



# Watch the GAP!

A critical civil society perspective on the development, potential impact and implementation of the 'Global Action Plan for Healthy Lives and Well-Being for All'

A large yellow diamond-shaped sign with a thick black border. Inside the diamond, the text "Watch the GAP!" is written in a large, bold, dark grey, sans-serif font.

**Watch  
the GAP!**



## About the 'Watch the GAP!' Task Group

“Watch the GAP!” is a task group of the Kampala Initiative. We intend to provide a critical civil society perspective on the “Global Action Plan for Healthy Lives and Well-Being for All”. We invite interested civil society colleagues to consider joining our group.

The Kampala Initiative is a democratic civil society space and structure (alliance, community) of independent, critical-thinking activists and organizations across Southern and Northern boundaries. Within this space, the critique of aid shall lead to formulating, promoting, disseminating and seeking political traction for a new, broadly shared civil society narrative on cooperation and solidarity within and beyond aid.

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## Preface

This paper provides a critical analysis and civil society perspective of the ‘Global Action Plan for Healthy Lives and Well-being for All’ (GAP) that was co-signed in September 2019 by twelve multilateral agencies *“to better support countries over the next 10 years to accelerate progress towards the health-related Sustainable Development Goals through strengthened collaboration and coordination”*.

This paper is written by members of the ‘Watch the GAP!’ Task Group of the Kampala Initiative that was set up in November 2019. We do not intend to provide an academic reflection, but rather an initial reference to rally civil society to advocate for more space for engagement with the GAP and closely follow the GAP’s role in strengthening coordination among the signatory agencies through proper appreciation of the reality in different contexts.

In this sense, the paper can be seen as a starting point for ‘Watching the GAP’. Firstly, we review how this global plan fits with national health policies and ownership, and global health governance (chapter 2) and provide some reflections on the GAP and civil society (chapter 3). Subsequently, we look at the GAP as a normative instrument and compare it with the track record of some of the GAP’s signatory agencies (chapter 4). We ask whether the GAP will make any difference to the existing power imbalance and determinants of health and, if so, if it is for better or worse (chapter 5). Finally, we link the GAP to the current COVID-19 pandemic (chapter 6) and end with our conclusions (chapter 7).

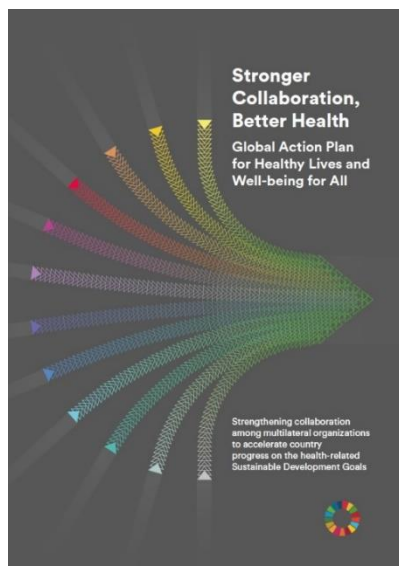


Figure 1: Cover of the GAP document



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## Executive summary

On 24 September 2019, at a side event to the United Nations High-Level Meeting on Universal Health Coverage (UHC), twelve multilateral health, development and humanitarian agencies launched the '**Global Action Plan for Healthy Lives and Well-being for All**' (GAP). It is a joint action plan "to better support countries over the next ten years to accelerate progress towards the health-related Sustainable Development Goals (SDGs) through strengthened collaboration and coordination".<sup>1</sup>

The twelve signatory agencies to the GAP are: Gavi the Vaccine Alliance, the Global Financing Facility, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, United Nations Development Programme, United Nations Population Fund, UNICEF, Unitaid, UN Women, World Bank Group, World Food Programme and the World Health Organization. The GAP is developed around seven accelerator themes and four core strategies: engage, accelerate, align and account.

The 'Watch the GAP!' civil society task group recognises the need to pay close attention to the implementation of the GAP and developed this analytical paper to inspire civil society to advocate for more space for engagement with the GAP and to closely follow its role in strengthening coordination among signatory agencies at global and country level.

We start the analysis by assessing some core elements and the language of the GAP, which is in principle a coherent document, soundly based on the narrative of the Sustainable Development Goals and aid effectiveness and highlighting repeatedly the value of country leadership and country ownership. Interestingly, despite a 'whole-of-society' approach, the decision-making power remains with governments. And while the GAP is quite outspoken in topics such as human rights and gender mainstreaming, for the sake of respecting the national ownership it becomes less bold and rather diplomatic.

Community and civil society participation are also highlighted throughout the GAP and comprise one of its seven core themes. However, despite the announcement of the GAP plan in October 2018, it was not until June 2019 that a public consultation process started, seeking feedback from non-state and state actors to some chapters of the GAP. A short report of this impact was published just before the GAP's launch, without any analysis on how and why certain inputs from civil society have been incorporated. It is still to be seen how civil society at global and national level will be included during the implementation of the GAP.

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<sup>1</sup> *Multilateral agencies launch a joint plan to boost global health goals.* WHO Press release, 24 September 2019 <https://www.who.int/news-room/detail/24-09-2019-multilateral-agencies-launch-a-joint-plan-to-boost-global-health-goals>



At the same time, the ‘whole-of-society’ approach opens the door for the private-for-profit corporate sector to engage in health. Some of the GAP signatory agencies are organised as ‘partnerships’ and explicitly welcome the private and philanthropic sector in their governance structure. Private involvement and partnerships have the risk to undermine the mandates of all the GAP agencies, as well as their independence, neutrality, and effectiveness when holding businesses to account, both at the global and country level. Our concern is that this may further move the world towards a privatised, undemocratic and inequitable global health governance.

The implementation of the GAP has already started, with some of its signatory agencies working together under different accelerator themes. Three major global health initiatives - the Global Fund to Fight Aids Tuberculosis and Malaria, the Global Financing Facility, and Gavi, the Vaccine Alliance - are collaborating under the topic of Sustainable Financing for Health. The GAP calls for signatory agencies to develop internal strategies to ensure alignment with the accelerator, agree on joint tools for identifying key bottlenecks of health financing, and support initiatives for joint learning and capacity-building. We analyse the track record of these three initiatives, their strategies, objectives and existing collaboration. We also aim to answer the question: how can the GAP make a difference in guiding these three agencies' work, without having any binding power? We agree that it is a renewal of commitments for collaboration and a new reference for these initiatives to be held accountable to. It can push them to use joint planning, monitoring and evaluation, as well as funding cycles, and it can be a step back to sector-wide approaches to health.

This also brings us to the question of how we can measure the GAP’s successes and failures, and its overall impact on healthy lives and well-being. Without explicit and concrete frameworks for monitoring, mutual accountability and clear and effective participation to address ever-growing power imbalances, the goal of accelerating achievement of health for all by 2030 will not be met. The COVID-19 pandemic could have been a first test case for the GAP. Have the agencies passed the test?

Our conclusion is as little surprising as the GAP itself: it’s all in the doing. The starting point, the plan itself, is a nice document and valid as such. One of the worst-case scenarios would be if it remains just a piece of ‘virtual’ paper, developed because some authorities wanted to see it, but without real commitment of using it. The second worst-case scenario would be if the GAP is used to strengthen the power imbalance between the most powerful global actors and the countries and their societies.



