy had some logic, FGHI did not appear to have fully assessed its political and operational feasibility, including GHI Board structures and constituencies, power dynamics and the timing of GHI strategies and replenishment processes – all of which shaped Board incentives to engage in reform.

'We must examine the governance of GHIs and who dominates the decisions. I sit on a Board where we have differential weights. The fiscal power dominates the reality. Out of x Board members, only x are implementing countries and we can't argue if we disagree.'
(KII, LMIC government/GHI Board member)

Opinions also varied on whether creating a new initiative outside existing mechanisms or structures was the most effective approach or whether reform discussions should have been more embedded into existing GHI Board discussions rather than have Board members participating in a separate FGHI process.

Finding 1.06. Greater political economy analysis could have strengthened FGHI's design and approach. Multiple interviewees suggested that the political dimensions of global health governance and associated institutional interests were underestimated.[18] A political economy analysis (PEA) may have helped anticipate competing interests and power dynamics and supported FGHI's approach towards engagement with civil society and GHI Boards. The political economy of GHIs shaped FGHI's outcomes, at times forcing a narrowing of reform ambitions and limiting systemic change. Greater attention to these dynamics from the start would have allowed FGHI to navigate constraints more effectively and maximise reform opportunities.

5.1.2. Governance and legitimacy of the process

Table 3. Key findings on governance and legitimacy in the process

#	Findings	Strength of evidence
1.07	The governance structure of FGHI was relevant and appropriately designed to reflect best practices in global health governance.	2
1.08	The leadership structure of the Steering Group was viewed as a credible and balanced HIC–LMIC partnership.	1
1.09	The Steering Group selection process could have better strengthened legitimacy and inclusivity.	1
1.10	The Steering Group made efforts to achieve broad representation, but geographic and civil society inclusion highlighted the complexities of balancing inclusivity, legitimacy and efficiency.	1

[17] Evidenced from the evaluation's stakeholder analysis.

[18] KIIs with multiple stakeholder groups (philanthropy, Research Consortia, Global North CSOs, GHI Secretariat staff). Internal documentation: Wellcome Trust's Final Project Review.

1.11	Balancing inclusivity and independence in the FGHI process proved challenging, with trade-offs in both LMIC engagement and GHI involvement.	1
1.12	Task Teams were established as focused technical platforms, with varying levels of integration with the SG.	2

Finding 1.07. The governance structure of FGHI was relevant and appropriately designed to reflect best practices in global health governance. FGHI governance aimed to balance transparency, inclusion, efficiency and agility. The structures set up comprised members and chairs of the SG, the Research and Learning Task Team (RLTT) and the CTT (subsequently the extended CTT). The SG, co-chaired by high-level representatives from a HIC and LMIC country respectively, was composed of members selected based on interest, commitment, decision-making authority, geographical diversity and gender balance, reinforcing an inclusive and representative approach.[19]

'The combination of a Steering Committee and Task Teams allowed for high-level direction planning as well as more detailed collaboration.' **(Survey response)**

FGHI's design aligned with best practice in global health governance, particularly in differentiating roles to enable collaboration, multi-stakeholder engagement, transparency, inclusivity and evidence-informed decision-making.[20] Governance structures were relatively flexible and evolved by expanding representation, most notably with the SG and CTT. However, while the design was conceptually strong, its effectiveness depended on implementation and the extent to which stakeholders engaged meaningfully in decision-making and governance processes. In this respect, there were challenges, as highlighted below.

Finding 1.08. The leadership of the Steering Group was viewed as a credible and balanced HIC–LMIC partnership. The leadership structure of the SG included co-chairs from the governments of Norway and Kenya, designed to address imbalances between the HIC and LMIC and create a level playing field where members could speak freely. This structure was positively regarded, with both co-chairs lending credibility to the process and leveraging their strong relationships and networks. Interviews and documents highlighted the pivotal role of these leaders, particularly John-Arne Røttingen, in shaping the evolution of the FGHI and fostering a more inclusive governance framework.[21] The main constraint to the leadership emerged after the Kenyan co-chair transitioned out of a government role and had much less availability to work for FGHI. This was reported to have weakened the intended dual leadership dynamic and challenged ongoing African stakeholder engagement.

Finding 1.09. The Steering Group selection process could have better strengthened legitimacy and inclusivity. From the outset, FGHI was intentionally positioned as an informal time-bound initiative. The GHI Reform Governance Proposal (June 2022) outlined FGHI's governance and documents and interviews confirmed that potential SG members were identified and informally engaged by the Wellcome Trust and co-chairs during the conceptualisation phase from March to

[19] Wellcome Trust Global Health Initiative Reform Governance Proposal, 16 June 2022.

[20] For example, best practice on global health governance emphasising the need for inclusive decision-making that brings together diverse actors, including governments, civil society, academia, and the private sector Frenk, J., & Moon, S. (2013). Governance challenges in global health. *New England Journal of Medicine, 368*(10), 936–942.

[21] Wellcome Trust internal documentation: Update to PSC Members.

September 2022.[22] A webinar held in August 2022 provided an opportunity to engage informally with a wider set of stakeholders, which evolved into a 'coalition of the willing', some of whom became members of the SG and/or later Task Teams.[23]

'I was working in this area for a number of years and was told about the webinar. I wasn't sure if FGHI was a real thing yet but that initial webinar was what got the idea going. It seemed think-tanky but not an official process, which resulted in backlash, but it continued to be a good forum to get ideas out on the table.' **(KII, UN partner)**

Membership of the SG and other working groups can be seen in the spider diagrams overleaf in Figures 1–3. While the figures presented here are based on the FGHI website and present a static situation, evaluation evidence pointed to the adaptation of FGHI governance structures to include more LMIC, CSO and GHI representation as the FGHI process evolved.[24] A rapid analysis of intended versus actual membership suggests that, while the SG composition broadly aligned with initial plans, FGHI's goal of engaging GHI Boards was not fully reflected in governance documents or structures.[25] At the same time, the lack of a structured and formal process for deciding membership selection was raised consistently across interviews with different stakeholder groups. While the need for speed and flexibility were factors driving the informality of FGHI, the ad hoc nature of choosing SG members raised questions over the fairness and transparency of the selection process and of the mandate and voice of those participating. The lack of clear selection criteria also prompted concerns about participation – for example, being based on pre-existing networks – which influenced perceptions of legitimacy and trust.

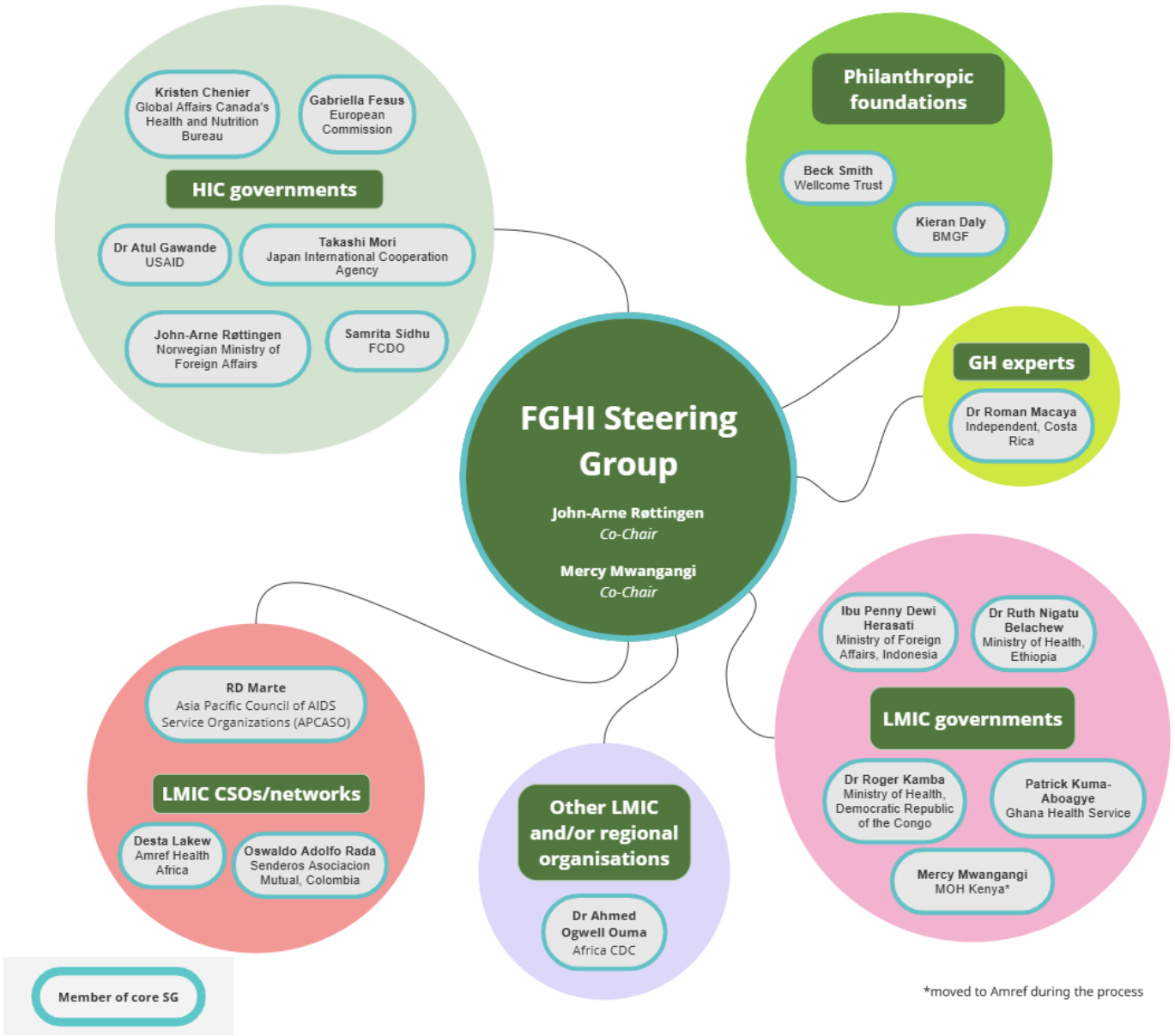
[22] Next steps/roles and responsibilities within the GHI reform process 27 April 2022; Wellcome/Norway: GHI Reform, 24 June 2022, minutes of meeting. GHI Reform Engagement plan: June–Sept 2022; FGHI: Update from the Secretariat, September 2022.

[23] Wellcome Trust registration summary spreadsheet of participants in FGHI webinar, August 2022.

[24] https://futureofghis.org/ about/. Accessed 11/03/2025.

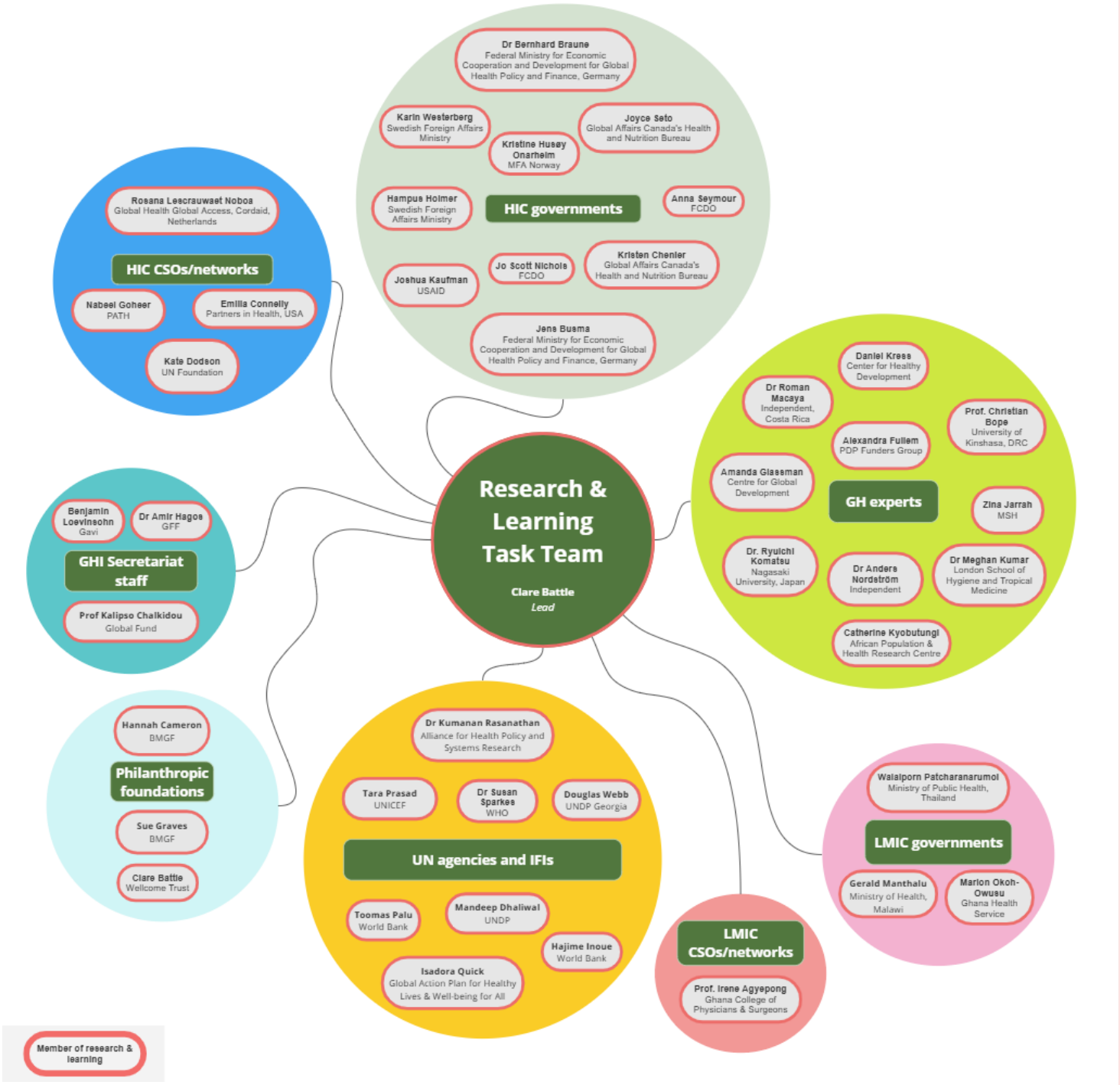
[25] For example, Some GHIs, such as Gavi and the Global Fund, had stronger Board representation in FGHI structures, while others were less engaged, with some Board members only having observer status.

Figure 1. Stakeholders involved in FGHI Steering Group



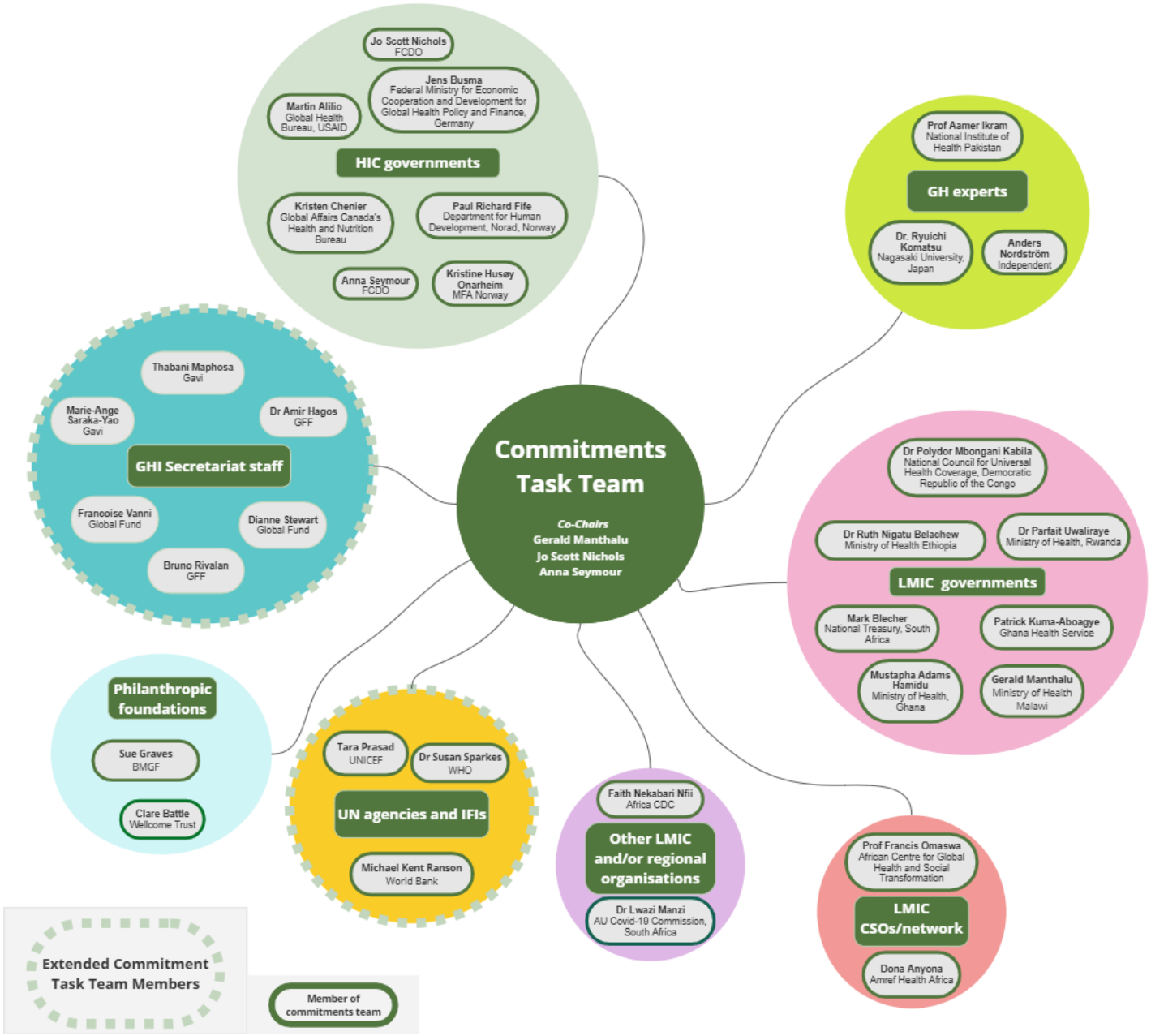
- The SG reflected a multi-stakeholder governance mechanism, engaging both funders and implementing countries.
- Six key stakeholder groups were represented: HIC governments, LMIC governments, philanthropic foundations, LMIC CSOs/networks, global health experts and Wellcome Trust.
- To ensure LMIC engagement, a co-chair leadership model was established between HIC and LMIC, alongside representation from LMIC CSO networks. However, LMIC representation remained limited and skewed towards African countries, reinforcing perceptions of FGHI as an African initiative.
- GHI Secretariats were excluded to allow open discussions on reforms.
- While senior figures were present across all groups, HIC and philanthropic foundations/Gates Foundation had stronger and more consistent executive representation, reflecting their long-term funding roles of GHIs. Their significant power and vested interest in GHIs heavily influenced FGHI strategic direction and outcomes of the process.

Figure 2. Stakeholders involved in Research & Learning Task Team (RLTT)



- The RLTT was an open group, which enabled the inclusion of a wider set of stakeholders, compared to the SG and CTT. Eight stakeholder groups represented a broader range of technical, research and multilateral stakeholders (compared to the SG).
- While both structures featured HIC and LMIC, philanthropic foundations and CSOs, the RLTT also incorporated UN agencies and international financial institutions (IFIs) (as FGHI observers), independent global health experts, GHI Secretariat staff (from Gavi and GFF) and other related entities such as alliances and working groups.
- The distribution of stakeholders skewed towards HIC representation, particularly in government, philanthropic and CSO groups.

Figure 3. Stakeholders involved in Commitments Task Team (CTT)



- The CTT and its extended version brought together eight stakeholder groups, which differed significantly from the SG and RLTT.
- Notably, the CTT included a larger number of HIC government representatives compared to other governance structures. There was also a stronger presence from LMIC, particularly from Anglophone African nations, as well as regional organisations like Africa CDC and other regional health bodies.
- The extended CTT also included direct participation from the Secretariats of three key GHIs – Global Fund, Gavi and GFF – along with representatives from some UN agencies and IFIs. For some GHIs, this marked their first opportunity to engage directly in FGHI governance structures and processes.

Finding 1.10. The Steering Group made efforts to achieve broad representation, but geographic and civil society inclusion highlighted the complexities of balancing inclusivity, legitimacy and efficiency. The SG faced a range of representation and inclusion imbalances, as highlighted in interviews,[26] survey responses[27] and documents.[28] Efforts were made by Wellcome and John-Arne Røttingen to address unequal geographic representation and engage Latin America[29] and Asia Pacific regions but this proved more challenging than anticipated, with SG country representation being skewed towards Africa.

Engaging civil society (CS) proved challenging throughout the FGHI process. While FGHI sought to ensure CS representation at SG level, determining who to engage and how was complex. For example, CSOs focused on health systems and equity were not well organised, while others, like the Global Fund Advocacy Network (GFAN), whose interests are aligned closely with the Global Fund and were perceived to have strong interests in maintaining the status quo, were not included on the SG. Ultimately three CSOs became members of the SG, but the selection process varied, raising concerns about legitimacy and accountability. The African Medical and Research Foundation (Amref)'s role as a pre-selected representative sparked questions about who it represented and how it was chosen.[30] The Asia Pacific Council of AIDS Service Organisations (APCASO) and Senderos Asociación Mutual were selected through a CSO-led nomination process run by StopAIDS in September 2022, funded by Wellcome, at the request of the FGHI co-chairs. However, these representatives participated in the SG in an individual capacity rather than as constituency delegates, limiting their ability to represent wider CS interests. This reportedly weakened legitimacy, accountability and depth of collaboration.

The logic behind selecting individuals for the SG is understandable, as it attempted to balance practicalities, project timelines, inclusivity and constituency-based decision-making. However, given the political nature and high stakes for different groups, this approach was widely seen as counterproductive and generated dismay and distrust about how CS engagement was managed.

'CSOs are used to representing a constituency but in this case, they represented themselves. Had this been done differently, the outcome would have been more collaborative and useful. This was a strategic error; we did not exploit the opportunities.' **(KII, FGHI Secretariat)**

Finding 1.11. Balancing inclusivity and independence in the FGHI process proved challenging, with trade-offs in both LMIC engagement and GHI involvement. Generating interest and ensuring meaningful participation from LMICs was also reportedly not straightforward. Engagement was primarily focused on government representatives, often through informal invitations, rather than official requests for representation and associated constituencies. As a result, LMIC representatives did not always formally represent their governments, unlike some of their HIC counterparts, who had clearer mandates to do so. The informal approach to determining LMIC participation tended to favour Ministries of Health (for example, Departments of Planning and/or

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26 KIIs with multiple stakeholder groups (Southern- and Northern-based CSOs, philanthropic organisations, Wellcome Trust, independent/technical expert).

27 Survey responses were mixed with 46% of respondents strongly agreeing or agreeing (8% and 38% respectively) that the FGHI governance structures enabled inclusive engagement from a wide range of stakeholders, 23% disagreeing or strongly disagreeing (8% and 15% respectively) and 30% not agreeing or disagreeing or not knowing (15% each).

28 Wellcome Trust internal documents including 24 June 2022 meeting report; FGHI Final Project Review, (Jan 2024).

29 Latin America and the Caribbean (LAC) government representation posed a specific challenge. Due to difficulties in identifying a current government official able to engage, USAID colleagues suggested a former government representative (ex-Head of Costa Rica's social security fund), who was chosen for his extensive experience and expertise.

30 Multiple KIIs from different stakeholder groups confirmed this point (external financing partners, Southern-based CSOs, LMIC, GHI Secretariat, Northern-based CSOs).

PHC) while limiting broader engagement with other key stakeholders, such as Ministries of Finance, which play a crucial role in shaping policy and funding decisions.

The strategic decision not to include GHI Secretariats in the SG was widely viewed as necessary to ensure that the agenda remained ambitious, country-driven and free from undue influence by institutions that were also major funders. This allowed for open discussions without the risk of self-censorship from participants who relied on GHIs for funding. GHI Board members – rather than Secretariats – were included in the SG, with the expectation that they would serve as the primary channel for building consensus and driving change. Later on, GHI Secretariats were included in the extended CTT but their early distancing from the FGHI process created frustration, causing some GHIs to perceive FGHI as adversarial rather than collaborative. Ultimately, the approach reflected a delicate trade-off between ensuring independence in agenda-setting and securing the necessary buy-in for FGHI solutions.

Finding 1.12. Task Teams were established as focused technical platforms, with varying levels of integration with the SG. The Research and Learning Task Team (RLTT) and Commitments Task Team (CTT) were established as temporary, task-specific sub-groups, composed of experts working towards defined deliverables. Each Task Team was led by an appointed representative of the SG co-chairs, ensuring structured coordination with the SG and FGHI Secretariat. Members of the SG and Task Teams were expected to be drawn from different stakeholder groups aligned with FGHI objectives, that is, HIC and LMIC governments, CSOs, global and regional health organisations and researchers and academic experts (both HIC and LMIC).

These teams had strengths, including tightly defined technical mandates, purpose and objectives and timelines,[31] and greater participation of working-level technical experts who might have been excluded from the SG (see Figures 1–3). However, opinions varied on their value. The CTT, described as the *'powerhouse'* was widely praised for its outputs, benefiting from co-chairs (Gerald Manthalu, Director of Planning and Policy, Ministry of Health, Malawi; and Jo Scott Nicholls and Anna Seymour, Senior Health Advisors, Foreign, Commonwealth and Development Office [FCDO], UK), dedicated staff time from FCDO and Wellcome, and broader inclusivity, notably from some GHIs (Global Fund, Gavi, GFF). For the RLTT, while Wellcome's role as a neutral convenor and facilitator of research was acknowledged, it was uncertain how insights from different pieces of research that were discussed in the RLTT were used to inform FGHI, or to balance/complement the findings of the main research piece. This raised questions about the utility of this aspect of the RLTT and the broader integration of Task Team efforts with the SG.

Box 4. Implications for ToC assumptions

Based on the findings described in the previous section, the team considered implications for assumptions underpinning the ToC (Annex 1). **Assumption 1** states that if the tactics and activities of the FGHI process are implemented as intended, then an evidence-based consensus will be achieved that the global health ecosystem – including GHIs – is failing to support equity, sustainability and system strengthening, and that collective action is necessary to address these problems. The evidence suggests that the assumption **partially holds.** The findings indicate that there was broad consensus on the need to address the systemic challenges that are failing to support equity, sustainability and system strengthening. However, the consensus on the need for reform that targets GHIs alone did not extend to all stakeholders, with arguments made to include global health actors involved in health financing and HSS. Furthermore, there were significant differences of opinion on the problem that needed to be

[31] FGHI CTT – Terms of Reference; FGHI RLTT – Terms of Reference.

addressed, and the scope and scale of reform required to tackle the problem. These issues and the lack of consensus on the problem went on to influence the policy and political streams through the nature of the policy solutions finally arrived at and the extent to which collective action really addressed the systemic issues first envisaged at the start of the process.

5.2. To what extent did FGHI implement its activities in the right ways?

In this section, we use the FGHI timeline (Figure 4) to examine the extent to which FGHI implemented its activities in the right ways (Module 2) and answer EQ3, EQ4 and EQ5 (Box 5). In Section 5.2.1, we present findings on the implementation and efficiency of FGHI and in 5.2.2, we examine equity, collaboration, voice and inclusivity of the FGHI process. At the end of the section, we reflect on implications for the assumptions underpinning the ToC (Box 6).

Box 5. Relevant EQs

EQ3: Was the FGHI process designed to maximise the chances of achieving the best outcomes?

EQ4: To what extent and how are the activities/key events of the FGHI process implemented in an efficient, collaborative and inclusive manner?

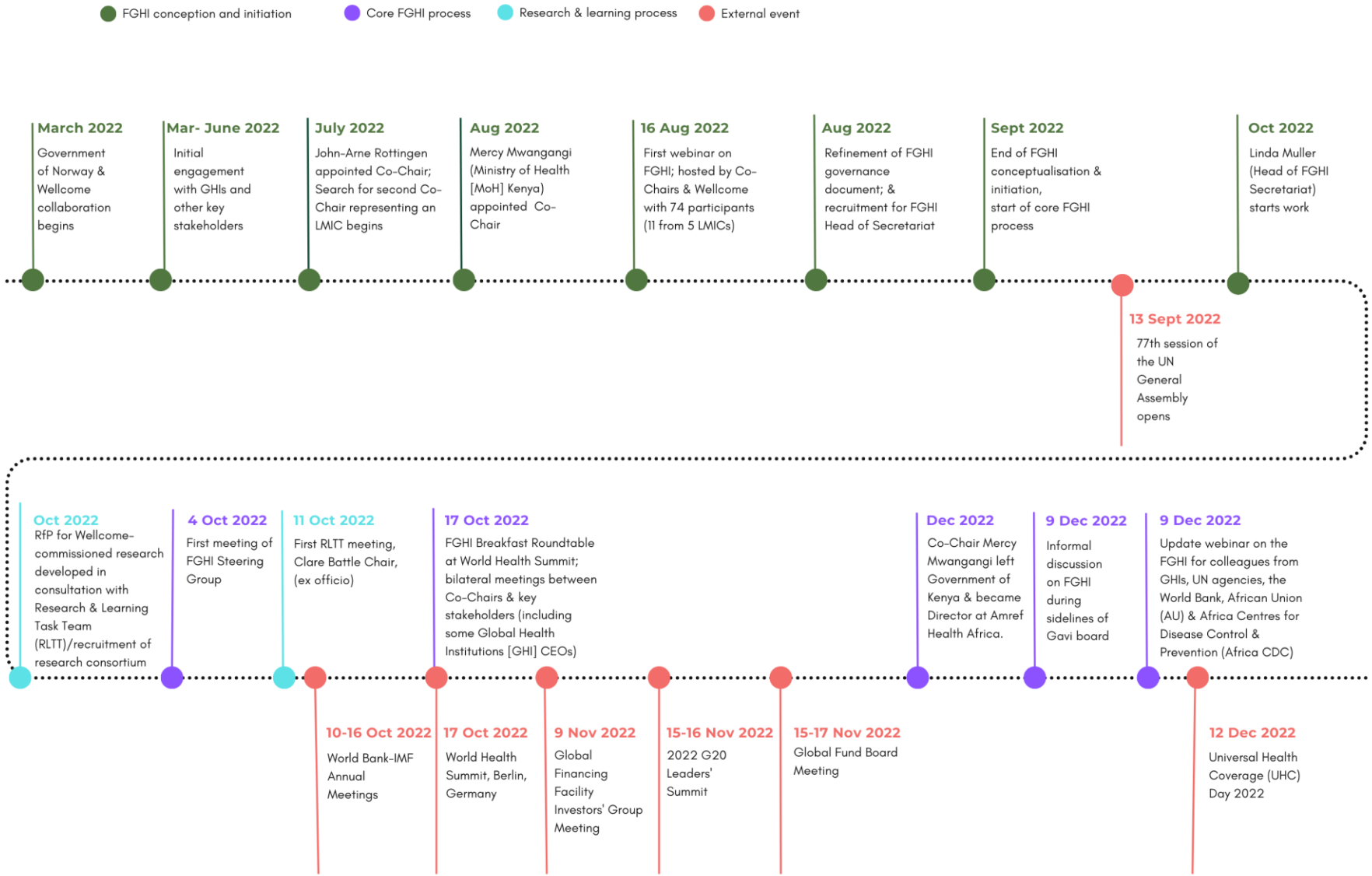
EQ5: How well did the FGHI governance and related structure work in practice?