## List of acronyms

CSEM	Civil Society Engagement Mechanism of UHC2030
CSO	Civil Society Organisation
DRM	Domestic Resource Mobilisation
GAP	Global Action Plan for Healthy Lives and Well-being for All
GFF	Global Financing Facility
GHI	Global Health Initiative
NGO	Non-governmental Organisation
ODA	Official Development Assistance
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SFHA	Sustainable Financing for Health Accelerator
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization



## 1. Introduction: What is the GAP and why should we watch it?

On 24 September 2019, at a side event to the United Nations (UN) High-Level Meeting on Universal Health Coverage (UHC), twelve multilateral health, development and humanitarian agencies launched the '**Global Action Plan for Healthy Lives and Well-being for All**' (GAP).<sup>2</sup> It is a joint action plan *"to better support countries over the next ten years to accelerate progress towards the health-related Sustainable Development Goals (SDGs) through strengthened collaboration and coordination"*.<sup>3</sup>

The twelve signatory agencies to the GAP are: Gavi the Vaccine Alliance, the Global Financing Facility (GFF), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), UNAIDS, United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), UNICEF, Unitaid, UN Women, World Bank Group, World Food Programme (WFP) and the World Health Organization (WHO). The GAP was signed by the heads of these organisations, and each one has nominated a 'Sherpa' as key representative in the GAP process. The Sherpas' names are not publicly available to date.

Developed over eighteen months, the GAP outlines how these twelve agencies will *"collaborate to be more efficient and provide more streamlined support to countries to deliver universal health coverage and achieve the health-related SDG targets"*. The agencies make four specific core commitments:

- To **engage** with countries better to identify priorities and plan and implement together;
- To **accelerate** progress in countries through joint action under specific accelerator themes and on gender equality and the delivery of global public goods;
- To **align** in support of countries by harmonising operational and financial strategies, policies and approaches; and
- To **account**, by reviewing progress and learning together to enhance shared accountability.

The GAP is developed around seven accelerator themes, which *"represent catalytic opportunities for the signatory agencies to collectively better leverage existing resources, expertise, reach and*

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<sup>2</sup> GAP website with full information: Stronger Collaboration, Better Health. Global Action Plan for Healthy Lives and Well-being for All <https://www.who.int/sdg/global-action-plan>

<sup>3</sup> *Multilateral agencies launch a joint plan to boost global health goals*. WHO Press release, 24 September 2019 <https://www.who.int/news-room/detail/24-09-2019-multilateral-agencies-launch-a-joint-plan-to-boost-global-health-goals>





*capacities in areas that are common challenges in many countries and cut across the agencies' mandates". These are:*

1. Primary Health Care
2. Sustainable financing for health
3. Community and civil society engagement
4. Determinants of health
5. Innovative programming in fragile and vulnerable settings and for disease outbreak responses
6. Research and development, innovation and access
7. Data and digital health

In terms of governance, at national level, *"consistent with the principle of national ownership, countries will coordinate the agencies' joint work at country level and ensure that the work takes into account the country context and existing coordination mechanisms and that the work is focused on agreed actions."* At global level, the work of the agencies' Sherpa group is coordinated by the GAP Secretariat, hosted by the WHO. Global-level work under specific accelerator themes may be coordinated by one or more of the signatory agencies acting as accelerator co-leads.

## **Why should we watch the GAP - and why this paper?**

During the development of the GAP, civil society organisations (CSOs) assessed shortcomings in the process. This was also discussed during a civil society workshop held in Kampala in November 2019, focussing on how to "advance cooperation and solidarity for health equity within and beyond aid". The workshop concluded with the launch of the **Kampala Initiative**<sup>4</sup>, a civil society space aimed at advancing cooperation and solidarity for health equity within and beyond aid. One of the four thematic working groups discussed the GAP and came up with several questions.

### **Questions at global level**

- Does the GAP provide entry points for mainstreaming contentious policies by some of its agencies, like privatisation or Public-Private Partnerships? Can the GAP be referred to as a normative instrument to improve 'aid effectiveness'? Can the GAP and the related agencies' commitments be used to address possible shortcomings of the signatory agencies individually?
- Questions around the governance of GAP implementation: roles and responsibilities, transparency and accountability, timelines, etc.

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<sup>4</sup> <https://www.medicusmundi.org/kampalainitiative/>



- GAP and global health governance: where is the added value of the GAP in global processes, especially in inter- and intra-coordination of the intergovernmental agencies?

## Questions at national level

- How can the global aid system use the GAP to better align with the existing plans, processes, monitoring and reporting structures of aid-recipient countries, without creating parallel donor systems? How is the GAP integrated in existing country-level mechanisms?
- Does the GAP change the power dynamics within the agencies and between the agencies and governments/civil society, or is it rather a practical demonstration of power imbalances in the field of aid?
- How is civil society conceptualised in the GAP? Does the GAP lead to a further “NGO-isation” of civil society?<sup>5</sup> Who benefits? Who is at the table and who is heard? Does the GAP support or disturb national political processes of negotiating health policies between the governments and civil society?

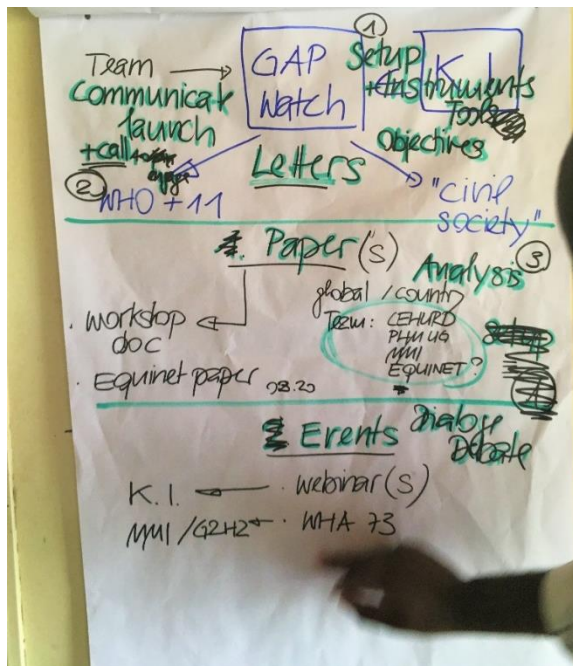


Figure 2: Watch the GAP brainstorming in Kampala, November 2019

<sup>5</sup> NGO-isation: institutionalisation, professionalisation, depoliticisation and demobilisation. See also: <https://en.wikipedia.org/wiki/NGO-ization>



The working group agreed that various aspects of the GAP deserve close civil society attention and decided to launch the ‘Watch the GAP!’ Task Group<sup>6</sup>. The collected questions, as outlined above, guided us in drafting this paper, which is a starting point for ‘Watching the GAP’. It is our intention to provide a map of global and national implementation challenges and answer the question of why and how to ‘Watch the GAP’. To do this, we review how the GAP fits with national health policies and ownership (chapter 2), reflect on the relation between the GAP and civil society (chapter 3), share our outlook at the GAP as a normative instrument compared to the track record of some of the GAP agencies (chapter 4), and ask the provoking question whether the GAP will make any difference to the existing power imbalance and determinants of health and, if so, for better or worse (chapter 5). Finally, we link to the current COVID-19 pandemic (chapter 6) and end with some concluding remarks (chapter 7).

This paper should not be treated as an academic piece, and it is neither intended to be comprehensive. It aims to inspire civil society to advocate for more space for engagement with the GAP and to closely follow its role in strengthening coordination among the signatory agencies through proper appreciation of the reality in different contexts.

## 2. The gap’s relation to country ownership and global health governance

In this chapter, we assess some core elements of the text (ambitions, narrative, concepts) of the GAP<sup>7</sup>, using quotes from the document and looking out for elements to be critically monitored during its implementation. We focus on the interaction of the GAP agencies with the countries and societies in which they work. At first sight, this is a rather difficult task.