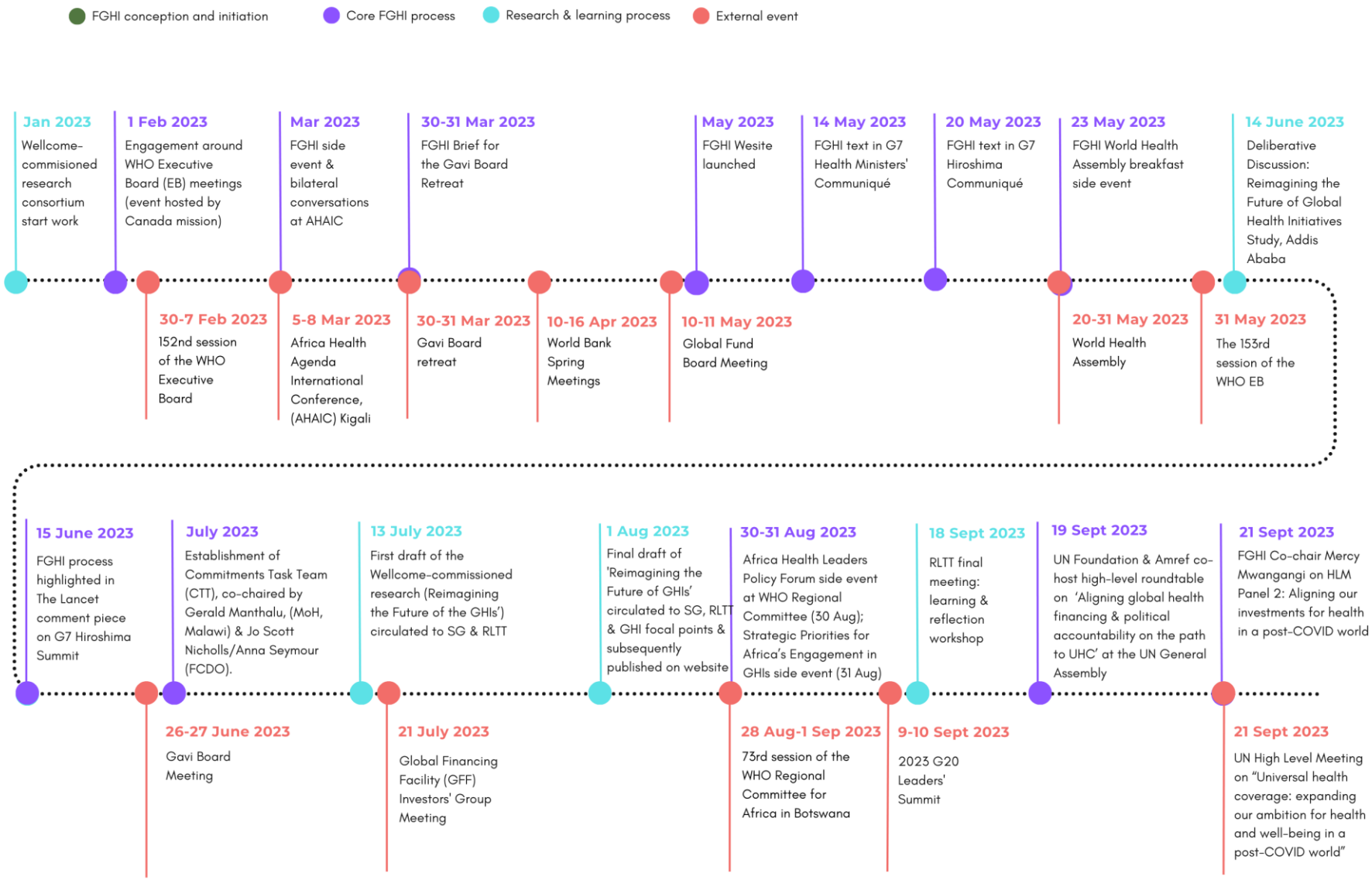
The timeline in Figure 4 was developed by the evaluation team to understand the working methods and tactics employed during the FGHI implementation phase and how these contributed to the achievement of the FGHI objectives. The timeline is not fully comprehensive but sets out key elements of the FGHI process (for example, it includes the starting point of the FGHI SG and both Task Teams but not every meeting held or all their outreach activities). Activities that are specific to FGHI appear above the line, with wider global health events appearing below. Events have been categorised according to the following system:

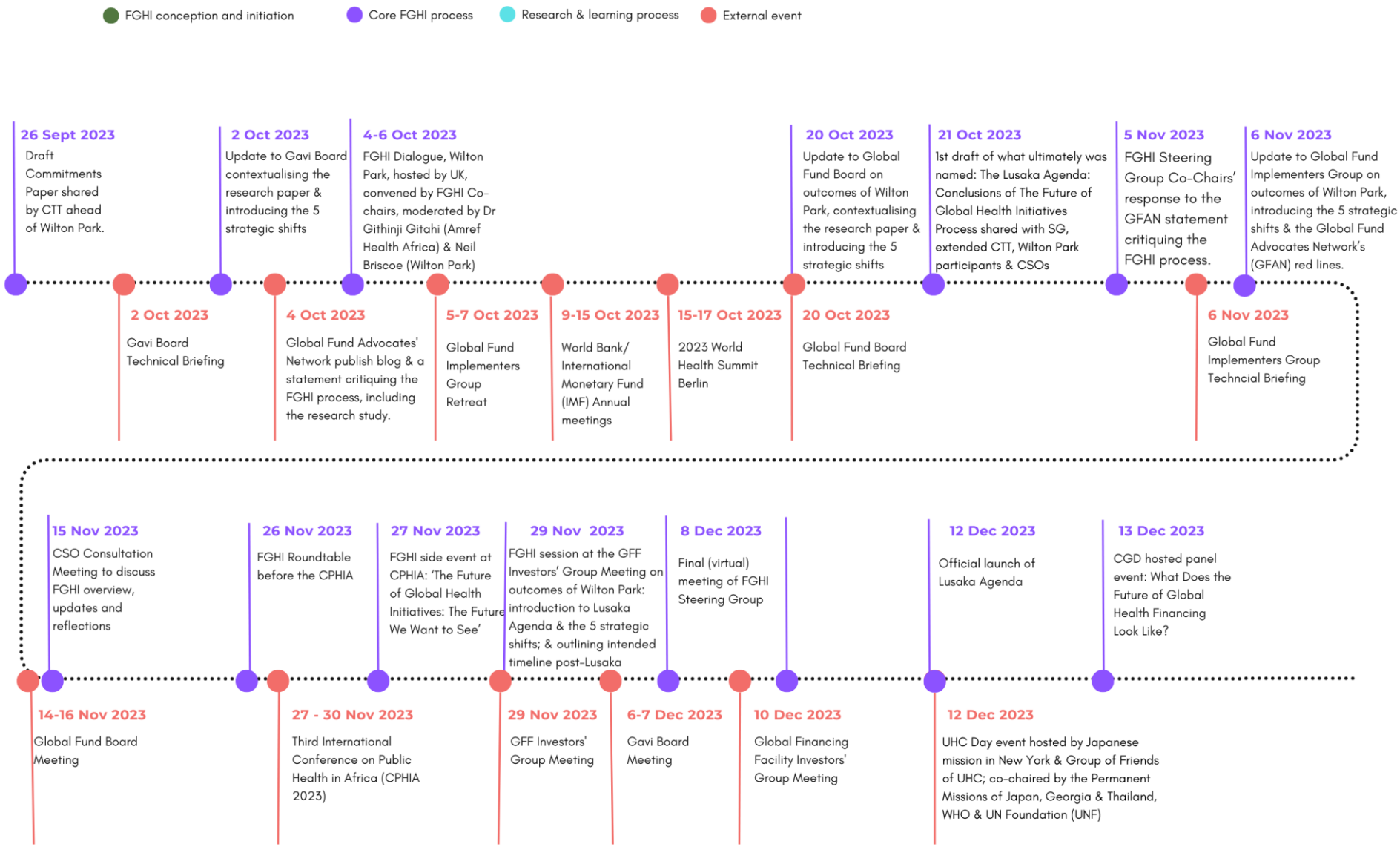
- Green (FGHI conception and initiation events)
- Purple (events relating to the core FGHI process)
- Blue (events relating to the research and learning process)
- Red (external Board, UN or other events related to global health).

The top line of the timeline refers to the conceptualisation/initiation of FGHI that took place between November 2021 and September 2022. Thereafter, the timeline refers to the implementation phase, from September 2022 to December 2023.

Figure 4. Timeline




FGHI conception and initiation
Core FGHI process
Research & learning process
External event
Jan 2023
Wellcome-commisioned research consortium start work
1 Feb 2023
Engagement around WHO Executive Board (EB) meetings (event hosted by Canada mission)
30-7 Feb 2023
152nd session of the WHO Executive Board
Mar 2023
FGHI side event & bilateral conversations at AHAIC
5-8 Mar 2023
Africa Health Agenda International Conference, (AHAIC) Kigali
30-31 Mar 2023
FGHI Brief for the Gavi Board Retreat
30-31 Mar 2023
Gavi Board retreat
10-16 Apr 2023
World Bank Spring Meetings
May 2023
FGHI Wesite launched
10-11 May 2023
Global Fund Board Meeting
14 May 2023
FGHI text in G7 Health Ministers' Communiqué
20 May 2023
FGHI text in G7 Hiroshima Communiqué
23 May 2023
FGHI World Health Assembly breakfast side event
20-31 May 2023
World Health Assembly
14 June 2023
Deliberative Discussion: Reimagining the Future of Global Health Initiatives Study, Addis Ababa
31 May 2023
The 153rd session of the WHO EB
15 June 2023
FGHI process highlighted in The Lancet comment piece on G7 Hiroshima Summit
July 2023
Establishment of Commitments Task Team (CTT), co-chaired by Gerald Manthalu, (MoH, Malawi) & Jo Scott Nicholls/Anna Seymour (FCDO).
26-27 June 2023
Gavi Board Meeting
13 July 2023
First draft of the Wellcome-commissioned research (Reimagining the Future of the GHIs') circulated to SG & RLTT
21 July 2023
Global Financing Facility (GFF) Investors' Group Meeting
1 Aug 2023
Final draft of 'Reimagining the Future of GHIs' circulated to SG, RLTT & GHI focal points & subsequently published on website
30-31 Aug 2023
Africa Health Leaders Policy Forum side event at WHO Regional Committee (30 Aug); Strategic Priorities for Africa's Engagement in GHIs side event (31 Aug)
28 Aug-1 Sep 2023
73rd session of the WHO Regional Committee for Africa in Botswana
18 Sept 2023
RLTT final meeting: learning & reflection workshop
9-10 Sept 2023
2023 G20 Leaders' Summit
19 Sept 2023
UN Foundation & Amref co-host high-level roundtable on 'Aligning global health financing & political accountability on the path to UHC' at the UN General Assembly
21 Sept 2023
FGHI Co-chair Mercy Mwangangi on HLM Panel 2: Aligning our investments for health in a post-COVID world
21 Sept 2023
UN High Level Meeting on "Universal health coverage: expanding our ambition for health and well-being in a post-COVID world"


FGHI conception and initiation
Core FGHI process
Research & learning process
External event
26 Sept 2023
Draft Commitments Paper shared by CTT ahead of Wilton Park.
2 Oct 2023
Update to Gavi Board contextualising the research paper & introducing the 5 strategic shifts
4-6 Oct 2023
FGHI Dialogue, Wilton Park, hosted by UK, convened by FGHI Co-chairs, moderated by Dr Githinji Gitahi (Amref Health Africa) & Neil Briscoe (Wilton Park)
20 Oct 2023
Update to Global Fund Board on outcomes of Wilton Park, contextualising the research paper & introducing the 5 strategic shifts
21 Oct 2023
1st draft of what ultimately was named: The Lusaka Agenda: Conclusions of The Future of Global Health Initiatives Process shared with SG, extended CTT, Wilton Park participants & CSOs
5 Nov 2023
FGHI Steering Group Co-Chairs' response to the GFAN statement critiquing the FGHI process.
6 Nov 2023
Update to Global Fund Implementers Group on outcomes of Wilton Park, introducing the 5 strategic shifts & the Global Fund Advocates Network's (GFAN) red lines.
2 Oct 2023
Gavi Board Technical Briefing
4 Oct 2023
Global Fund Advocates' Network publish blog & a statement critiquing the FGHI process, including the research study.
5-7 Oct 2023
Global Fund Implementers Group Retreat
9-15 Oct 2023
World Bank/ International Monetary Fund (IMF) Annual meetings
15-17 Oct 2023
2023 World Health Summit Berlin
20 Oct 2023
Global Fund Board Technical Briefing
6 Nov 2023
Global Fund Implementers Group Techncial Briefing
15 Nov 2023
CSO Consultation Meeting to discuss FGHI overview, updates and reflections
26 Nov 2023
FGHI Roundtable before the CPHIA
27 Nov 2023
FGHI side event at CPHIA: 'The Future of Global Health Initiatives: The Future We Want to See'
29 Nov 2023
FGHI session at the GFF Investors' Group Meeting on outcomes of Wilton Park: introduction to Lusaka Agenda & the 5 strategic shifts; & outlining intended timeline post-Lusaka
8 Dec 2023
Final (virtual) meeting of FGHI Steering Group
12 Dec 2023
Official launch of Lusaka Agenda
13 Dec 2023
CGD hosted panel event: What Does the Future of Global Health Financing Look Like?
14-16 Nov 2023
Global Fund Board Meeting
27 - 30 Nov 2023
Third International Conference on Public Health in Africa (CPHIA 2023)
29 Nov 2023
GFF Investors' Group Meeting
6-7 Dec 2023
Gavi Board Meeting
10 Dec 2023
Global Financing Facility Investors' Group Meeting
12 Dec 2023
UHC Day event hosted by Japanese mission in New York & Group of Friends of UHC; co-chaired by the Permanent Missions of Japan, Georgia & Thailand, WHO & UN Foundation (UNF)

5.2.1. Implementation and efficiency of the FGHI

Table 4. Key findings on implementation and efficiency of the FGHI

#	Findings	Strength of evidence
2.01	FGHI's structured timeline facilitated progress but also led to trade-offs in research quality and endorsement and advocacy for the Lusaka Agenda.	1
2.02	While the research aimed to provide rapid, evidence-based analysis to inform the process, this approach involved trade-offs in terms of analytical depth and rigour.	1
2.03	Implementation of the core FGHI process was marked by a series of key moments and strategic steps that drove progress forward.	1

Finding 2.01. GHIs' structured timeline facilitated progress but also led to trade-offs in research quality and endorsement and advocacy for the Lusaka Agenda. The FGHI process unfolded in distinct phases and workstreams: conceptualisation/initiation discussions (March–September 2022), FGHI research and evidence generation (January–August 2023) and coalition and consensus-building on policy solutions through to the drafting of the Lusaka Agenda (September–December 2023).

An analysis of the timeline reveals an uneven distribution of activity, with periods of slower FGHI engagement interspersed by intense bursts of work. The early conceptualisation/initiation phase was relatively prolonged, reflecting the time needed to engage a broad range of stakeholders – including LMICs and CSOs – and to establish the SG, RLTT and FGHI Secretariat. Core FGHI activity began in late 2022, with the first SG meeting in October and continued coalition building through side meetings (e.g., at the Gavi Board meeting in December 2022) and webinars. In a separate workstream, the Wellcome-commissioned research began in January 2023, with initial findings shared in April 2023 in Addis Ababa and draft and final papers in July-August 2023.

The most concentrated period of work took place between July and December 2023, when multiple critical activities were accelerated within a short window: finalising and disseminating research findings; establishing the CTT and developing the Commitments Paper; convening the Wilton Park Dialogue to build consensus on policy solutions (the Five Shifts); socialising the Five Shifts through wider GHI stakeholder meetings; drafting and agreeing the Lusaka Agenda.

The compressed timeline brought both advantages and drawbacks. On the positive side, FGHI's time-bound approach was widely reported as efficient in driving results, with deadlines seen as crucial for political engagement and key informants emphasising the risk of open-ended processes without results. However, the uneven pacing of the process created pressure points with compromises in terms of depth of quality of outputs. The most significant impact of the time-bound nature of FGHI emerged in the final phase of the process, where the rush to conclude created challenges with formal institutional endorsement processes and limited the effectiveness of SG members championing and promoting the agenda. A critical gap was the absence of a clear exit strategy and sustainability plan following Wellcome's planned withdrawal of support at the end of 2023. Multiple stakeholders highlighted concerns that the process ended too soon and without a longer-term plan to support implementation.

'The timeline was important as it made us work faster and probably more efficiently than we would have done if we just went on and on… but we need another year so we can articulate and define the Lusaka Agenda better.' **(KII, LMIC CSO)**

'The pace between bringing the Steering Group work to a close and wanting to morph it into the [Lusaka] Agenda, and then get political endorsement, all in two months after the process has taken nearly two years, is hard. There should have been more time to get comfortable with the agenda and orient others to champion it. I think they missed an opportunity to do that just because there wasn't enough time. If there was more time, we [donor] might have endorsed it, having had time to wade through the bureaucracy of government.' **(KII, HIC financing partner)**

Finding 2.02. While the research aimed to provide rapid, evidence-based analysis to inform the process, this approach involved trade-offs in terms of analytical depth and rigour. The Research and Learning timeline can be seen in Figure 4 and is set out below. The accelerated timeline enabled timely insights that drove momentum but came at the expense of depth and comprehensiveness of analysis. A longer, more rigorous study might have addressed these concerns and enabled deeper engagement with stakeholders, potentially enhancing credibility and navigating complex power dynamics but risked losing the timeliness and relevance necessary to influence ongoing debates.

- **Deliberative Discussion on the *Reimagining the Future of Global Health Initiatives* Study (14 June 2023, Addis Ababa).** Organised by the research consortium,[32] in collaboration with the Africa CDC, this meeting served two purposes: to provide a platform to share and gather feedback on preliminary findings of the *Reimagining the Future of Global Health Initiatives* research study; and as an additional data collection opportunity, where stakeholders could provide inputs on the research questions. This fulfilled the RLTT's intention to stimulate discussion of the GHI ecosystem by fostering open, technical deliberation on country experiences with GHI business models. While separate from the core FGHI process, the initial set of independent recommendations from the research aimed to inform the deliberations of the FGHI partners and the ongoing process. Details on stakeholder participation at the Addis consultation are provided in the spider diagram in Figure 5. Key observations include: the exclusion of the GHIs themselves from this meeting; significant representation from HIC-based organisations; and the inclusion of African regional organisations and LMIC government representatives. Notably, there was broad stakeholder consensus on the preliminary findings from the research, which resonated with LMIC government experiences of GHIs. However, there was no clear alignment around the specific problem to be addressed or the solutions, and while some reforms were discussed, a clear set of recommendations was not arrived at.

  'The research report was written as a straw man and that got a lot of people talking/caught people's attention.' **(KII, UN)**

- ***Reimagining the Future of Global Health Initiatives* publication (July-August 2023).** In contrast to the positive feedback from LMICs during the Addis consultation, the dissemination of the *Reimagining the Future of Global Health Initiatives Study* in mid-July (first draft) and early August 2023 (final draft) received significant pushback from some stakeholders, most prominently from the GHIs themselves (the Global Fund, Gavi and Unitaid), CS networks (such as GFAN, which issued CSO 'red-lines' against FGHI, and Unitaid's NGO and communities delegation), and certain financing partners, including the Gates Foundation.

[32] Geneva Centre of Humanitarian Studies, University of Geneva (Switzerland), Queen Margaret University Edinburgh (Scotland), Aga Khan University (International) in the UK, Cheikh Anta Diop University (Senegal), Stellenbosch University (South Africa) .

Much of this criticism appears to reflect the political economy of GHIs, where powerful institutional interests, with better resources and established mechanisms shaped perceptions of the report's credibility.[33] While some pushback was driven by stakeholders with vested interests, other observers – including those more neutral or sympathetic to the report's objectives – also raised concerns about the report's scope, analysis and findings. Specific criticisms related to the lack of rigorous evidence-based analysis, including what they viewed as inadequate examination of the benefits and drawbacks of GHIs and their results. Additionally, there was criticism regarding the limited analysis of the broader global health landscape and limited engagement with GHI internal audits and evaluations, which could have offered more comprehensive insights into their operating models. Despite these criticisms, the research served as an important 'provocation paper' that stimulated conversations about needed changes in the global health ecosystem. It also effectively articulated LMIC challenges with existing GHI arrangements, with several LMIC informants indicating that the study was important in pulling together recent country evidence and laying the foundations for subsequent consensus towards the Lusaka Agenda via the Five Shifts. Overall, maintaining an evidence-based research-focus as a key approach for FGHI, both through this piece of work and through the work of the RTTL, was appreciated by a wide set of stakeholders.[34]

'Good research that provided good ideas and starting point. The research was complemented by additional studies, including one commissioned by NORAD about progressing from Lusaka Agenda and projecting into the future.' **(KII, LMIC government)**

Finding 2.03. Implementation of the core FGHI process was marked by a series of key moments and strategic steps that drove progress forward. An analysis of the timeline and evaluation evidence indicates that several key moments and strategic steps influenced the core FGHI progress that overlapped with and continued after the Research and Learning process. These are detailed below and in the spider diagrams and accompanying text.

- **Draft of the *Commitments Paper* (September 2023).** The CTT was established in July 2023 (see Figure 3) to provide technical support to develop a set of commitments for collective action. Reflecting resistance to the research report, the CTT developed a new background paper (the *Commitments Paper*) through an iterative process, that was better received and more focused on consensus building around solutions (known subsequently as the 'Five Shifts'). While its development was overseen by the CTT, in reality the paper was drafted by a small group of FGHI stakeholders, largely from HICs. The original research findings were important in identifying the Five Shifts that became central to FGHI, although the way these were eventually incorporated into the Lusaka Agenda were quite different and reportedly 'blander' than the original research recommendations.[35] The development of the Five Shifts was widely viewed as marking a new phase in the FGHI process, with a move away from the original agenda of systemic reform and the rebalancing of power, towards pragmatic

[33] Evidence from Written responses to Reimagining the FGHIs (undated, from FGHI website); GFAN Urgent Action Sign on the CSO red-lines on the FGHI (undated, available on FGHI website); KIIs with multiple stakeholder groups including GHIs, research consortium, HIC CSOs, HIC and LMIC.

[34] Evidenced by multiple KIIs (Global North governments, Global South governments, Wellcome Trust, philanthropic foundations, Global South CSOs/networks, GHI Secretariat staff).

[35] KIIs with HIC, Research Consortium, WT, GHIs.

solutions that focused on shorter-term actions that would be easier for GHIs to comply with.[36]

- **UN General Assembly (UNGA) high level meeting (HLM) on UHC, Panel 2: *Aligning our investments for health in a post-COVID world* (21 September 2023, New York).**[37] This meeting, where FGHI ex-co-chair (Mercy Mwangangi) was a panel member, emerged as a crucial point for building political support for FGHI and in driving forward an AU decision on the Lusaka Agenda.[38] At this forum, direct dialogue between African Ministers of Health and GHIs amplified implementing countries' experiences and viewpoints on the urgency of reform.

  'The meeting had eight African Ministers present, but we need more of these meetings with more ministers. Because they had been briefed about the FGHI process, they backed it up, providing rationale and country experience and underscored the importance of this FGHI process.' **(KII, LMIC Regional Organisation)**

- **Wilton Park Dialogue (4-6 October 2023, UK).**[39] The Wilton Park Dialogue was a critical milestone in the FGHI process, widely regarded by interviewees as well-timed and instrumental in advancing discussions. The meeting played a pivotal role in securing agreement around the Five Shifts and moving FGHI to the final stage: the drafting of what became the Lusaka Agenda. It was successful in bringing together higher-level stakeholders, including GHI CEOs/Directors, whose presence was essential for gaining agreement on the Five Shifts. However, concerns were raised about stakeholder representation at Wilton Park, particularly regarding the limited participation from the LMIC governments and CSOs, which was seen as disappointing[40] (see Figure 6) and insufficient time to resolve major emerging issues, despite the extended format of the meeting.[41]

- **FGHI Lusaka Consultation Meeting (26 November 2023, Lusaka – ahead of the 3rd Conference on Public Health in Africa (CPHIA)).**[42] This roundtable consultation was co-chaired by John-Arne Røttingen, FGHI co-chair and Desta Lakew, FGHI SG member, and aimed to finalise the FGHI *Commitments Paper* ahead of its launch on UHC Day (12 December 2023). The meeting was scheduled in advance of the main CPHIA event, taking advantage of the opportunity to secure input from African stakeholders in attendance. The meeting was also attended by the Minister for Health, Ethiopia, alongside participants from other ministries of health, CSOs, and global and regional health organisations. The Lusaka Consultation was noted as a significant milestone through allowing Africa-led discussions to drive towards a subsequent AU political declaration.[43] While the meeting location led to the rebranding of the *Commitments Paper* as the 'Lusaka Agenda', several informants noted that

[36] KIIs with multiple stakeholders (HIC financing partners, UN, Research Consortium, Wellcome Board, GHI).

[37] UNGA 2023 – The Future of Global Initiatives process at the UN General Assembly (futureofghis.org); Opening Statement of Ghana's Minister for Health at the FGHI UNGA event.

[38] KIIs with multiple stakeholders (UN, HIC financing partners, LMIC governments, LMIC CSO, Wellcome Secretariat).

[39] Wilton Park Meeting Report, 2023.

[40] KIIs with multiple stakeholders (Wellcome Trust, LMIC CSO, GHI).

[41] KIIs with multiple stakeholders (GHI, HIC CSO, LMIC government).

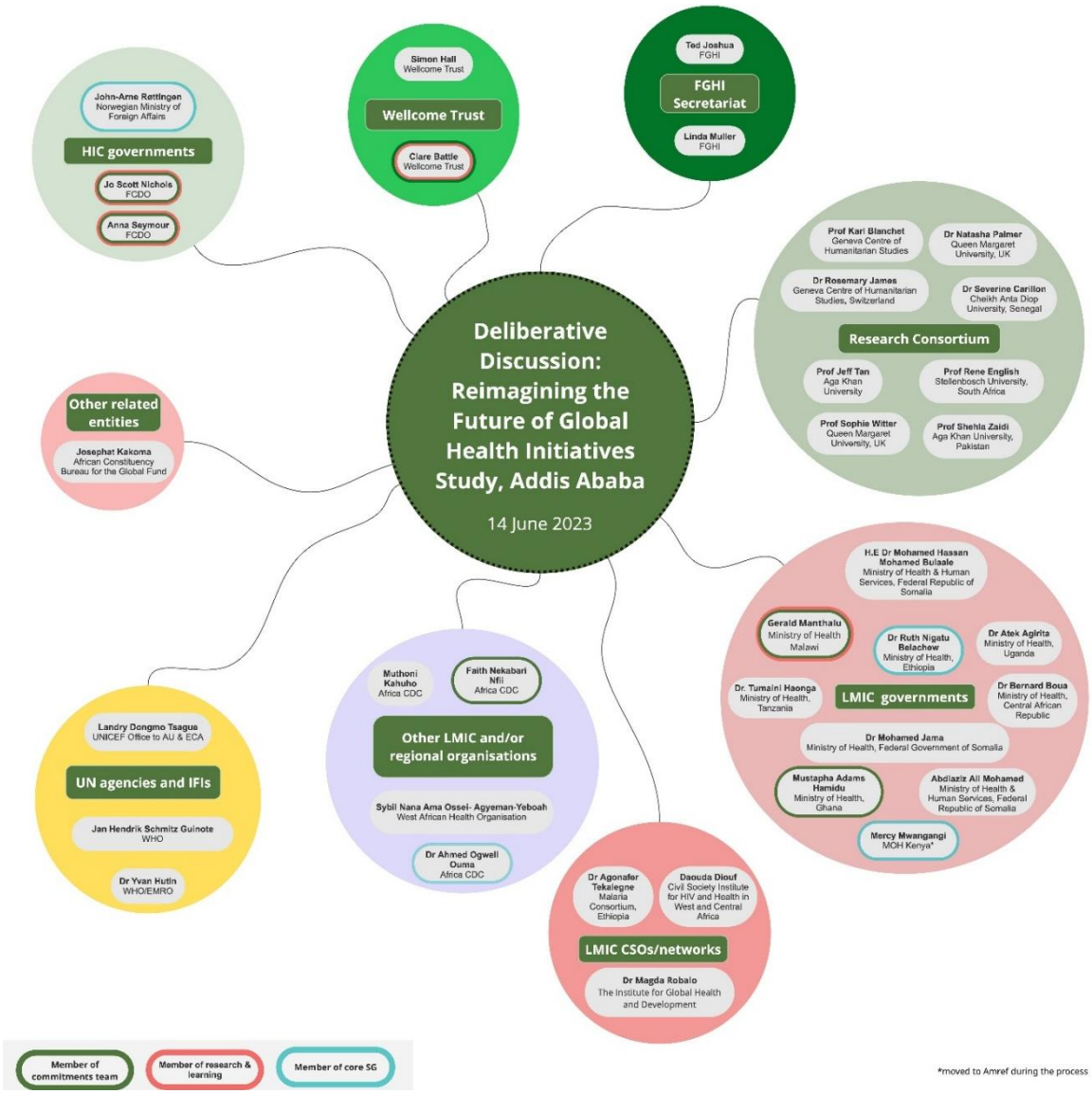
[42] 3rd CPHIA, November 2023.

[43] Following the Lusaka Consultation, and the subsequent launch of the Lusaka Agenda, the AU Champion on COVID-!9, H.E Cyril Ramaphosa, was briefed on the Lusaka Agenda ahead of the 37th Ordinary Session of the Assembly of the Africa Union in February 2024. During Session, Ramaphosa recommended to the AU Heads of State and Government to adopt the Lusaka Agenda, tasking the Africa CDC to host the Secretariat. The decision can be found online here: https://d2nhv1us8wflpq.cloudfront.net/prod/uploads/2024/09/44015-ASSEMBLY_AU_DEC_866_-_902_XXXVII_E.pdf (Accessed 27 March 2025).

it lacked sufficient depth and senior leadership presence to challenge the status quo more effectively.

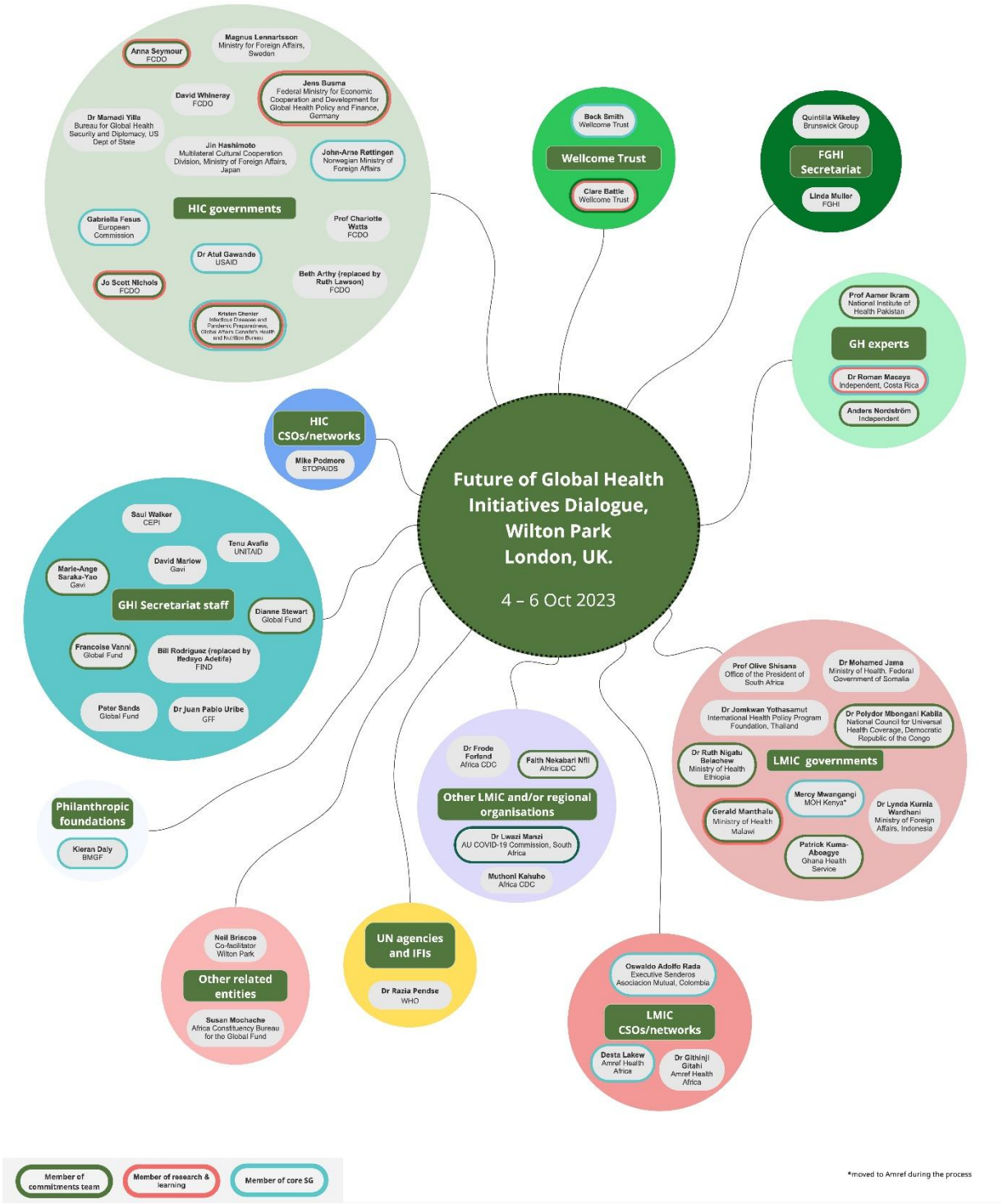
'It was misleading to call it Lusaka Agenda since it never originated from Africa and was never discussed in Africa. It is more about getting African validation than genuine consultation. The brief duration of the Lusaka Consultation at Conference on Public Health in Africa (CPHIA) –only a few hours in the afternoon – and lack of sufficient senior leadership presence limited its effectiveness in final consensus building.' **(KII, LMIC CSO representative)**

Figure 5. Stakeholders involved in Deliberative Discussion: Reimagining the Future of Global Health Initiatives Study, Addis Ababa



- The Addis Ababa meeting, organised by the Wellcome-commissioned Research Consortium and hosted under the AU, served to build consensus based on preliminary findings from the FGHI research 'Reimagining the Future of GHIs', which was intended to inform FGHI policy solutions. The meeting brought together diverse stakeholders, notably research consortia members, LMIC government representatives, Wellcome Trust, FGHI Secretariat and UN agencies. Some attendees were SG members, RLTT members or later joined the CTT. A notable shift was the stronger presence of regional organisations such as Africa CDC and the AU, alongside increased African LMIC government representation (nine in total). These groups largely supported the report's emerging messages. GHIs were not included in this meeting, which may have led some – such as the Global Fund – to take a defensive, critical stance, evidenced through written responses and sign-on actions.
- Virtual attendees included: Dr Parfait Uwaliraye, Ministry of Health, Rwanda; Oswaldo Adolfo Rada Londoño, Senderos Asociación Mutual, Colombia; Sue Graves, Bill & Melinda Gates Foundation; Dr Yap Boum, Institut Pasteur de Bangui, Central African Republic; Stephanie Hueng, Clinton Health Access Initiative; Radhika Khanna, Hexter UHC, Malaria Consortium; Mark Blecher, National Treasury, South Africa; Alex Harris, Wellcome Trust; Tom Harrison, Wellcome Trust; Dr Mandeep Dhaliwal, United Nations Development Programme; Dr Jean Marie Masumbuko, Independent consultant; Jin Hashimoto, Ministry of Foreign Affairs, Japan; Hajime Inoue, World Bank and Global Fund Board Member; Prof Yogan Pillay, Stellenbosch University & Gates South Africa; and Thulani Masilela Department of Planning, Monitoring and Evaluation, South Africa.