In the founding document of the GAP, we read: *“The measure of success is not writing a plan – it’s delivering results. The success of this plan will ultimately be reflected in improved health and lives saved.”*

And this: *“By developing the Global Action Plan, the 12 agencies recognize that further effort is needed to ensure that their collaboration is more purposeful, systematic, transparent and accountable. Accordingly, the Plan commits the agencies to changing the ways they work with*

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<sup>6</sup> <https://www.medicusmundi.org/watch-the-gap/>

<sup>7</sup> All GAP quotes, if not explicitly mentioned: Stronger collaboration, better health: global action plan for healthy lives and well-being for all. The GAP is available as PDF document at <https://www.who.int/publications-detail/stronger-collaboration-better-health-global-action-plan-for-healthy-lives-and-well-being-for-all>



*countries and with each other; to closer alignment of their programmatic, operational and financial policies and approaches, including their approaches to advancing gender equality and human rights; to increasing their support for global public goods; and to monitoring progress in their joint efforts. This new approach to collaboration will help the agencies move from complementarity to synergy, increase their overall effectiveness and efficiency and better leverage their joint capacity to respond to the needs and priorities of countries striving to achieve the health-related SDG targets.”*

Language matters. Too often, the story about poor health and poverty is one of charity, one of generous donors in the “global North” knowing what is good and needed by the “global south”.<sup>8</sup>

The GAP is another story of strong actors based in the global North and what they do for better health in the global South. However, you will not easily find any kind of neo-colonialist or paternalistic narrative in it; just the contrary. So, congratulations to the communication departments of the signatory agencies for having produced a nice, smart and coherent document, which is soundly based on the SDG “partnership” discourse and on the “aid effectiveness” narrative, providing a self-confident (*“global action plan”*) but *humble* (*“we fully align with countries”*) picture.

The GAP is confidently presented as *“a collective commitment”* developed *“with enthusiasm”* in a *“highly engaged and constructive way”* and involving countries. As a result of *“discussions among the agencies and with several countries during the development of the Global Action Plan”*, the starting point of the GAP is a *“confirmed significant demand for joint action by the agencies based on country priorities and health strategies and plans that countries own and lead.”*<sup>9</sup>

## A mantra

This “country leadership and ownership” that’s at the core of the GAP, is repeated again and again, as a mantra:

*“I know first-hand from my experience as a health minister how helpful the support of the multilateral agencies can be, especially when they work effectively together and align with countries’ plans and priorities. I also understand that countries have the ultimate responsibility to*

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<sup>8</sup> This is the starting point of another working group launched at the civil society workshop in Kampala, in November 2019, as part of the „Kampala Initiative“: See „Track Changing Initiative“: <https://www.medicusmundi.org/track-changing-initiative/>

<sup>9</sup> Page 30



*achieve SDG 3 and the other health-related SDG targets and that they must lead and own work under the Global Action Plan, backed by our commitment to serve them better.”<sup>10</sup>*

*“The agencies recognize that country governments will play the driving role in setting priorities, developing implementation plans and ultimately delivering on the health-related SDG targets. The Global Action Plan focuses on how the agencies can maximize their collective effectiveness as enablers and supporters of countries’ efforts. Consequently, there will not be country-level versions of the Global Action Plan. Instead, the approach embodied in the Plan and the proposed actions under the accelerator themes will inform the way the agencies engage with governments and other stakeholders to optimize coordination and collaboration in support of national priorities and strategies.”<sup>11</sup>*

Tensions and cracks that might affect its implementation or move it into a direction that does not correspond with the overall discourse are not easy to find in the text of the GAP and in-between its lines. However, here is a selection of our findings:

## **Alignment in support of countries vs. alignment with countries**

In the aid effectiveness language, the term “alignment” is normally used as alignment of aid with country priorities, policies and strategies.<sup>12</sup> In the GAP, “alignment” stands for alignment of the agencies in support of the countries (also expressed as “coordination”), based on an “engagement” with countries to prioritise, plan and implement together. The question of who aligns with whom, however, remains unanswered throughout the document. Only its implementation will show how the difficult balance between agencies and countries will play out.

Remarkably, in an earlier draft of the GAP, the “engagement” element was missing.<sup>13</sup> A next draft included the top-down notion of “assessing country needs”, which was finally replaced by the politically correct term of “engagement with countries”. The question is: does this change of narrative come “from the heart” of the GAP partners? Is this a lesson learnt from the consultation process, or is it just a matter of changing the language to please those who might not have been “amused” by the perspectives of being first assessed and then supported?<sup>14</sup>

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<sup>10</sup> Foreword by Dr Tedros

<sup>11</sup> Page 26

<sup>12</sup> See Paris Declaration on Aid Effectiveness

<https://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm>

<sup>13</sup> Towards a Global Action Plan <https://apps.who.int/iris/bitstream/handle/10665/311667/WHO-DCO-2018.3-eng.pdf>

<sup>14</sup> The making of a “Global Action Plan for healthy lives and well-being for all”: We are still not amused.... Blog by Thomas Schwarz, MMI Network, 19 June 2019. <http://g2h2.org/posts/still-not-amused/>



## Expectations regarding ‘national dialogues’

This leads to the issue of how country ownership is framed in the ambition of “*engaging with countries better to identify priorities and plan and implement together*”. Who is “the country”?

The GAP is not as clear about “country ownership” as one might think when just reading the headlines. For example: “*Although country requests for support under the Plan will normally be signalled by governments, demand from civil society, the private sector or other country stakeholders may also be evident.*”<sup>15</sup> Or: “*While country governments will play the primary role in determining national priorities, strategies and implementation approaches, achieving the health-related SDG targets requires a whole-of-society effort.*”<sup>16</sup>

The ‘multi-stakeholder’ narrative here clearly expresses the mainstream approach of the SDG era. But this ‘whole-of society’ rhetoric contradicts the fact that it is up to the governments to decide the rules of the game: “*Some countries may choose to define their priorities and needs for strengthened collaboration among the agencies through an inclusive process of national dialogue, using existing processes or platforms where possible, such as national health planning processes or reviews, country coordinating mechanisms and national SDG coordination groups.*”

Or: “*Consequently, there will not be country-level versions of the Global Action Plan. Instead, the approach embodied in the Plan and the proposed actions under the accelerator themes will inform the way the agencies engage with governments and other stakeholders to optimize coordination and collaboration in support of national priorities and strategies.*”<sup>17</sup>

It is clear that this narrative also opens a door for engaging with the private for-profit corporate sector: “*Countries – including governments, civil society, communities, research institutions, the private sector and other national stakeholders – are at the forefront of efforts to achieve the health-related SDG targets.*”<sup>18</sup> Referring to the language of the WHO Framework on Engagement with non-State Actors, and maybe to please or appease the WHO, the GAP agencies declare that they “*will pursue additional opportunities for closer engagement of the private sector, while managing conflicts of interest.*”<sup>19</sup>

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<sup>15</sup> Page 28

<sup>16</sup> Page 26

<sup>17</sup> Page 26

<sup>18</sup> Page 11

<sup>19</sup> Page 20





## **“National” ownership and leadership vs. rights language: Examples of gender equity and promotion of civil society**

The GAP is quite outspoken in some topics, such as promoting human rights, addressing structural determinants of health, gender mainstreaming, and the overall promotion of a democratic dialogue with civil society. But in the way these issues are framed, and the actions are suggested, the agencies’ ambitions, priorities and objectives may not find open ears among some of the world’s governments (and not only the notorious authoritarian and chauvinist ones). For example, there is some bold language, particularly for gender mainstreaming:

*“Gender equality and women’s empowerment are essential to achieving health and well-being for all and ensuring that no one is left behind and are part of broad multisectoral efforts needed across the SDGs to address determinants of health. To advance the objectives of the Global Action Plan, the agencies will work together and with other partners to increase investment and action on gender equality and address the influence of gender on behaviours, norms, policies, and gender- and human-rights related barriers to health services.”<sup>20</sup>*

However, sometimes, for the sake of respecting the “national ownership paradigm”, the GAP narrative becomes a bit blurred, or rather diplomatic. For example, in the field of gender equality, it proposes *“indicative actions that countries may wish to consider taking.”<sup>21</sup>*

So, shall we bother about this incoherence between national leadership and the promotion of an “own” agenda by the GAP agencies? Is the overall “take it or leave it” approach strengthening or weakening the GAP? Shall we, for the sake of defending “national ownership”, reject some positions of the GAP agencies that most of us share? The issue is tricky, and we will discuss it further in the next chapter on the GAP and civil society.