Figure 6. Stakeholders involved in Wilton Park



- The Wilton Park conference was a pivotal moment in the FGHI process, bringing together a broad range of stakeholders. Figure 6 reflects a diverse mix, with notable shifts in representation, including participation from all six GHIs and both HIC and LMIC CSOs/networks.
- HIC governments and philanthropic foundations – such as UK FCDO, European Commission, France, Canada, Sweden and the Gates Foundation – remained strongly represented, indicating continued influence on agenda-setting and decision-making.
- LMIC governments from Africa and Asia were present but fewer than at the Addis meeting. A key shift was the strong presence of more senior-level decision-makers, including GHI CEOs/Directors, enabling GHIs to exert influence over the FGHI trajectory at this critical point.

Figure 7. Stakeholders involved in Lusaka

- Similar to Wilton Park, the Lusaka meeting brought together a diverse range of stakeholders but with some key differences. Figure 7 features fewer high-level HIC government and philanthropic representatives but increased inclusion and representation from African regional organisations and CSOs.
- LMIC government representation was similar to Wilton Park, suggesting a shift towards greater engagement with African-led institutions and decision-makers, and reinforcing efforts to ensure regional leadership in the commitments and implementation processes. This tallies with observations on power shifts from FGHI conceptualisation to the end of the FGHI process where the early stages were dominated by HIC financing partners, and the mid–later stages (Wilton Park and Lusaka meeting) expanded stakeholder groups, bringing more implementing country voices into discussions, though HIC influence remained high.
- Virtual attendees included: Dr Polydor Kabila, Democratic Republic of the Congo; Dr Patrick Kuma-Aboagye, Ghana Health Service; Lynda Wardhani, Ministry of Foreign Affairs, Indonesia; Ryuichi Komatsu, Japan; Professor Aamer Ikram, Pakistan; Hajime Inoue, World Bank; and Dr Susan Sparkes, WHO.

Equity, collaboration, voice and inclusivity of the FGHI process

Table 5. Key findings on equity, collaboration, voice and inclusivity of the FGHI process

#	Findings	Strength of evidence
2.04	Informal selection processes enabled diverse participation but power imbalances hampered meaningful engagement of some LMIC stakeholders.	1
2.05	Amongst HICs there was varied engagement, which weakened their ability to push for change.	2
2.06	During implementation, FGHI partners missed opportunities to address specific problems in the global health architecture.	1
2.07	The FGHI Secretariat played a strong operational role, with some limitations.	1

Finding 2.04. Informal selection processes enabled diverse participation but power imbalances hampered meaningful engagement of some LMIC stakeholders. While deliberate efforts were made to include LMIC governments and, to some extent, CSOs, issues of representation and power imbalances affected meaningful participation. LMIC participants noted that their involvement in the FGHI process often occurred through individuals rather than institutions or official nominations, which limited their ability to represent their constituencies fully and affected their decision-making and accountability to their organisations or constituencies. HIC participants had inherent advantages in terms of resources, English language proficiency and informal influence.[44] This disparity was evident in the support systems available to different representatives, with some LMIC government and CSO respondents highlighting how limited resources and institutional support affected their preparation, attendance and ability to participate effectively.[45] Although their inclusion brought valuable lived experiences to the dialogue, it left them in a weaker position compared to HIC stakeholders, who typically represented their governments or organisations and had the necessary resources to participate more effectively.

Finding 2.05. Amongst HICs there was varied engagement, which weakened their ability to push for change. At the highest political level, there was notable buy-in from a sub-set of HICs, with Norway, the UK and Canada consistently driving the FGHI process through their interventions, with support from others such as Japan. Other HICs, such as France, were absent from FGHI discussions and, in the case of the US, a special engagement strategy was negotiated through USAID, enabling Atul Gawande to participate in discussions. Stakeholders reported a lack of unified engagement among HIC partners, which affected their ability to push for more substantial changes to GHIs.[46]

'Overall, they didn't come together as a group and didn't align on how much to push for change and the level of change. They didn't work together and had split internal incentives.' **(KII, Research Consortium)**

Finding 2.06. During implementation, FGHI partners missed opportunities to address specific problems in the global health architecture. Two particular examples of opportunities that were missed included: the launch of a new Pandemic Fund, hosted at the World Bank, which was an example of a new initiative running counter to efforts to reduce fragmentation in the health architecture; and, by contrast, the withdrawal of resources from FIND – one of the six GHIs

[44] KIIs with WT, HIC, GHI, LMIC government.

[45] KIIs, as above.

[46] KIIs with UN, Research Consortium, GHIs.

included in FGHI – during the FGHI timeline, after a major governance restructuring. Despite widespread agreement on the necessity of its purpose and importance of providing funding for its functions, FIND was severely streamlined, its functions were not absorbed elsewhere in the architecture and future resources were not secured.

Finding 2.07. The FGHI Secretariat played a strong operational role, with some limitations. Established in October 2022 to support the SG co-chairs and Task Teams, the FGHI Secretariat emerged as one of the most critical and effective components of the FGHI process. Even though Wellcome funded the Secretariat, it was allowed to work independently, which was positively viewed, with Wellcome credited for making sure the Secretariat was in place.

Box 6. Implications for ToC assumptions

Based on the findings, the team considered the implications for the relevant assumptions underpinning the ToC (Annex 1). **Assumption 2:** if the tactics and activities of the FGHI process are implemented as intended, then an evidence-based consensus will be achieved that the global health ecosystem – including GHIs – is failing to support equity, sustainability and system strengthening, and that collective action is necessary to address these problems. **Assumption 3:** if the tactics and activities of the FGHI process are implemented as intended, then actionable policy solutions will be generated for stakeholders to consider and agree, influenced by policy entrepreneurs in building consensus around their acceptability, technical feasibility and likely risks, constraints or unintended consequences. **Assumption 4:** if the tactics and activities of the FGHI process are implemented as intended, then the interests of all stakeholders (HIC, LMIC, LIC) will be recognised, key interest groups will align with them and those with the most to gain from reform will have the influence and the power to drive change.

Evidence suggests that the above assumptions hold to some degree. The findings indicate that the assumptions hold to some degree but are challenged by structural issues and disparities in stakeholder engagement. **Assumption 2** partially holds as FGHI succeeded in establishing a structured timeline, facilitating discussions and generating consensus among some stakeholders. However, meaningful engagement from all parties was not achieved. The resistance from major GHIs and financing partners to the research findings highlighted difficulties in achieving broad, evidence-based consensus. **Assumption 3** partially holds, with the creation of actionable policy solutions through the Commitments Paper and the Five Shifts. However, GHI political economy and the adaptation of research findings to gain wider acceptance resulted in diluted recommendations. **Assumption 4** is the weakest of the three. While HIC stakeholders, particularly those actively involved in the process, had the influence and resources to drive the agenda, the engagement of LMIC stakeholders was often limited by informal selection processes, insufficient resources and power imbalances. The findings suggest that while alignment of interests was sought, true recognition and empowerment of all stakeholders were not fully achieved.

The Secretariat's strong operational role ensured key processes were coordinated, momentum was maintained, and logistical aspects – such as large-scale global events, meeting preparations and day-to-day operations – were efficiently managed. However, while the Secretariat had strengths in tactical short-term planning, gaps were reported in longer-term strategic thinking. Furthermore, stakeholder opinions on FGHI communications were mixed: the Secretariat was commended for maintaining a steady flow of information; but some stakeholders voiced concerns over the lack of proactive outreach and strategic engagement with key stakeholders such as GHIs and civil society organisations (CSOs), who were aware of FGHI but less involved in its processes.

5.3. Did FGHI deliver the right results?

In this section we examine the results that FGHI has achieved (Module 3) and answer EQ6 and EQ7 (Box 7). In Section 5.3.1, we focus on the results achieved through the FGHI up to December 2023 (when the Lusaka Agenda was published). In Section 5.3.2, we reflect on some of the longer-term outcomes, recognising that these were out of scope for this evaluation. Finally, we address the implications for the assumptions underpinning the ToC (Box 9).

Box 7. Relevant EQs

EQ6: Did the short-term outputs and outcomes of the FGHI process deliver on the three objectives?

EQ7: What do stakeholders perceive to be the prospects for the longer-term results of the FGHI process in relation to its original three objectives?

5.3.1. Results up to December 2023

Table 6. Key findings results

#	Findings	Strength of evidence
3.01	The original FGHI objectives were regarded as controversially bold in their reform proposals but over time became less ambitious, due to variable engagement and time constraints to reach agreement.	1
3.02	The Lusaka Agenda reconfirmed existing commitments but missed opportunities to advance the debate, in the face of changing donor priorities and GHI competition for resources.	1
3.03	FGHI achieved partial success in building consensus on key challenges and potential solutions.	1

Box 8. Evolution in FGHI objectives

Planned objectives for FGHI: At the outset, FGHI identified three high-level objectives:[47]

1. Global health initiatives are more efficient, effective and equitable in complementing and strengthening health system capacities and delivering health impacts.
2. Financing streams across GHIs – and between GHIs and the broader health architecture at national, regional and global levels – are better balanced and coordinated, with stronger mutual accountability for meeting current and future global health needs.
3. Global health initiatives incentivise increased and sustained domestic investments in health that are more efficiently, effectively and equitably allocated, implemented and accounted for to achieve UHC.

Lusaka Agenda Five Shifts agreed through FGHI: By the end of FGHI, the Lusaka Agenda recommended Five Shifts to shape the evolution of GHIs and the broader global health ecosystem:

1. Make a stronger contribution to PHC by effectively strengthening systems for health.
2. Play a catalytic role towards sustainable, domestic-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, R&D and regional manufacturing to address market and policy failures in global health.

Finding 3.01. The original, bold FGHI objectives and reform proposals received a mixed reaction but over time evolved into the less ambitious Lusaka Five Shifts, due to variable engagement and time constraints to reach agreement. FGHI's original, bold objectives were considered controversial due to the ambitious reform aims proposed, which were not adjusted to reflect what was feasible within FGHI's relatively short timeframe. As shown in Box 10, FGHI's objectives evolved from ambitious reform goals to five more modest shifts for change, formalised in the Lusaka Agenda of December 2023. This shift in ambition reflected the political economy of GHIs, which played out in consultative dialogue and engagement with FGHI stakeholders, including GHIs, who were more directly engaged later in the process. The most significant progress towards consensus was made during the three to four months leading up to the FGHI meeting in Lusaka in December 2023. The Wilton Park Dialogue in September 2023 saw a significant step change in the consensus-building process around the problems to be addressed but this progress came late in the day and the more complex task of agreeing solutions for the deeper systemic reforms fell out of scope. This suggests that stakeholders had to navigate a trade-off between short-term consensus, at the cost of ambition.[48] The wording of the Five Shifts allowed consensus to be achieved and made it possible for varied stakeholders to align more easily.

Finding 3.02. The Lusaka Agenda reconfirmed existing commitments but missed opportunities to advance the debate, in the face of changing donor priorities and GHI competition for resources. The FGHI process and the Lusaka Agenda served to increase attention to, and revitalise momentum towards, existing priorities and earlier commitments for change, rather than

[47] Concept Note: Aligning Global Health Initiatives behind Agenda 2030, to improve health quality and equity and maximise health impacts through stronger and more resilient health systems. Wellcome, June 2022.

[48] As evidenced by KIIs with multiple stakeholders (Wellcome Trust, GHI Secretariat Staff, FGHI observer).

introducing new, transformative reforms. The Five Shifts outlined in the Lusaka Agenda reflected and reinforced a number of existing commitments in global health.[49] Shifts 1, 2 and 3 on PHC, HSS, equity in health outcomes and sustainability are consistent with existing strategic priorities to which GHIs and LMIC governments are committed, for example, as articulated in GHI strategies. Shift 4, which emphasises the need for strategic and operational coherence aligns with previous development effectiveness principles, endorsed by global health stakeholders through frameworks such as the Paris Declaration of Aid Effectiveness[50] and the Busan Partnership for Effective Development Cooperation.[51] It has also been reflected in ongoing efforts to enhance coordination and blended finance operations, such as between the World Bank and the Global Fund and through the SDG3 GAP financing working group. In comparison, Shift 5, which focuses on coordinating approaches to products, R&D and regional manufacturing, represents a relatively new, post-COVID-19 agenda. Overall, while the FGHI process successfully revitalised attention to established priorities, it missed opportunities to tackle deeper systemic reforms within the GHA – HSS, accountability, domestic resource mobilisation – as reflected in the original planned objectives of FGHI.

Finding 3.03. FGHI achieved partial success in building consensus on key challenges and potential solutions. Interactions between defining the problem, identifying opportunities for reform and power dynamics over the 18 months of the overall FGHI process contributed to the outcomes, in terms of the short- and longer-term results achieved. During its first year, FGHI conducted a period of stakeholder engagement aimed at building an understanding of the need for change, with a growing recognition that the status quo was unsustainable.[52] While there was broad agreement that reforms were needed, there was no clear identification of the specific GHI-related problems FGHI sought to address (Section 5.1.1). The process was designed with the expectation that ideas for potential reforms would unfold over time. However, significant differences emerged and persisted throughout the process about how much change and how fast, and what that change should look like.[53] Despite these differences, FGHI made progress on building consensus around the challenges and proposed solutions.

5.3.2. Longer-term outcomes

Table 7. Key findings on longer-term outcomes

#	Findings	Strength of evidence
3.04	One year on, post-Lusaka, agreement has superficially been achieved on the key shifts needed, but deeper consensus on the feasibility of and accountability for next steps has yet to be resolved.	1
3.05	The AU's commitment to establish a Lusaka Secretariat at Africa CDC may have the potential to stimulate sustained impact in Africa.	2

[49] Refer to section 2.1 on the Global Health Architecture. This includes earlier commitments for One Plan, One Budget and One M+E approach to health.

[50] OECD (2005) The Paris Declaration of Aid Effectiveness, https://www.oecd.org/en/publications/2005/03/paris-declaration-on-aid-effectiveness_g1g12949.html. Accessed 11/03/2025.

[51] OECD (2011) Busan Partnership for Effective Development Cooperation, https://www.oecd.org/en/publications/busan-partnership-for-effective-development-co-operation_54de7baa-en.html. Accessed 11/03/2025.

[52] Is Global Health Financing fit for purpose, Wellcome internal doc (no date), row 79 Doc Matrix.

[53] Evidenced by KIIs with multiple stakeholders (FGHI Secretariat, GHI Secretariat staff, Global South CSOs/networks).

3.06	Other follow-on processes include the Joint Committee Working Group (JCWG) between GFF, Global Fund and Gavi Secretariats, and their work alongside 'champion countries.'	2

Please note, in depth evaluation of the implementation of the Lusaka Agenda was outside the scope of this study.

Finding 3.04. One year on, post-Lusaka, agreement has superficially been achieved on the key shifts needed, but deeper consensus on the feasibility of and accountability for next steps has yet to be resolved. The Lusaka Agenda itself identified a set of 'Next Steps', including specific actions for joint work, joint oversight, cross-Board and cross-country collaboration, as well as for developing a vision for regional R&D work.[54] Meanwhile, the terms 'Lusaka Agenda' and the 'Five Shifts' have gained traction and are now widely used in the African region and by some GHI Boards to encapsulate GHI reform and enhanced cooperation around contributions to HSS.[55] By way of follow-up, several working groups and committees were launched during 2024, focused on advancing the Lusaka shifts; these are out of scope of this evaluation but we note their formation.[56] The Lusaka Agenda Working Group (LAWG) was deliberately kept time limited and dissolved as planned June 2024, just after presentations were made at GHI Boards on FGHI. The notes of its final meeting say:

'In frank recognition that Lusaka Agenda implementation is a long game, meeting participants committed to advancing the Agenda's key shifts in their work in the months and years to come [and] expressed an interest in having informal touchpoints after the end-June sunsetting of the Working Group and Secretariat.'