## **A “global” action plan and its reference to other existing global frameworks and instruments**

The GAP signatories declare to be *“committed to avoiding the creation of new platforms or initiatives under the Plan. Actions by the agencies at country level will leverage and align with existing country-led health and development planning and assessment processes, such as*

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<sup>20</sup> Page 33

<sup>21</sup> Page 68



*national health plans, summits, review processes, SDG coordination mechanisms, health sector working groups and United Nations Sustainable Development Cooperation Frameworks.*<sup>22</sup>

The GAP claims to be a “global” action plan. The list of signatories, however, excludes bilateral agencies (whereas the Paris Declaration and Accra “Aid effectiveness” agenda were mainly driven by the OECD and its member states), large international NGOs and philanthropic foundations, and refers only vaguely to the UN Development System reform in which the UN GAP agencies are “concurrently engaged”.<sup>23</sup>

In its appreciation of these other actors and platforms, the GAP remains vague: *“Many other development partners – especially bilateral donors – currently provide support to countries. The agencies look forward to working with them to ensure that the Global Action Plan provides a foundation for better alignment and coordination across all development partners in health.”*<sup>24</sup>

Rather than seeing this blind spot as a strength of the GAP, we consider it a weakness. It is not clear, for example, how the UN agencies engaged in the UN Development System reform will act if it turns out that some of the approaches and instruments of the two processes do not comply.

### 3. GAP and civil society: a bad start, and many open questions

A ‘Global Action Plan’ drafted by a small group of powerful actors and delivered top-down: is the GAP process already a manifestation of inadequate global health governance? Regarding civil society, at some points the ambitions of the GAP do not match the reality. There are issues of transparency, representation, co-optation/tokenism, amongst others.

After the plea for action towards SDG3 by the governments of Ghana, Norway and Germany, and the announcement of a framework by Dr Tedros at the World Health Summit in Berlin in October 2018, it took less than a year for the GAP to be fully developed and launched. Willingness to expand community and civil society participation is highlighted as one of the GAP’s seven accelerators. But, was this willingness also expressed in the process of drafting it? Did (and do) the signatory agencies ‘walk the talk’?

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<sup>22</sup> Box 2, page 18

<sup>23</sup> Page 39

<sup>24</sup> Page 45. See also box on page 18





## A bad start

The GAP was developed around seven cross-cutting accelerators. Subgroups of the twelve agencies developed discussion papers on each of the seven accelerators, also using feedback from external partners, i.e. the Wellcome Trust, a global health foundation<sup>25</sup>. Civil society came on board only after the development of the accelerators and the discussion papers.

The GAP was on the agenda of the 144<sup>th</sup> WHO Executive Board meeting in January 2019.<sup>26</sup> Ahead of this meeting, civil society in Geneva held discussions to inform and update each other around relevant developments.<sup>27</sup> In April 2019, a non-state actor consultation with CSOs took place in New York, led by the Civil Society Engagement Mechanism of UHC2030 (CSEM)<sup>28</sup>. This consultation was announced to address only two of the seven accelerators: accelerator 3. civil society and community engagement, and accelerator 4. the determinants of health. However, more accelerators were discussed in the end.

In May 2019, the Civil Society Advisory Group for the GAP (CSAG, see box below) wrote a letter to request an opportunity for communities, civil society and other non-state actors to provide feedback on the draft of the GAP before its release, which was planned for the UN General Assembly in September 2019. At the 72<sup>nd</sup> World Health Assembly, the CSAG hosted a side event titled '*Community and civil society engagement for the Global Action Plan on Health and Well-being for All*'.<sup>29</sup> At this event, civil society again urged the GAP signatories to allow review of the draft before it was presented to Member States.

### **Box: The GAP Civil Society Advisory Group (CSEM)**

CSEM and the Global Fund Advocates Network held a two-day meeting in New York in December 2018 to raise awareness, discuss and strategise on how to meaningfully engage and coordinate civil society in the drafting and implementation of the GAP. One of this meeting's outcomes was the formation of an advisory group consisting of eight individuals, the 'Civil Society Advisory Group'.<sup>30</sup> The group was set up as an entry point for CSOs interested in the GAP and is currently reconsidering its role and mandate.

<sup>25</sup> <https://wellcome.ac.uk/>

<sup>26</sup> [http://apps.who.int/gb/ebwha/pdf\\_files/EB144/B144\\_11Rev1-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB144/B144_11Rev1-en.pdf)

<sup>27</sup> <http://g2h2.org/posts/january2019/>

<sup>28</sup> Civil Society Engagement Mechanism of UHC2030: <https://www.uhc2030.org/what-we-do/civil-society-engagement/>

<sup>29</sup> [https://globalhealth.org/wp-content/uploads/2019/06/WHA-event-report\\_Community-and-civil-society-engagement-in-GAP\\_FINAL.pdf](https://globalhealth.org/wp-content/uploads/2019/06/WHA-event-report_Community-and-civil-society-engagement-in-GAP_FINAL.pdf)

<sup>30</sup> [https://www.globalfundadvocatesnetwork.org/wp-content/uploads/2019/03/CS-engagement-GAP-12-13Dec2018-meeting\\_FINAL.pdf](https://www.globalfundadvocatesnetwork.org/wp-content/uploads/2019/03/CS-engagement-GAP-12-13Dec2018-meeting_FINAL.pdf)



It was not until June 2019, after the World Health Assembly, that a public consultation process started, calling all stakeholders (states, businesses, CSOs, etc.) to provide input to the GAP via an online form.<sup>31</sup> Not only did this consultation come at a very late stage, but it also invited feedback on incomplete papers, like the GAP outline and some of the draft accelerator discussion papers.<sup>32</sup> The input of all actors, received between 17-30 June, was published in July 2019. The GAP Secretariat provided a document with all stakeholders' input as submitted, without an overview or table of contents.<sup>33</sup> No analysis of this input was provided at the time, even though some stakeholders questioned the process. For example, the United States suggested that member states and other stakeholders should be allowed another opportunity for consultation and that if more time would be needed, the plan should not go to the UN General Assembly for any kind of rollout or endorsement.

A short report on the online public consultation was only published in September 2019, just before the official launch.<sup>34</sup> It seems, however, that apart from this online public consultation, several discussions happened at country level and with national stakeholders during and after the World Health Assembly. Nevertheless, no reports from these discussions have been published to date and, hence, it is not possible for civil society to assess which specific inputs have been incorporated and why.

## How to deal with civil society? Uncertain perspectives

The role of civil society, globally and nationally, in such efforts of alignment and coordination of global health initiatives (GHIs) is crucial. But it can only be effective under the right circumstances: when policy-making is not delivered top-down, but, instead, is inclusive and transparent, and fully uses the capacity and expertise of civil society.

If we look at the GAP document itself and particularly at accelerator 3. community and civil society engagement<sup>35</sup>, we find remarkable statements, such as the following:

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<sup>31</sup> <https://www.who.int/sdg/global-action-plan/public-consultations/invitation-for-public-comment-global-action-plan-for-healthy-lives-and-well-being>

<sup>32</sup> <https://www.who.int/sdg/global-action-plan/public-consultations/invitation-for-public-comment-global-action-plan-for-healthy-lives-and-well-being>

<sup>33</sup> [https://www.who.int/docs/default-source/global-action-plan/sdg-gap-public-consultation-comments-all.pdf?sfvrsn=2e1feb73\\_2](https://www.who.int/docs/default-source/global-action-plan/sdg-gap-public-consultation-comments-all.pdf?sfvrsn=2e1feb73_2)

<sup>34</sup> [https://www.who.int/docs/default-source/global-action-plan-update-sept19/public-consultation-report-gap-september2019-1.pdf?sfvrsn=3a968bfb\\_2](https://www.who.int/docs/default-source/global-action-plan-update-sept19/public-consultation-report-gap-september2019-1.pdf?sfvrsn=3a968bfb_2)

<sup>35</sup> page 62 ff.



*“The agencies have an important role to play in optimizing opportunities for communities and civil society to contribute to achieving the health-related SDG targets, including through their participation in local, country, regional and global processes.”*

*“The agencies further recognize their shared responsibility to strengthen meaningful, pragmatic collaboration with communities and civil society organizations and ensure a culture in which trust and genuine partnership with governments can flourish.”*

*“The agencies have different mechanisms, capacities and records of working with communities and civil society. Action under this accelerator theme provides opportunities to learn from best practices and to adopt effective, harmonized approaches for all the agencies.”*

In the ‘non-state actors’ hearing of the drafting process, this “boost” for communities and civil society was celebrated by the NGO audience, and there were strong voices to even “*make funding to countries conditional on listening to beneficiaries needs and monitoring and reporting on engagement indicators.*”<sup>36</sup> Again, what is wrong with this?

First, it looks as if some of the civil society colleagues - having worked with and within the setting of GHIs for years - are tempted to see these actors and their money and power, by nature, as good and helpful, without questioning their role, legitimacy and “unwanted” side effects of their action. As a critical civil society representative stated at the time of the hearings: “*A naive view of the global health initiatives as stewards of good governance and promoters of democracy ignores that these actors are more often rather part of governance and policy failures, distorting national policies and structures, their main legitimacy being their huge economic power.*”<sup>37</sup>

So, at the global level, there is at least no solid answer to how the GAP agencies will deal with civil society, but rather a strong tension between giving more attention to civil society actors on the one hand, and inclusiveness as tokenism, and democracy and human rights only “on demand” on the other hand.

At national level, activists might ask themselves whether support from powerful external actors might strengthen their case, or whether it leads to further “NGO-isation” and a donor-driven setup of what should be a socio-political struggle for social and political rights.

The existing national “multi-stakeholder engagement” mechanisms in the field of aid need to be carefully assessed. Often dominated by international NGOs, they are already distorting or damaging the existing and often fragile democratic spaces and processes at national level, where people

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<sup>36</sup> Report of Non-state Actor Consultation on the Global Action Plan for Healthy Lives and Well-being, 30 April 2019 <https://www.who.int/sdg/global-action-plan/public-consultations/upcoming-non-state-actor-consultation-on-the-global-action-plan-for-healthy-lives-and-well-being>

<sup>37</sup> Quoting Thomas Schwarz: “We are still not amused”



and governments are expected to “negotiate”, as right-holders and duty-bearers, the terms of their social contract for health.

The WHO has recently shown that it would be open to look at the matter in a more thoughtful way. Together with UCH2030, civil society and member states representatives, the WHO is developing a ‘Handbook for social participation for UHC’. It aims to provide governments with some guidance on ‘what to do with civil society’. We consider this a useful project. A series of webinars around this theme, held in spring 2020 provided lots of great food for thought.<sup>38</sup>

## 4. The GAP as a normative instrument compared with the track record of some of its signatory agencies

One of the commitments of the GAP signatories is to enhance their shared accountability by reviewing and learning together. However, the GAP document does not address the question of whether the GAP has the strategic and technical elements in place to operate effectively toward results in the years ahead, and to credibly demonstrate such results in future evaluations.

Within and between the lines and chapters of the GAP, there is the issue of diversity in institutional cultures and narratives. Five of the signatory agencies are, in principle, funders while the other seven mainly provide normative and policy guidance and technical assistance<sup>39</sup>. It raises the question whose positions and narratives are best represented in the GAP?

And then, there is the issue of accountability. It is unclear who the agencies are accountable to. Compared with initial drafts of the GAP, however, there is a bit of progress in terms of narrative and procedures.

As stated in the GAP, *“the agencies will prepare annual joint progress reports to inform and engage Member States and non-state actors. These reports may be used in appropriate formats to inform their governing bodies, including the World Health Assembly, of progress under the Global Action Plan. An independent evaluation of the Global Action Plan is proposed for 2023, with collaboration, as appropriate, among the agencies’ monitoring and evaluation teams.”*<sup>40</sup>

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<sup>38</sup> Civil society consultation on Handbook on Social Participation for UHC

<https://www.uhc2030.org/what-we-do/accountability/civil-society-consultation-on-handbook-on-social-participation-for-uhc/>

<sup>39</sup> Self-definition, page 11

<sup>40</sup> Page xxiii



How can we measure the GAP's successes and failures, and its impact on healthy lives and well-being? It seems that the signatories recognised this need and therefore sought an assessment of the "evaluability" of the GAP from the early stages of implementation.<sup>41</sup> This exercise will look at all of the key strategic elements that should be in place to maximise the likelihood that the GAP will be successful in supporting the achievement of the SDGs. As civil society, we are looking forward to the outcomes of this assessment and the lessons for the signatory agencies.

## **Narrative vs. realities?**

So, once more, the GAP document provides both solid and valid language: *"The success of the Global Action Plan will depend on accountability for the commitments made and continuous learning within and across the agencies, as well as identifying the enabling contributions of countries and partners. However, the agencies have sought to avoid creating heavy monitoring and evaluation processes under the Plan that would entail transaction costs better invested in supporting countries."*<sup>42</sup>

Our conclusion is as little surprising as the GAP itself: it's all in the doing. The starting point, the plan itself, is a nice document and valid as such. One of the worst-case scenarios would be if it remains just a piece of "virtual" paper, developed because some authorities wanted to see it, but without real commitment of using it. The second worst-case scenario would be if the GAP is used to strengthen the power imbalance between the most powerful global actors and the countries and their societies.

## **Looking at the track record of some GAP agencies: a focus on Gavi, the Global Fund and the Global Financing Facility**

We focused our analysis of the track record of the GAP agencies on these three GHIs for different reasons: they all share the same purpose of raising and allocating financial contributions to health in low- and middle-income countries, all three have been actively engaged with drafting the sustainable financing for health accelerator with a joint action plan, and they all claim to invest resources to strengthen health systems.

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<sup>41</sup> <http://www.uneval.org/resources/images/vacancies/SDGGAPJointEvaluabilityAssessment-FinalConsultancyTOR25Feb2020.pdf>

<sup>42</sup> Page 42



To reflect upon the three GHIs' approach to the four strategies of the GAP - i.e. engage-accelerate-align-account - we will briefly look into their joint action plan and their individual track record.



Figure 3: Illustration of four commitments of the GAP agencies to guide implementation of the Plan (from page 26 in the GAP document)

## Engage

### Gavi

Country leadership, management and coordination is one of Gavi's strategic enablers in their strategy for 2016-2020<sup>43</sup>, and repeated as a principle in the strategy for 2021-2025<sup>44</sup>. Gavi recognises the role of civil society in reaching hard-to-reach populations, strengthening health systems, influencing public policy, supporting resource mobilisation and ensuring transparency and accountability. Gavi has its CSO constituency, with more than 4000 CSOs to support immunisation, and supports CSO Country Platforms in twenty-six countries.<sup>45</sup> In practice, Gavi considers its health systems strengthening activities as country-led because governments develop their proposals in line with the national health plan. However, the proposals must also be related to Gavi's vaccination goals and approved by Gavi's independent review committee. If they are rejected, countries have to adjust and resubmit them. This time-consuming process often burdens already capacity-limited Ministries of Health.