Finding 3.05. The AU's commitment to establish a Lusaka Secretariat at Africa CDC may have the potential to stimulate sustained impact in Africa. In February 2024, the AU Assembly agreed to '*support the establishment of an accountability mechanism within the AU architecture to ensure the effective implementation of the Lusaka Agenda in Africa*',[57] and in December 2024, a Continental Secretariat for Lusaka Agenda Implementation was established at the Africa CDC. This is a significant institutional commitment to long-term implementation, capitalising on initial post-Lusaka momentum and which has the potential to provide support to Ministries of Health and promote learning between countries,[58] if implemented effectively. One of the key tasks for the Secretariat is to set in place an accountability framework for monitoring adherence to Lusaka principles. The response of the Director General of Africa CDC to the Lusaka Agenda was that it will reiterate prior commitments and could act as *'a catalyst for realizing a new public health order in Africa.'*[59] While positive for Africa, some concerns have been raised that the Lusaka Agenda could become predominantly focused on the African continent rather than truly global,[60] which stakeholders saw as potentially limiting its broader applicability and impact.

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[54] Lusaka Agenda: https://d2nhv1us8wflpq.cloudfront.net/prod/uploads/2023/12/Lusaka-Agenda.pdf. Accessed 11/03/25.

[55] Evidenced by KIIs with multiple stakeholders (Global North governments, GHI Secretariat staff, FGHI observers, Wellcome Trust, FGHI Secretariat).

[56] The four follow-on channels we heard of were: LAWG, Lusaka Secretariat at AU – Africa CDC, JCWG, WHO support to Lusaka.

[57] Africa CDC. (2024). Statement on Continental Secretariat for Lusaka Agenda Implementation Launch. Available online at: https://africacdc.org/wp-content/uploads/2024/12/Statement-on-Continental-Secretariat-for-Lusaka-Agenda-Implementation-Launch.pdf. Accessed 11/03/2025.

[58] It will help address LMIC Ministry of Health insufficiency in their preparedness in terms of framing and engaging on the conversations.

[59] Response to the Lusaka Agenda by the Director General, Africa CDC.

[60] Evidenced by KIIs with multiple stakeholders (Global South governments, philanthropic foundations, other related entities – e.g. UHC2030, GFF alignment WG, SDG3 GAP, Brunswick Group, Global North governments, GHI Secretariat staff, Global South/CSO networks, GHI Secretariat staff).

Finding 3.06. Other follow-on processes include the Joint Committee Working Group (JCWG) between GFF, Global Fund and Gavi Secretariats, and their work alongside 'champion countries.'
The establishment in 2024 of JCWG between GFF, Global Fund and Gavi Secretariats has been seen as a positive step to improve coordination between major GHIs, particularly in areas like malaria vaccines, HSS, back-office operations and country-level planning. This is evident in joint programmes of work between Global Fund and Gavi on malaria.[61] However, the operational and technical focus of the JCWG is seen by some as *'very GHI centric'*, potentially limiting the broader reform agenda.[62] Progress has also been reported at country level through coordination and alignment initiatives, including in 'champion countries'.[63] For example, Muhammad Ali Pate, Nigerian Federal Minister of State for Health and Social Welfare, promoting a sector-wide approach (SWAp) and putting forward aligned health financing resolutions, and Ethiopia's Ministry of Health implementing a *'One Plan, One Budget, One M&E process'*.[64] Likewise, in DRC, efforts are underway to promote joint planning between GFF, Global Fund and Gavi. While positive, these country examples are not new initiatives catalysed by the FGHI process but rather existing initiatives that have been revitalised under a new Lusaka banner.

'The reality of planning at the country level is far from the aspiration of the "one unified plan" sought in the Lusaka Agenda, and the use of government systems is lagging.' **(KII, GHI)**

Box 9. Implications for Theory of Change (ToC) assumptions

Based on the findings described in the previous section, the team considered the implications for the relevant assumptions underpinning the ToC (Annex 1). **Assumption 5** states that if the problem is correctly defined, the right policy solutions are proposed, and appropriate stakeholders are included and able to influence critical moments in the FGHI process, then the right combination of short- and long-term actions and outcomes will be agreed upon and operationalised, leading to the achievement of Wellcome's project objectives. The evaluation evidence indicates that **Assumption 5 was met to some extent**. However, trade-offs were made throughout the process – related to political economy, stakeholder dynamics and tight timelines – meaning that FGHI was less successful in achieving its original objectives. Progress on results has been influenced by how FGHI defined the problem to be addressed, the policy solutions it supported and the stakeholders and drivers of interest it engaged with.

6. Lessons learned

The main data collection activities (document reviews, KIIs, etc.) for this evaluation were conducted over the period November 2024 – early February 2025. The tail end of this period, of course, has marked a moment in time where there have been momentous (and ongoing) shifts in the landscape of global health funding and programming – specifically, the recent US decision to pause foreign development assistance and instigate huge ongoing funding cuts, the UK's sudden announcement of a 40% cut to overseas development assistance (ODA) (on top of previous cuts), and the predicted ODA resource envelope shrinking in France and Germany during 2025. Together, these shifts mean that, without doubt, funding realities at the global and country level will change in coming months and years (and have indeed changed already). It is in this context

[61] Evidenced by KIIs with multiple stakeholders (FGHI observers, Global South governments).

[62] Evidenced by KIIs with multiple stakeholders (Global South governments, FGHI observers).

[63] 'Champion countries' were established as part of the Lusaka next steps process, as can be seen here: https://unfoundation.org/what-we-do/issues/global-health/global-health-resource-center-2/lusaka-agenda-explained/ (Accessed 25 March 2025)

[64] Evidenced by KIIs with multiple stakeholders (Global South governments, Global north governments, FGHI observers).

that the conclusions and lessons learned from this study need to be framed, and we have attempted to take this new challenging environment into account as we have thought them through. This said, it is worth remembering that the data collected for this study represents a period of time prior to the dramatic events of recent months and, as such, we need to be aware of this limitation.

Lesson 1: Reform to the global health ecosystem remains a priority issue

The first lesson from this evaluation of the FGHI is that there was, and remains, a strong appetite for reform within the global health ecosystem. Stakeholders from all groups agree that health systems in many LMICs are under-resourced and that the current system often operates counter to sensible and efficient planning and budgeting to ensure maximum value for money, whether from domestic sources or international partners. The role of GHIs specifically within this is more contested, with significant differences within and between stakeholder groups in terms of what the problem is and how best to address it.

Efforts are continuing to grapple with these issues, with momentum in the African region particularly, albeit within the rapidly evolving global health resource context. Wellcome and its partners involved in conceptualising FGHI correctly identified that the global health ecosystem as it is currently structured is neither fit for purpose nor sustainable, either for supporting and strengthening health systems or for delivering disease impact. This is well documented in the literature and, for countries that depend on external resources for large proportions of their health budgets, GHIs' lack of budgetary alignment creates serious distortionary problems. These issues were highlighted during the COVID-19 response, and FGHI emerged during a period of consensus on the wider need for reform.

Lesson 2: Define the problem clearly from the outset and leverage the work of previous efforts

FGHI's lack of consensus among stakeholders on problem definition highlighted the importance of achieving clarity early in the process. FGHI allocated insufficient time to agreeing the problem upfront and, as a result, while it disrupted the status quo, it is not clear that it laid the foundation for lasting institutional change, grounded in the realities of Board and grant business models (see below) and domestic health financing systems (for LMIC countries and their CSO partners). Future work should invest time and resources to develop a shared understanding that is, first, sufficiently grounded in evidence of what worked well/less well from prior efforts (IHP+, UHC2030, SDG3 GAP, etc), and, second, supported by a broad coalition.

FGHI problem definition challenges also underlined the importance of building on past initiatives. Any future efforts by Wellcome and/or others to build consensus around reform should not start from scratch but instead closely examine the strengths and weaknesses of prior initiatives and identify specific problems to target. Collaboration with initiatives like the Pandemic Fund and other pre-existing global health frameworks can enhance coherence and effectiveness in addressing health challenges.

Lesson 3: Establish inclusive and transparent governance structures

The FGHI governance structure aimed to be inclusive but fell short due to inconsistent and informal selection processes. Effective governance requires transparent, structured mechanisms for selecting participants and ensuring all relevant voices are heard. Balancing efficiency, inclusivity and legitimacy is crucial in order to foster credibility and trust. FGHI had strong rationales justifying its relatively informal processes but this presented difficulties for participation and may have been a factor in limiting LMIC country representation, particularly at

the start. The informal nature of FGHI had subsequent implications for the legitimacy of the whole process, including the outcome – the Lusaka Agenda – which was more of a declaration of intent lacking binding commitments, notwithstanding subsequent momentum. Future efforts should mobilise effective stakeholder engagement via clear strategies that go beyond invitations to participate. Ensuring institutional backing for LMIC representatives and CSOs, as well as including and resourcing them meaningfully in decision-making processes, is essential for achieving balanced representation and fostering ownership of outcomes.

Lesson 4: Sophisticated, multi-layered political economy analysis of GHI Boards is essential to drive change

Integrating PEA early in the process can enhance the understanding of power dynamics, competing interests and institutional constraints. Such analysis is vital for designing strategies that effectively engage diverse stakeholders and navigate political complexities. Not surprisingly, the political economy of FGHI was dominated by existing complex power dynamics that play out across GHI Boards and other health-related intergovernmental bodies. This went beyond simple HIC–LMIC or government–non-government dichotomies, since each of the GHIs has its own micro-political economy: individual GHI power dynamics are significantly different[65] and Boards have little bandwidth for cooperation amongst themselves, despite having significant overlap in member constituencies.

The FGHI process highlighted the challenge of aligning the interests of GHI Boards with reform goals. Attempts by Wellcome and others to to engage GHI Boards were not fully effective due to limited political feasibility assessments and inconsistent participation. Future initiatives should consider designing governance structures that include formal mechanisms for GHI Board engagement from the outset. This approach would help to secure genuine buy-in, align institutional interests with reform objectives, and enhance the feasibility of proposed solutions.

Lesson 5: Capitalise on windows of opportunity – in 2025 as much as 2022 – to address fundamental issues in sustainable health financing

FGHI emerged during a window of opportunity in the late COVID-19 era, capitalising on a broad consensus for reform in the global health system. A new opportunity is now arising in 2025, spurred on by major shifts in bilateral and multilateral funding sources, particularly affecting African economies that heavily rely on such support. FGHI demonstrated that structured timelines can drive action and efficiency but also revealed the risks of compressed timeframes that can undermine quality and stakeholder engagement when political momentum wanes. Future reform efforts must adopt realistic timelines, adapted to the problem they are trying to solve, and that allow space for inclusive dialogue, research validation and advocacy to secure wider buy-in.

Despite challenges noted in this evaluation, growing momentum across the Africa region, exemplified by the prominence of the Lusaka Agenda, reflects ongoing appetite for reform, even in a shifting resource environment. The AU's ownership and championing of this agenda is recognised and appreciated by governments and other stakeholders in that region. It needs to be

[65] For example, the roles played by the Global Fund's Country Coordinating Mechanisms (CCMs) or non-state HIV service providers and campaigners are crucial to its functioning but offer little relevance to Gavi or GFF. Likewise, the particular dynamics that operate amongst the core and expanded partners that form the Gavi Alliance are not replicated at the Global Fund or GFF. And the relationship between the International Development Association (IDA) and its member countries heavily influences how the GFF functions within the World Bank system but has limited resonance for the Global Fund or Gavi.

balanced by identifying mechanisms to support the agenda in other regions, where some LMICs remain heavily dependent on GHIs for important parts of their health budgets.

At the global level, GHIs are collaborating to refine business models, though their focus remains on operational alignment rather than systemic transformation. Most GHIs profess to follow a 'country-led' model yet maintain discretionary controls behind the scenes. As a result, despite aspirations for support to HSS and UHC that is aligned, on-plan, and non-distortionary, GHIs remain driven by a need to demonstrate efficient disbursement, measurable impact and minimised fiduciary risk to their Boards. This conservative stance reflects the imperative to avoid negative media attention that could jeopardise donor replenishments, a situation that will be all the more acute in the new resource environment. In future, real reform will require joint accountability mechanisms to improve coordination between global and regional or national stakeholders aligned with the Lusaka Agenda.

While FGHI's final outcomes favoured governance-related reforms, they largely avoided deeper challenges such as sustainable financing and domestic resource mobilisation. Future reform efforts must go beyond surface-level changes, developing actionable frameworks that strengthen domestic funding and integrate with other international mechanisms like the Pandemic Fund. Declining aid budgets from traditional donors underscore the urgency for innovative financing strategies and regional funding solutions, within a governance framework that facilitates cross-GHI communication and cooperation, and for which there is potentially a role for relative newcomers like the Wellcome Trust.

Annex 1. Theory of Change & Assumptions

Figure 8. Theory of Change

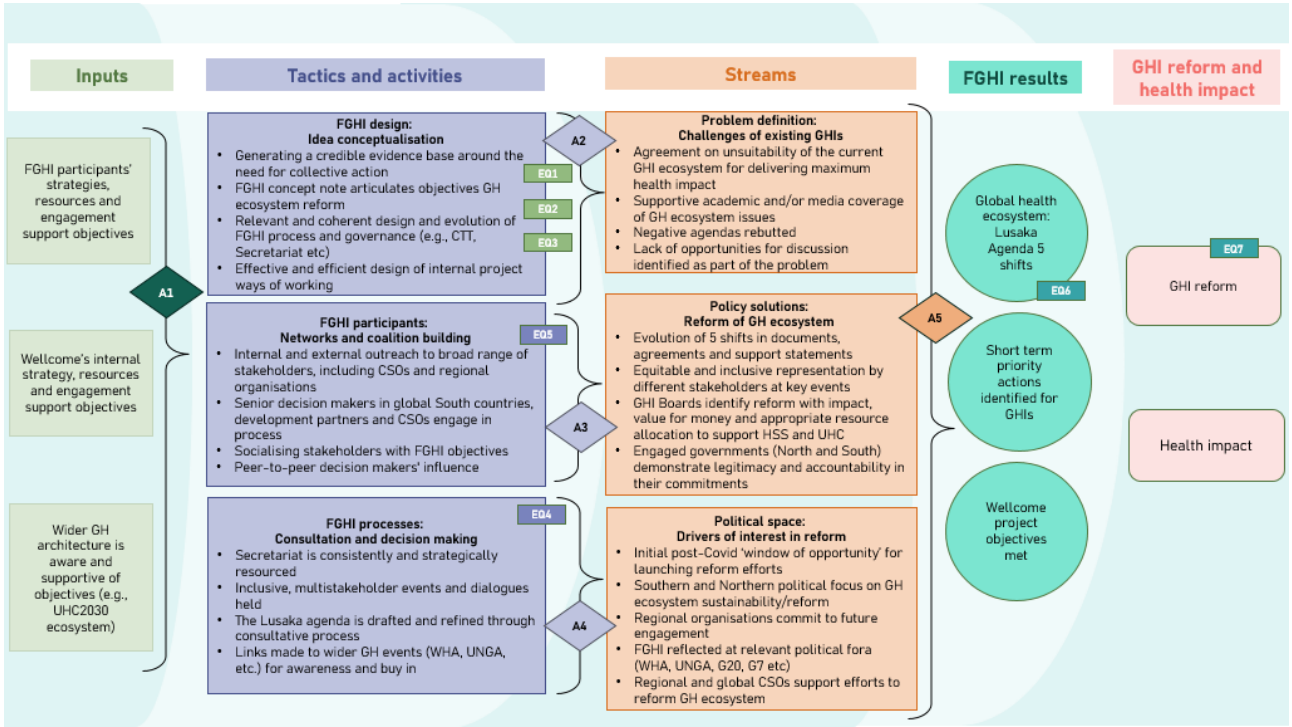


Figure 9. Assumptions

Assumptions:

A1 If adequate resources and engagement are provided, then the tactics/activities of the FGHI process will be implemented as planned/intended.

A2 If the tactics and activities of the FGHI process are implemented as intended, then an evidence-based consensus will be achieved that the global health ecosystem—including GHIs—is failing to support equity, sustainability, and system strengthening, and that collective action is necessary to address these problems.

A3 Assumption for policy stream: If the tactics and activities of FGHI are implemented as intended, then actionable policy solutions will be generated for stakeholders to consider and agree, influenced by the role of policy entrepreneurs in building consensus around their acceptability, technical feasibility and likely risks, constraints or unintended consequences.