<sup>43</sup> <https://www.gavi.org/sites/default/files/document/2019/Gavi%20Strategy%202016-2020.pdf>

<sup>44</sup> <https://www.gavi.org/sites/default/files/board/minutes/2019/Gavi%20strategy%202021-2025%20one-pager.pdf>

<sup>45</sup> <http://www.gavi-cso.org/gavi-cso-country-platforms-project/country-updates/who-are-the-gavi-cso-platforms>





## Global Fund

Partnership and country-ownership are also key principles of the Global Fund's current strategy 2017-2022<sup>46</sup>, of which one key indicator is improving alignment of investments with country "need", with need defined in terms of disease burden and ability to pay. A key element and tool to achieve this is the Country Coordinating Mechanisms, which are national multi-stakeholder committees including civil society, ministries, multi- or bilateral agencies, academia, private sector, trade unions, technical agencies and people affected by HIV/AIDS, tuberculosis and malaria. It is recognised by the Global Fund that strong health systems are essential to making progress against HIV/AIDS, tuberculosis and malaria, and to ensuring that countries can address the varied health challenges they face. However, for the Global Fund, health systems strengthening means that countries must meet the standards of its programmes, in terms of procurement and supply chains, financial management, data systems and analytical capacity. It also includes strengthening the health workforce in its objectives.

## GFF

When joining the GFF as a recipient country, the respective government develops the Investment Case, which outlines the national strategy for women's, children's and adolescents' health, which interventions will be part of the benefit package, and how they will be funded. The GFF supports Investment Cases for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) developed by the countries and aligning with national health financing strategies. In GFF countries there is a multi-stakeholder Country Platform, formed by either an existing governance structure, or if there is no structure in place, by a new one. The Country Platform is similar to the Global Fund's Country Coordinating Mechanism.

## Accelerate

The three GHIs committed to work closely on the **Sustainable Financing for Health Accelerator (SFHA)** to help countries improve mobilisation, allocation and use of health financing. This accelerator is based on (a) domestic resource mobilisation (DRM), (b) more value for money, meaning better public financial management and efficiency, and (c) effective development assistance and innovation.

This seems to be a straightforward area of collaboration between the three GHIs and an obvious option for partnering up, given that they all have a health financing perspective. All three

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<sup>46</sup> [https://www.theglobalfund.org/media/2531/core\\_globalfundstrategy2017-2022\\_strategy\\_en.pdf](https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy_en.pdf)



emphasise the need of country governments to co-finance the respective programmes. They also underscore the importance of DRM to achieve the specific objectives and to guarantee sustainability of leveraged results - although the term DRM is maybe linked to efficiency measures and private sector involvement, rather than reforms for tax justice. Let's focus in more detail on some of each GHI's characteristics:

### *Gavi*

In its current strategy for 2016-2020, Gavi supports its mission on four strategic goals, one of which is “to increase effectiveness and efficiency of immunisation delivery as an integrated part of strengthened health systems”.<sup>47</sup> This promise is renewed in the 2021-2025 strategy, where health systems strengthening is framed as a way to increase equity in immunisation.<sup>48</sup> Resource mobilisation, including domestic investments in immunisation, is recognised as a critical enabler of Gavi's mission. It remains vague, though, what health systems strengthening concretely entails for Gavi. The idea of including health systems strengthening in Gavi's funding programmes came up and was endorsed fifteen years ago, when the Board opened a new “window” for health systems strengthening initiatives based on the argument that a strong health system is needed to sustain high vaccination coverage.<sup>49</sup> This marked a substantial broadening of the scope of Gavi's funding power, though highly contentious.<sup>50</sup> The question remains whether Gavi's approach to supporting health systems strengthening can have a sustainable and substantive impact on countries' health systems, or whether it primarily serves its own vaccination coverage objectives.

### *Global Fund*

The Global Fund, launched in 2002, followed Gavi's example with a single round of dedicated health systems strengthening funding, with similar ambivalence within its Board. The core objectives of its current strategy (2017-2022) are to maximise impact against the three diseases, build resilient and sustainable systems for health, promote and protect human rights and gender equality, and mobilise increased resources. The Global Fund considers DRM as key to strengthening sustainability of their investments and encourages countries to approach health financing comprehensively and include a health financing strategy in their grant design. The Global Fund also encourages institutionalising national health accounts to track domestic and external health and disease programme spending. All Global Fund investments come with co-financing

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<sup>47</sup> <https://www.gavi.org/sites/default/files/document/2019/Gavi%20Strategy%202016-2020.pdf>

<sup>48</sup> [https://www.gavi.org/sites/default/files/board/minutes/2019/2019-Mtg-1-pres\\_06%20-%20Gavi%205.0%20The%20Alliances%202021-2025%20Strategy.pdf](https://www.gavi.org/sites/default/files/board/minutes/2019/2019-Mtg-1-pres_06%20-%20Gavi%205.0%20The%20Alliances%202021-2025%20Strategy.pdf)

<sup>49</sup> <https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-7-16#Tab1>

<sup>50</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4166931/pdf/rqph-9-865.pdf>





requirements for recipient countries according to their national income level and disease burden. Two core requirements are progressive government expenditure on health and a progressive uptake of key programme costs, including those funded by the Global Fund.

## GFF

The GFF was initiated in 2015 as the financing branch of the “Every Woman Every Child” strategy. The GFF, a platform bringing together different stakeholders, holds a fund at the World Bank to catalyse additional funding for SRHR projects in seventy-six eligible countries. Grants from this fund are traditionally linked to a larger World Bank loan that countries will take to finance a new project for four to five years. The grant linked to the loan is meant to pay for a fraction of a comprehensive strategy. Therefore, mobilisation of resources is in the heart of the GFF mechanism, as well as efficiency gains through high-impact interventions. Its business plan explains that the GFF intends to achieve its objectives by triggering “*smart, scaled and sustainable financing*”, emphasising the much-needed increase of domestic resources to fill the massive resource gap in women’s, children’s and adolescents’ health. However, so far it has been difficult to identify and pinpoint exactly where and how the GFF has supported genuine efficiency gains and DRM, as recent case studies and information from the countries show.<sup>51</sup> The GFF also means to contribute to UHC in its partner countries. In fact, strengthened systems for UHC is an objective of the GFF, next to improved health for women, children, and adolescents. The identification of financing needs and necessary systems reforms is supposed to form part of the GFF investment case.

## Align

There is already a link between the three GHIs, as Gavi and Global Fund have contributed to the GFF’s Trust Fund and they are members of the Investors Group<sup>52</sup>, one of the main governance bodies of the GFF. Moreover, the Global Fund also plans to expand towards RMNCAH and integrate this into its programming and to do so, it plans to collaborate with Gavi, the GFF, and with UN bodies like UNFPA and the WHO. At global level and apart from co-signing the GAP, all three are engaged in the “Every Woman Every Child UN strategy”. Global Fund and Gavi each have a seat at the GFF Investors Group, and both have long-standing bilateral collaborations that

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<sup>51</sup> <https://www.csogffhub.org/resources/comparative-analysis-of-the-gff-enhancing-inclusivity-transparency-and-accountability/>

<sup>52</sup> For more information on the GFF’s governance set-up read Wemos factsheet here: <http://www.wemosresources.org/finance-for-health/factsheet-the-global-financing-facility/>



are expected to further deepen after the recent move of their headquarter offices to the same campus.

Before the meeting of the GFF Investors Group in November 2019, a paper was presented about the positioning of the Gavi, the Global Fund and the GFF in the global health architecture, their focus, and opportunities of intensified collaboration.<sup>53</sup> The paper showed that all attach importance to country ownership with country-led programmes, and they work with a similar set of in-country stakeholders, like Ministries of Health and Ministries of Finance. Besides their different programmatic focus areas, all three GHIs prioritise and place *UHC* and *health systems strengthening* as well as *DRM high* on their agenda. These priorities are also expressed in the GAP and in the SFHA, where joint country-level and global and regional-level actions are proposed.

### *The SFHA and their joint global work plan*

The GAP calls for signatory agencies to develop internal strategies to ensure alignment with the SFHA, agree on joint tools for identifying key bottlenecks of health financing, and support initiatives for joint learning and capacity-building. To date, no such strategy has been developed by the three GHIs. However, a global joint work plan has been developed for the SFHA and the agencies report to the GAP Secretariat and the Sherpas. The joint plan also includes the World Bank and WHO, but here we focus only on Gavi, Global Fund and GFF. In their global work plan for joint health financing activities, there are tasks on each topic of the SFHA:

**(a) DRM:** the three GHIs will be focusing on pro-health taxes in coordination with the IMF and in dialogue with country teams and governments. There is also going to be a joint statement on excise taxes for health by the IMF, World Bank and the three GHIs. The partners will also work with civil society on health financing and budget advocacy training, something that already started in April 2020. They will also support joint dialogues between Ministries of Health and Finance. Finally, they will coordinate their approaches towards DRM, however, we have no details on this to date.

**(b) more value for money, meaning better public financial management and efficiency:** we expect to see a framework on the use of country systems and donor support to country public financial management systems for health. Partners furthermore plan to mainstream guidance on results-based financing (RBF) and produce global guidance on whether and how to introduce it.

**(c) effective development assistance and innovation:** led by the Global Fund, partners of the SFHA will investigate the mechanics of donor cooperation by a landscape analysis. We are not

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<sup>53</sup> [https://www.csogffhub.org/wp-content/uploads/2019/09/Global-Health-Architecture\\_Gavi-GFF-GF.pdf](https://www.csogffhub.org/wp-content/uploads/2019/09/Global-Health-Architecture_Gavi-GFF-GF.pdf)



aware of any outcomes yet. They will also coordinate and provide long-term technical assistance to countries.

Some frontrunner countries have been selected to demonstrate potential gains, as highlighted in the GAP. Each Accelerator has its own list of countries that it is focusing on, with overlap where possible. Focus countries under the SFHA are Ivory Coast, Ghana, Laos, Niger, Pakistan, Tajikistan, Zimbabwe, Kenya, and Myanmar.

## Account

As stated, the GAP will not create new data collection requirements, outcome or impact indicators or lines of reporting. Agencies will prepare annual joint reports to inform Member States and non-state actors. The partners of the SFHA plan to provide bi-monthly updates to the Sherpa, as well as quarterly newsletters and a progress report at the World Health Assembly. We are looking forward to receiving such updates, especially from the front-runner countries.

The negative effects of poor collaboration between GHIs have been discussed and documented extensively, and there is now broad consensus that for aid to be effective, there needs to be harmonisation between GHIs themselves and with the recipient countries. The ambition to harmonise is not new; there have been other efforts in the past. One was the “Health Systems Funding Platform”, a funding collaboration between the Global Fund, Gavi and the World Bank, established in 2009 and facilitated by the WHO.<sup>54</sup> It was intended to accelerate progress towards the Millennium Development Goals, but was stalled at the implementation phase.<sup>55</sup> How could the GAP make a difference in guiding these three agencies' work, in addition to their existing cooperation? The GAP does not have any binding power. Nevertheless, it is a renewal of commitments for collaboration and a new reference for GHIs to be held accountable to. It can push GHIs to use joint planning, monitoring and evaluation, as well as funding cycles, and it can be a step back to sector-wide approaches to health.

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<sup>54</sup> <https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-7-16>

<sup>55</sup> <https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-9-9>



## 5. GAP, power relations and determinants of health: Will the GAP make any difference? If so, for better or for worse?

Is the GAP fit for addressing power relations and dealing with structural determinants of health and health policies? This question cannot be easily answered. Much depends on the willingness and power of the “owners” of the GAP to use it as an instrument to counter some current global trends that rather deepen than overcome health inequities. The outlook is, therefore, rather dire...

Once again, if we just look at the text of the GAP, it looks all nice and sound. One of the seven accelerators focuses on determinants of health. With the statement that “*health and well-being are shaped by the conditions in which people are born, grow, live, work and age, and these are in turn shaped by social, economic and environmental factors*”<sup>56</sup>, the GAP directly refers to the report of the WHO Global Commission on Social Determinants of Health and their 2005 ground-breaking report “Closing the Gap in a Generation”<sup>57</sup>. The GAP rightly highlights two blind spots of the WHO Commission that have only recently found the attention needed: the environmental and commercial determinants of health.

Through this accelerator, agencies aim to address environmental determinants of health (air, water and soil pollution, bio-diversity, and food security due to climate change), commercial and economic determinants of health (implications arising from market globalisation and trade of harmful goods, like tobacco and ultra-processed foods), and social and structural determinants of health (inequalities and exclusion due to age, gender, ethnicity, race, religion, disability, sexual orientation, gender identity and vulnerability to violence, as well as their intersectionality) through inclusive economic growth, resilient equity and guaranteed human security. These are central to health and the well-being of people and to achieve the 2030 SDG agenda of leaving no one behind.

So, can we expect the GAP to contribute to “closing the gap in a generation”? Not quite. The analysis and references are sound, but the proposals are weak. The GAP states that “*while the category of social and structural determinants is broad, this accelerator theme focuses on gender norms and inequalities, human rights and legal barriers, stigma and discrimination that shape health and impede access to health services*”. However, it does not give a good argument for this narrow focus. For the commercial determinants of health, the GAP states that addressing them

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<sup>56</sup> Page 65.

<sup>57</sup> [https://www.who.int/social\\_determinants/thecommission/en/](https://www.who.int/social_determinants/thecommission/en/)



*“requires multi-stakeholder responses involving a range of public and private sector actors in health, industry, finance, environment, media and other sectors.”<sup>58</sup>*

Knowing that our paper cannot cover the full range of issues related to the gap between the claim of the GAP being a “global action plan for healthy lives and well-being for all” and the reality of defining only a small set of “accelerators” and actions, this chapter focuses on the realities behind the GAP agencies’ “multi-stakeholder” approach to commercial determinants of health. And yes, there is a problem.

## Welcome to the private sector

Some of the GAP agencies are organised as “partnerships” and explicitly welcome the private and philanthropic sector in their governance structure<sup>59</sup>. From their institutional history and culture, they are tempted to use a multi-stakeholder approach in their programmes, and this might be reinforced by the GAP and its language on multi-stakeholder approaches. At least, this is how we read the statement on the commercial determinants, quoted above.

The strong influence of the private sector on these agencies does not help them to be aware of the issues related to an on-going corporatisation (transformation of state-owned agencies or organisations into corporations<sup>60</sup>) of national programmes depending on their support. Multi-stakeholderism contributes to rolling back the social and economic responsibilities of the state.

For the UN agencies within the GAP team, and in particular the WHO, the ownership remains essentially with the legitimate membership and voting power of their Member State governments. Nevertheless, non-state actors, especially multinational corporations like big pharma and foundations, are increasingly influencing WHO’s policies and programmes.