A4 Assumption for political stream: If the tactics and activities of FGHI are implemented as intended, then the interests of all stakeholders (global North and South) will be recognised, key interest groups will align with them, and those with the most to gain from reform will have the influence and power to drive change forward.

A5 If the problem is correctly defined, the right policy solutions are proposed and appropriate stakeholders are included and able to influence critical moments in the FGHI process, then the right constellation of short- and long-term actions and outcomes will be agreed and operationalised, and Wellcome's project objectives will be achieved.

Annex 2. Evaluation framework

The table below sets out the EQs, which were mapped to the ToC to ensure a holistic and collective understanding of how the FGHI's activities and outputs are expected to work. Each EQ is also now accompanied by a set of sub-questions which were used to deepen the analysis based on the Kingdon framework and to input into guidelines for data collection and analysis.

Table 8. Evaluation framework

	Module 1 Right things		
	EQ	**Refined EQ**	**Sub-questions**
Part A (external): Overall FGHI process	**EQ1:** Were the FGHI objectives appropriate, relevant and coherent?	**EQ1:** Were the FGHI objectives and intended outcomes relevant and coherent?	How and why did FGHI (i.e. the reform of the global health ecosystem/GHIs) emerge when it did? Who was involved in the conceptualisation of FGHI and how were the objectives developed? How much agreement was there among global and country stakeholders that GHIs were problematic, and reform was needed? How did different participants define the problem the FGHI was trying to solve? To what extent were different participants' views considered? How did FGHI add value to other ongoing efforts to improve coordination and alignment among GHIs?
	EQ2: Was the 'FGHI architecture' (co-chairs/Steering Group/Secretariat etc.) designed to optimise the chances of achieving the best outcomes?	**EQ2:** Were the FGHI project governance and related structures (co-chairs, Steering Group, Task Teams) designed to maximise the chances of achieving the best outcomes?	How was the membership of the Steering Group and Task Teams decided? Who was left out of the governance structures (or declined to participate)? Which elements of governance/structures worked well/less well and how did this affect the process? How well did the governance structures enable inclusive and balanced decision-making and reflect different participants' priorities?

	EQ3: Was the 'FGHI process' designed and managed to optimise the chances of achieving the best outcomes?	**EQ3:** Was the FGHI process designed to maximise the chances of achieving the best outcomes?	How did the time-bound nature of FGHI influence the process, ways of working and outcomes? How sufficient was the planning and resourcing of the FGHI process (beyond the Wellcome Trust) to support the FGHI process? How well did the Secretariat's set-up (structure, resources, ways of working) support the FGHI process?
Module 2 Rights			
	EQ	**Refined EQ**	**Sub-questions**
Part A (external): Overall FGHI process	**EQ4&6:** How well were the 'FGHI processes' operationalised – were they efficient, optimised and collaborative? (including looking at the interim effectiveness of key 'events' e.g. Addis Ababa, Wilton Park and the drafting process for final Lusaka Agenda)	**EQ4:** To what extent and how were the activities/key events of the FGHI process implemented in an efficient, collaborative and inclusive manner?	Were the FGHI processes implemented as intended (logical sequencing of activities, implementation of phases, strategic engagement of stakeholders and engagement with wider global health events)? Was the timing of key milestones (e.g. the research study, and events like Wilton Park and the Lusaka consultation) appropriate/optimal? How flexible were the FGHI processes and did they adapt and change to foreseen challenges (e.g. stakeholder feedback or global events)? Was the participation of all stakeholders in the process well managed to allow for adequate representation in decision-making and consensus building? How effective were the different key events in contributing to consensus on defining the problem and identifying potential solutions (e.g. gathering inputs, fostering collaboration, inclusiveness, consensus building and decision-making, drafting of the Lusaka Agenda)? Was the Reimagining FGHI research implemented on time and as intended? How were the findings of the research used in the FGHI process and how did they help to build

			consensus on both the problem and solution to the GH ecosystem?
	EQ5: How well was the FGHI 'architecture' operationalised and were they efficient, optimised and collaborative (including the work of the Research and Learning Task Team and the commissioning of the Reimagining the FGHI study)?	**EQ5**: How well did the FGHI governance and related structures work in practice?	How effective were the governance and related structures in enabling activities and outputs to be delivered on time? How effectively did the members of the different groups of the FGHI process engage and champion the process in their respective organisations and the wider GHI ecosystems? Did the FGHI process, governance and related structures enable equitable inclusion and meaningful participation from different stakeholder groups? How did the Wellcome Trust contribute to and add value in leading the Research and Learning Task Team of the FGHI process? How did the structures help build consensus on the need for GHI reform along with realistic policy solutions to the problem of GHIs? What kind of political support was evident for the process, amongst Northern and Southern partners as well as regional organisations and CSOs? How well did the FGHI governance and structures leverage on the political forces in the post-pandemic context to deliver on the much-needed reforms in the GHIs?
Module 3 Right results			
	EQ	**Refined EQ**	**Sub-questions**
Part A (external): Overall FGHI process	**EQ7**: Did the short-term outputs and outcomes of the FGHI process meet the objectives identified and were they well received?	**EQ6:** Did the short-term outputs and outcomes of the FGHI process deliver on the three objectives?	Was consensus achieved through the FGHI process on the problem being addressed, and how best to solve it? Were there any key windows of opportunity that were either used or missed by the participants and how did they emerge? Were there any notable policy entrepreneurs who really drove the process and without whom the

			objectives would not have been achieved?
	EQ8: What do stakeholders perceive the prospects to be for longer-term effectiveness of the FGHI process in relation to a) GHI efficiency, effectiveness and equity; and b) sustainable, coordinated and accountable global and domestic health financing?	**EQ7:** What do stakeholders perceive to be the prospects for the longer-term results of the FGHI process in relation to its original three objectives?	What were the short-term intended and unintended results achieved? What are the likely long-term results of the FGHI process?

Annex 3. Key informants interviewed

Table 9. Key informants interviewed

First and last name	Organisation	Position/ role
Wellcome Trust		
Alex Harris	External consultant	Former Managing Director, Wellcome/Former Associate Director, Government Relations and Strategic Partnerships Team (GRSP)
Clare Battle	Wellcome Trust	Policy Lead
John-Arne Røttingen	Wellcome Trust	CEO
Elhadj As Sy	Wellcome Trust	Governor, Board of Governors
Julia Gillard	Wellcome Trust	Chair, Board of Governors
Silaja Birks	Wellcome Trust	Strategic Partnerships Lead / project co-lead, GRSP
Simon Hall	Wellcome Trust	Policy Advisor, Policy Team
Tom Harrison	Wellcome Trust	Senior Policy Officer, Policy Team
HIC governments		
Anna Seymour	FCDO	Co-chair of the Commitments Task Team
Kristen Chenier	Global Affairs Canada's Health and Nutrition Bureau	Director of Policy, Infectious Diseases and Pandemic Preparedness
Kristine Husøy Onarheim	Norwegian Ministry of Foreign Affairs (MOFA)	Policy Director (Health, Education and Nutrition)
Nidhi Bouri	USAID	Deputy Assistant Administrator for Global Health
LMIC governments		
John Rumunu	Ministry of Health, South Sudan	Director General Preventive Health Services
Patrick Kuma-Aboagye	Ghana Health Service	Director-General of Ghana Health Service FGHI Steering Group member Member of the Interim Working Group Lusaka Agenda
Gerald Manthalu	MoH Malawi	Director of Planning and Policy at MoH
Mercy Mwangangi	Ex MoH Kenya	FGHI Steering Group Co-chair
Mohammed Jama	Ministry of Health, Federal Government of Somalia (MoH FGS)	Advisor
Polydor Kabila	National Council on Universal Health Coverage (UHC) in DRC	National Coordinator
HIC CSOs/networks		

Katy Kydd Wright	GFAN	Director
Mike Podmore	StopAIDS	CEO
LMIC CSOs/networks		
Catherine Kyobutungi	African Population & Health Research Centre	Executive Director
Desta Lakew	Amref Health Africa	Group Director of Partnerships and External Affairs
Githinji Gitahi	Amref Health Africa	CEO/Co-facilitator @Wilton Park
Rosemary Mburu	GFAN	Executive Director of WACI Health
Magda Robalo	Institute for Global Health and Development, Guinea-Bissau (now chair of UH2030)	President and co-founder
Other LMIC and/or regional organisations		
Ahmed Ogwell Ouma	Africa CDC	Deputy Director-General
UN agencies and wider IFIs		
Bruce Aylward	WHO	Senior Advisor to the Director-General
Juan Pablo Uribe	GFF	Director, HNP and GFF Gavi Board Member
Susan Sparkes	WHO	Health Financing Technical Officer
Kalipso Chalkidou	Global Fund	Ex-Director of Health Finance Department (now WHO)
GHI Secretariat Staff		
Bill Rodriguez	FIND	CEO
Bruno Rivalan	GFF (now World Bank)	Senior Partnership Specialist
Dianne Stewart	Global Fund	Deputy Director, External Relations and Communications Division and Head, Donor Relations Department
Emi Inaoka	Japan/Global Fund	Senior Advisor, Health Finance Dept.
Peter Sands	Global Fund	Executive Director
Saul Walker	CEPI	Director for Public Partnerships
Tenu Avafia	Unitaid	Deputy Executive Director
Thabani Maphosa	Gavi	Managing Director, Country Programmes Delivery
GH experts and independent consultants		
Justice Nonvignon	MSH	Technical Director, Primary Health Care Efficiency, Effectiveness, and Equity

FGHI Secretariat		
Linda Muller	FGHI	Head of FGHI Secretariat/consultant
Reimagining the Future of GHIs' Research Consortium		
Karl Blanchet	Geneva Centre of Humanitarian Studies	Director
Sophie Witter	Institute for Global Health and Development Division, Queen Margaret University	Professor
Philanthropic foundations		
Sue Graves	Gates	Deputy Director, Health Funds and Architecture

Annex 4. Documents reviewed

Table 10. Documents reviewed

Conceptualisation and project start-up	
16-Nov-21	Global health architecture and role for Wellcome Note of Board of Governors discussion
Jan-22	Global Health Architecture – options for discussion. Board of Governors Paper.
27-Apr-22	Next steps/roles and responsibilities within the GHI reform process
Jun-22	Concept Note: Aligning Global Health Initiatives behind Agenda 2030, to improve health quality and equity and maximise health impacts through stronger and more resilient health systems.
16-Jun-22	Global Health Initiative Reform Governance Proposal
24-Jun-22	Global Health Initiatives: Wellcome/Norway: GHI Reform Meeting PowerPoint slides
24-Jun-22	Wellcome/Norway: GHI Reform Meeting note
12-Aug-22	Reforming Global Health Initiatives: Project Plan
16-Aug-22	The Future of Global Health Initiatives: How can the current GHI landscape evolve to maximise health impacts? Webinar slides.
16-Aug-22	The Future of Global Health Initiatives: How can the current GHI landscape evolve to maximise health impacts? Webinar participants list.
No date	Is global health financing fit for purpose?
No date	FGHI Theory of Change
No date	The Future of Global Health Initiatives – What is it and why is Wellcome involved?
Jan-23 / Dec-22	FGHI Project: Follow-up note for PSC
No date	Terms of Reference for Secretariat to support Dialogue Process on Global Health Initiatives
No date	Request for Proposal for Head of Secretariat
Nov-22	Future of Global Health Initiatives Communications Support
Nov-22	Request for Quote (RfQ) for Future of Global Health Initiatives Communications and Project Support
24-Nov-22	Future of Global Health Initiatives (FGHI) – Board of Governors' Executive Leadership Team
08-Dec-22	Future of Global Health Initiatives (FGHI) PSC Minute (email)
Nov-22	The Future of Global Health Initiatives (FGHI) for ID Heads
14-Nov-22	Speaker briefing: 'How is the global health landscape evolving, and what does this mean for Wellcome?'
No date	Wellcome FGHI project team
FGHI process	
No date	Future of Global Health Initiatives Research and Learning Task Team – Terms of Reference

No date	Future of Global Health Initiatives Commitments Task Team – Terms of Reference
Feb-23	Wellcome FGHI Project: mid-point check-in summary note
Feb-23	Future of Global Health Initiatives: Project overview, February 2023
21-Jun-23	Future of Global Health Initiatives process: June update (email)
Jan-24	FGHI Final Project review summary of notes
No date (2023)	'Guiding principles' for Wellcome's engagement in FGHI deliberations
29-Oct-23	FGHI Wilton Park briefing
Oct-23	How is the global health landscape evolving, and what does this mean for Wellcome?
No date	Steering Group Starting Statement: The problem and what needs to change
08-Dec-23	Future of Global health Initiatives Steering Group Meeting
12-Dec-23	UHC Day Reception event summary
16-May-23 5-Jul-23 17-Aug-23 30-Oct-23 15-Dec-23	FGHI Newsletters: 1, 2, 3, 4 and 5
4-Oct-22 1-Dec-22 27-Feb-23 18-Apr-23 19-Jul-23 14-Se-23 26-Oct-23	Notes of seven Future of Global health Initiatives Steering Group Meetings
Wellcome-commissioned study	
No date	Request for Proposal (RfP) for Research on the Future of Global Health Initiatives
2023	Reimagining the Future of Global Health Initiatives study report
2023	Progress on the research report
14-Jun-23	Deliberative Discussion Reimagining the Future of Global Health Initiatives Study, 14 June 2023 AU Commission, Addis Ababa, Ethiopia – Meeting Summary and Participants List
No date	Responses to the Reimagining the Future of Global Health Initiatives study report
Oct-23	URGENT ACTION: Sign-on the CSO Red-Lines on the Future of Global Health Initiative (FGHI). Statement by Global Fund Advocates' Network.
Oct-23	Future of Global Health Initiatives Co-Chairs' Response to the Global Fund Advocates' Network Statement
Engagements with wider events and GHI Boards	

17-Oct-22	Future of Global Health Initiatives (FGHI) Breakfast Roundtable in the Margins of the World Health Summit Roundtable summary.
Mar-23	Future of Global Health Initiatives Brief for the 30–31 March 2023 Gavi Board Retreat
26-Nov-23	Future of Global Health Initiatives Roundtable in the Margins of the Conference on Public Health in Africa (CPHIA) in Lusaka, Zambia. Meeting summary.
26-Nov-23	Future of Global Health Initiatives Official CPHIA Side Event – The Future of Global Health Initiatives: The Future We Want to See, in the Margins of the Conference on Public Health in Lusaka, Zambia. Meeting summary.
May-23	G7 Leaders refer to the FGHI process in their Hiroshima Communiqué
May-23	FGHI referenced in G7 Health Ministers' communiqué
31-Aug-23	WHO-AFRO Regional Committee Meeting side event: WHO-AFRO and the African Constituency Bureau for the Global Fund (ACB) official side event, Strategic priorities for Africa's engagement in GHIs
30-Aug-23	WHO-AFRO Regional Committee Meeting side event: African Health Leaders Policy Forum dinner co-convened by the Ministers of Health of Ethiopia and Rwanda; and the WHO-AFRO/Africa Constituency Bureau for the Global Fund co-hosted Strategic Priorities for Africa's Engagement with GHIs.
23-May-23	World Health Assembly breakfast side event on 23 May 2023, Geneva: 'Reimagining the Future of Global Health Initiatives: what are the incentives for change?' Event summary.
19-Sep-23	Roundtable on the margins of UNGA: Aligning global health financing and political accountability on the path to UHC. A side meeting co-hosted by Amref Health Africa and UN Foundation.
19-Sep-23	Opening remarks by the honourable Minister for Health Ghana at the 78th UNGA global health Initiatives side event 'Describe how global health financing must meet the demands and needs of national interest'
21-Sep-23	The Future of Global Health Initiatives process at the United Nations General Assembly Remarks by FGHI Co-Chair
02-Oct-23	Technical briefing for Gavi board members
20-Oct-23	Technical briefing for Global Fund board members
06-Nov-23	FGHI Discussion with Global Fund Implementor Group
29-Nov-23	FGHI Global Financing Facility Investors' Group Meeting
17-Oct-22	Future of Global Health Initiatives (FGHI) Breakfast Roundtable in the Margins of the World Health Summit Roundtable summary.
06-Mar-23	Meeting notes: Roundtable official side event of the Africa Health Agenda International Conference (AHAIC).
Mar-23	Future of Global Health Initiatives Brief for the 30–31 March 2023 Gavi Board Retreat
Other inputs to dialogue	

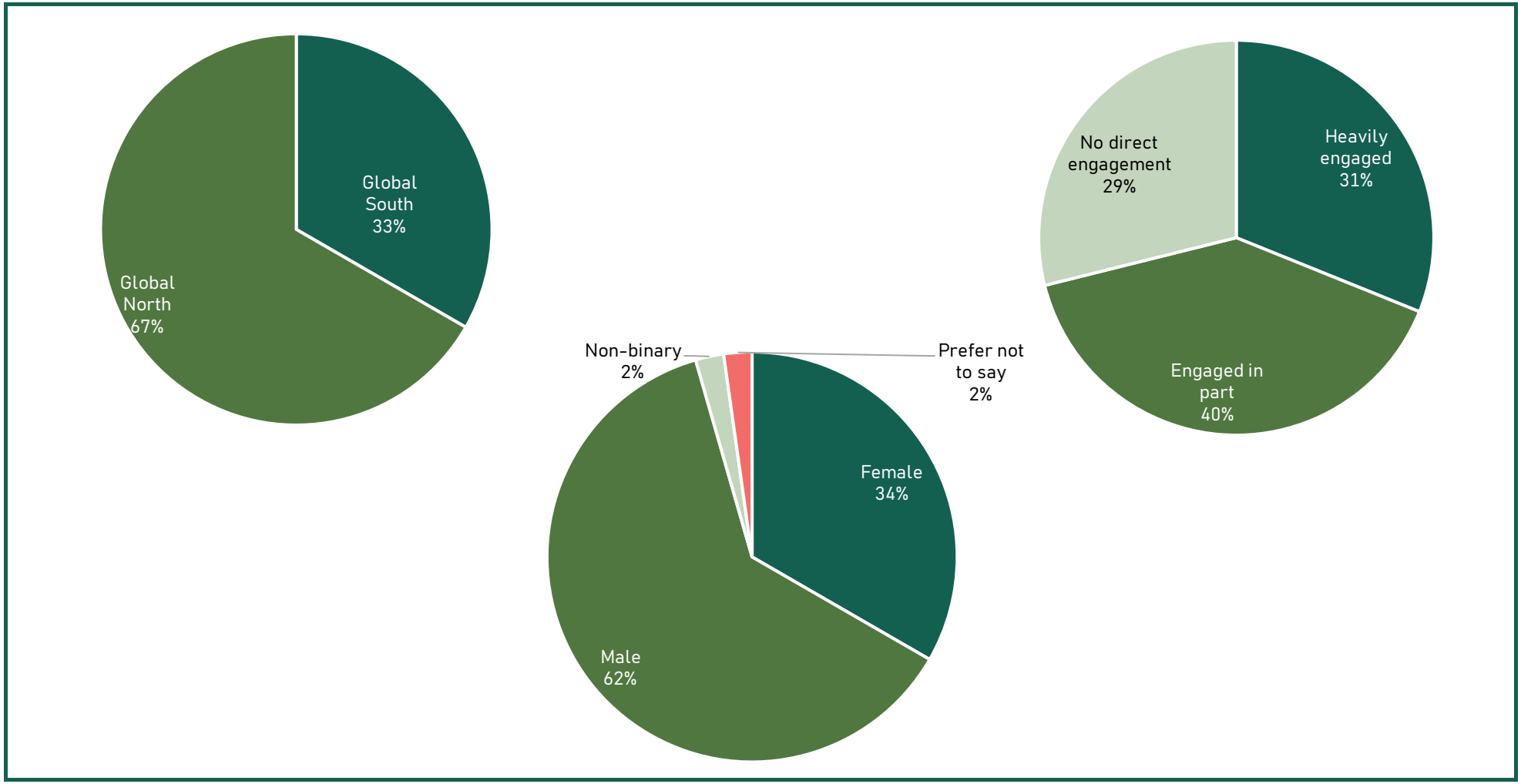
No date	Executive Summary FCDO-Commissioned Research Global Health Initiatives Country Case Study Research Integrating GHI programmes: Pooled Funding Models in Tanzania, Zimbabwe and Ethiopia
05-May-23	Why the global health system needs a re-think – Op-ed in *The Telegraph*
15-Jun-23	Health outcomes of the G7 Hiroshima Summit: breaking the cycle of panic and neglect and achieving UHC. Comment Piece in *Lancet*.
26-Aug-23	Strengthening Africa's voice on boards of global health initiatives. *Lancet* Comment.
05-Oct-23	Facilitating Health Budget Accountability and Health Financing Reforms through the ALM and NHFDs
No date	Lessons learned from joint financing of health systems strengthening in low- and middle-income countries, Sustainable Financing for Health Accelerator (SFHA)
2023	What worked? What didn't? What's next? 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All
Sep-23	Global Health Procurement & Supply Chain (PSM) Collaboration Current efforts to strengthen cross-agency and cross-program collaboration among GHIs and the wider PSM community.
Oct-22	WHO Eastern Mediterranean Regional Committee resolution on optimizing Gavi and Global Fund support to EMR countries.
28-Jun-23	Summary: Webinar MFA Norway. Development assistance for health: What is the level of proliferation and fragmentation in channels and implementers?
28-Jun-23	Development assistance for health: Proliferation and fragmentation amongst disbursing agencies and implementers –IHME
29-Jun-23	Trends and fragmentation in official development finance (ODF) to health – OECD
29-Jun-23	Insights on the Proliferation and Fragmentation of Aid in the Health Sector – World Bank
26-Sep-23	FGHI Commitments Paper
04-06-Oct-23	Wilton Park Event Programme
No date	Wilton Park – List of expected participants
04-06-Oct-23	Wilton Park Survey results
04-06-Oct-23	Future of Global Health Initiatives Wilton Park report
No date	FGHI Co-Chairs' Technical Note
Lusaka Agenda	
12-Dec-23	The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process
No dates	Responses to Lusaka Agenda 1. Minister for Health of Ghana, Hon. Kwaku Agyeman-Manu 2. Minister for Foreign Affairs of The Republic of Indonesia, H.E. Retno L.P. Marsudi 3. Minister for International Development of Norway, Anne Beathe Tvinnereim 4. Minister of State of the United Kingdom for Development and Africa, Rt Hon. Andrew Mitchell MP

	5. Director General, Africa CDC, H.E Dr Jean Kaseya 6. Ambassador, Assistant Minister, Director-General for Global Issues, Ministry of Foreign Affairs of Japan, Takeshi Akahori 7. Deputy Minister of International Development, Global Affairs Canada, Christopher MacLennan 8. Associate Director of Policy, Wellcome Trust, Beck Smith 9. Co-Chair, UHC2030, Justin Koonin 10. Executive Coordinator of Senderos Asociación Mutual, Oswaldo Adolfo Rada Londoño 11. Gavi 12. The Global Financing Facility Commits to the Lusaka Agenda 13. Global Fund Welcomes Lusaka Agenda Recommendations 14. WHO Response to the Lusaka Agenda 15. United Nations Foundation
May-23	G7 Leaders refer to the FGHI process in their Hiroshima Communiqué
May-23	FGHI referenced in G7 Health Ministers' communiqué
Sep-23	Reflections from the FGHI Research & Learning Task Team
06-Nov-23	FGHI Discussion with Global Fund Implementor Group
29-Nov-23	FGHI Global Financing Facility Investors' Group Meeting
Post-Lusaka Agenda Launch Activities	
6-7-Jun-24	Gavi Alliance Board Meeting
4-5 Dec-24	Gavi Report to the Board 4-5 December 2024
4-5 De-24	Gavi Update on Collaboration with Other Organisations
4-Apr-24	Letter-to-GHI_Board-Chairs-3.4.24-Final
5-6 Nov 24	GFF-IG19-4-ENG-Alignment-Stocktaking
No date	Lusaka Agenda Working Group Co-Chairs' Statement
27-Jun-24	Lusaka Agenda Working Group Meeting 27-Jun-24
13-Jun-24	Technical Consultation on the Lusaka Agenda in Addis Ababa
18-Feb-24	African Union Assembly Lusaka Agenda Decision
4-Apr-24	Letter-to-Board-Chairs-3.4.24-Final
23-May-24	Lusaka Agenda Working Group Meeting 23-May-24
11-Apr-24	Lusaka Agenda Working Group Meeting 11-Apr-24
6-Mar-24	Lusaka Agenda Working Group Meeting 6 March 2024
8-Feb-24	Lusaka Agenda Working Group Meeting 8 February 2024
FGHI process Task Team members	

No date	FGHI Steering Group members
No date	FGHI Research and Learning Task Team members
No date	FGHI Commitments Task Team members
No date	FGHI process timeline

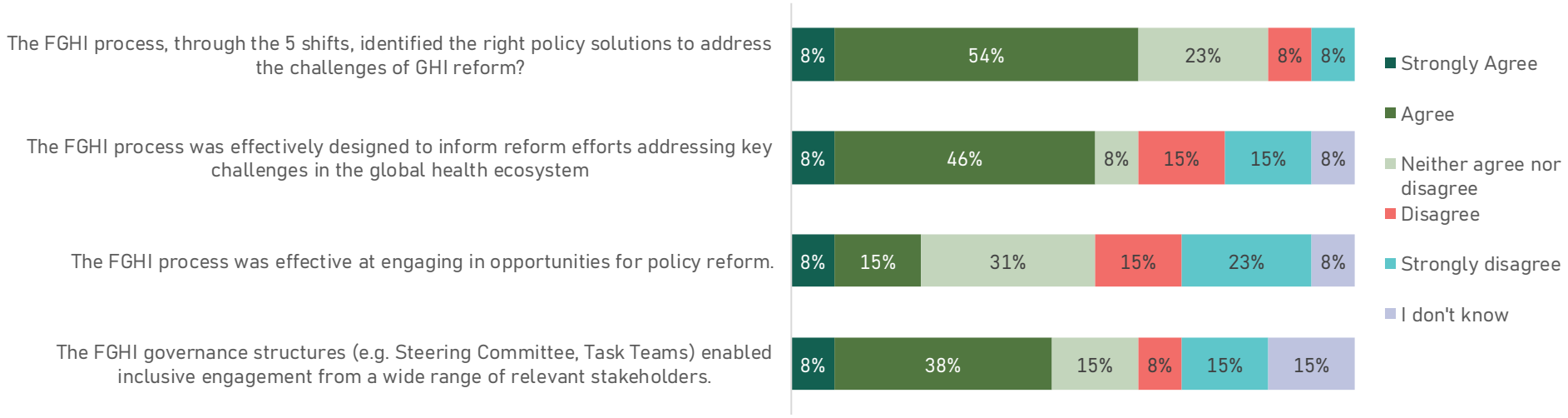
Annex 5. Survey findings and respondent demographics

The survey respondent demographics are summarised in the charts below.

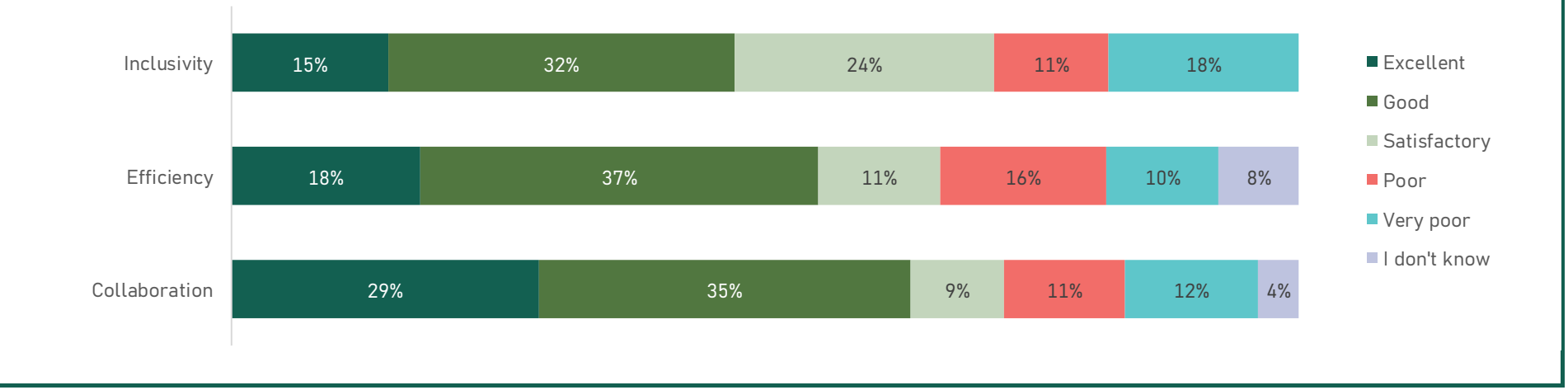


Findings from the online survey are presented together here for ease of reference. They are referred to throughout the report, according to where the evidence was most appropriately triangulated with other KII and document findings.

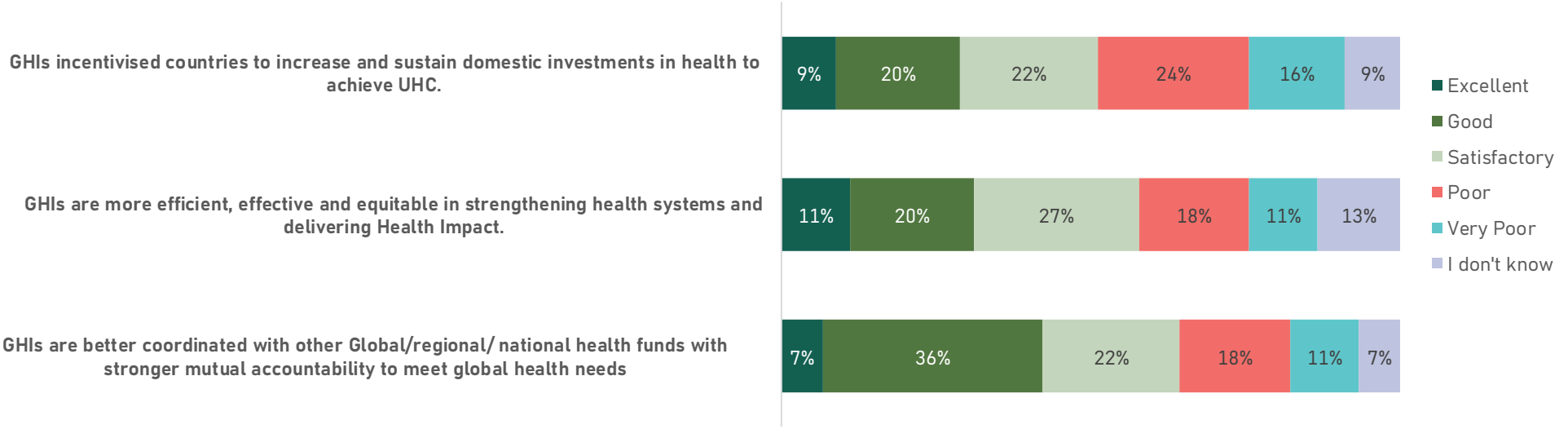
Qs 9, 13, 16, 18: Agreement with process and design statements:



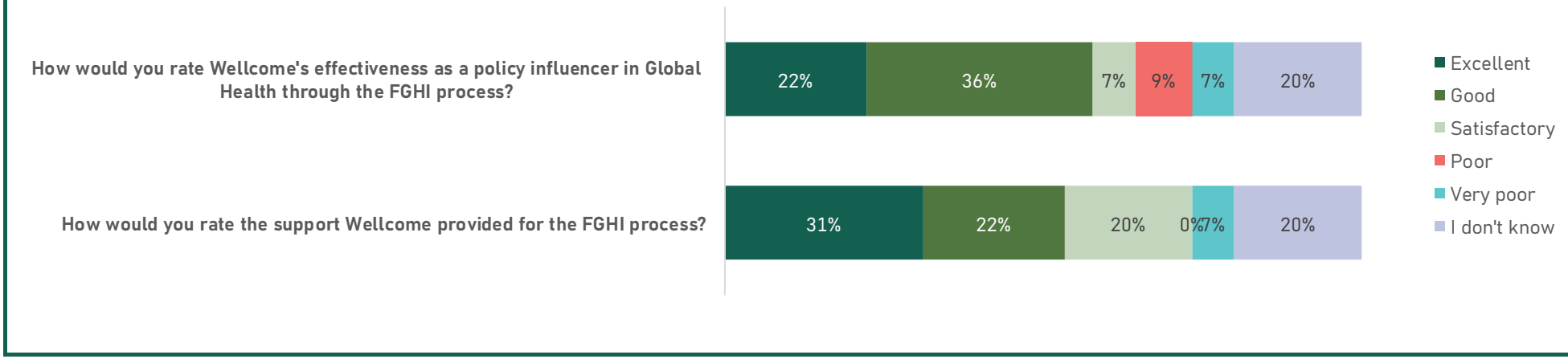
Q11: Was the FGHI process implemented in an efficient, collaborative and inclusive manner?



Q20: To what extent did the actions taken as part of the FGHI process contribute to progress on its three main objectives?



Q22: Perception of Wellcome's role in support of the FGHI process:



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