Besides the impending and imminent capture of the UN system through the UN’s Strategic Partnership Agreement with the World Economic Forum<sup>61</sup> in 2019 - which will unavoidably allow the influence of the private forces in the UN agencies’ decisions - the WHO has strategically opened itself to partnerships with the private sector, mainly to close its financing gap. We do not

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<sup>58</sup> Page 67

<sup>59</sup> See, as initial reference: Civil society participation in global public private partnerships for health. Katerini Tagmatarchi Storeng, Antoine de Bengy Puyvallée, HEAPOL 2018  
<https://academic.oup.com/heapol/article/33/8/928/5085423>

<sup>60</sup> How Does Corporatization Improve the Performance of Government Agencies? Lessons From the Restructuring of State-Owned Forest Agencies in Australia ResearchGate

<sup>61</sup> World Economic Forum and UN Sign Strategic Partnership Framework -  
<https://www.weforum.org/press/2019/06/world-economic-forum-and-un-sign-strategic-partnership-framework/>



yet know how the WHO will cope with the expected further shortfall in its funding due to the halting of the USA funding and the threat to even withdraw from the WHO, resulting from the quarrel over COVID-19 information transparency.

All in all, private involvement and partnerships have the risk to undermine the mandates of all the GAP agencies, as well as their independence, neutrality, and effectiveness when holding businesses to account, both at the global and country level. This may further move the world towards a privatised, undemocratic and inequitable global health governance.

Even though private interference is not new in the agencies' systems, under the new collaboration of the WHO and the eleven agencies through the GAP, countries may be permanently associated indirectly with transnational corporations. In the long-term, this may permit corporate forces to unquestionably turn into 'silent advice-givers' to the front-runners of agencies' departments. In turn, this might lead to distorted priorities that would further widen the health inequity and poor global health outcomes, which the GAP intently aims to tackle through its "determinants of health" accelerator.

But the story still needs to be written. The GAP calls for "*reviewing the agencies' policies for engagement with the private sector to build on good practices for meaningful and effective contributions to national health responses, including through public-private partnerships, in order to achieve the health-related SDG targets, while reviewing code of conduct policies on private sector engagement and managing conflicts of interest between public health and those who develop, market or sell health-harming products, such as the fundamental conflict of interest between the tobacco industry and public health.*"<sup>62</sup>

So, let us watch carefully if such a review will be implemented - and where it will lead the GAP agencies to. If the strong language of the section on social determinants is not supported by practice or by institutional change among the signatory agencies, the GAP turns out to be a recycled product of vested economic powers in global health.

## Public goods vs. private finance

What is the likelihood that the GAP and the strengthened collaboration between its agencies contribute to the agencies' internal strategies to address the existing financialization of global public and common goods for health? This is difficult to predict, as we have already shown in the previous chapter. The GAP's SFHA at least does not provide clear guidance.<sup>63</sup> How the GAP

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<sup>62</sup> Box, page 71

<sup>63</sup> Page 56ff.





agencies define their unified work on achieving better outcomes on common goods for health remains an unanswered question.

We define global public goods as goods with benefits and/or costs that potentially extend to all countries, people, and generations. Global public goods have a dual sense: they are public as opposed to private and they are global as opposed to national.<sup>64</sup> Access to health and health care as a “global public goods” has just been fiercely debated during the drafting of a resolution on COVID-19 in view of the 73<sup>rd</sup> World Health Assembly.

Each GAP agency has a unique way of going about the health agenda with unique priorities – a challenge that still renders GAP half-valid to secure the collaboration. In line with this case, the World Bank has global public goods in its strategies and annually devotes USD 100 million to them, to set up a crisis risk platform, for the pandemic emergency financing facility, global preparedness monitoring board, knowledge generation and sharing programmes through research and development. Likewise, the WHO has global public goods in its three key pillars and has an established knowledge programme on their financing. However, other agencies have not yet integrated a global public goods approach into their internal strategies, even though the GAP talks about it in the SFHA.<sup>65</sup> For instance, Gavi and the Global Fund don't explicitly define global public goods<sup>66</sup> or common goods for health in their internal strategies. They don't directly support product development for neglected diseases, but rather innovations and smooth entry of new products in the markets.

And the world, and even the GAP agencies themselves, have not been waiting for the GAP. Global cooperation in health, humanitarian and development programmes through multilateral agencies is growing faster than one can imagine. The huge (!) gap<sup>67</sup> in Official Development Assistance (ODA)<sup>68</sup>, created by a fall in the net ODA flows by 2.7% in real terms from 2017 to 2018<sup>69</sup>, has largely been closed by the GAP agencies' contributions. This raises an issue of the alignment between the agencies' internal strategies<sup>70</sup> and their approaches on global public and common goods for health, with the health and development ambitions, strategies, and visions of the targeted aid recipients, essentially in the global South.

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<sup>64</sup> Wikipedia [https://en.wikipedia.org/wiki/Global\\_public\\_good](https://en.wikipedia.org/wiki/Global_public_good)

<sup>65</sup> Page 60, Stronger Collaboration, Better Health Global Action Plan for Healthy Lives and Well-being for All

<sup>66</sup> Page 4, Aligning multilateral support for global public goods for health under the Global Action Plan -Kaci Kennedy McDade, Jessica Kraus, Hugo Petitjean, Christina Schrade, Sara Fewer, Naomi Beyeler, Gavin Yamey

<sup>67</sup> "2018 ODA data tables - OECD.org." 10 Apr. 2019, <https://www.oecd.org/dac/financing-sustainable-development/development-finance-data/ODA-2018-complete-data-tables.pdf>. Accessed 10 Mar. 2020.

<sup>68</sup> Strengthen means of implementation and revitalize the global partnership for sustainable development- SDG 17

<sup>69</sup> Sustainable Development Goal 17 – United Nations

<sup>70</sup> Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-being for All



The agencies can't sustainably support their global mandates without external support or resources, which raises questions on the survival of this synergy. World Bank and Gavi still embrace the use of impact bonds and vaccine bonds to scale up financing for their focus areas, which allows entry of financialization. And so, their operations and functioning largely depend on private finance, which limits support for global public goods for health that underpin global health security. This indicates that the agencies have not yet designed unified sustainable strategies to ensure long-term collective financing for their synergy and unified approach. The progress of this collaboration remains to be seen, since all agencies have independent mandates and structures with lack of a clearly defined scope of work.

For guaranteed sustainability of this collaboration, agencies should design collective financial arrangements that will pull a variety of both public and private resources in support of the ongoing international initiatives. Also, they should provide direct and coordinated response to a global set of priorities, such as provision of global public goods, preventing and combating communicable diseases, and addressing food security and climate change challenges.

## **Distortion of national policies and processes through financing initiatives**

Multiple financing initiatives have been established by agencies to support health for better health outcomes, for example, the GFF (see above, chapter 4). Much as GFF and World Bank are part of the twelve multilateral agencies in GAP and pivotal in transforming the health outcomes of RMNCAH, they can distort national health financing in their own way.

In Uganda, we experience that the GFF and the World Bank lack an approach to address the financing bottlenecks to ensure sustainable domestic financing and reduce external dependence of the health sector. While they have been instrumental in implementing performance-based and results-based financing mechanisms, they have not succeeded much in the expenditure priority setting. In April 2020, the World Bank re-allocated USD 15 million from the Uganda Reproductive Maternal and Child Health Improvement Project to the COVID-19 response.<sup>71</sup> This is already a distortion in the existing health priorities, funding mechanisms and processes, which is likely to disrupt ongoing projects in the health sector. Such diversionary approaches may result in poor harmonisation of operations and financial strategies, policies and structures in realising better health outcomes, which underpins low value for money - and contravenes the alignment commitment in the GAP.

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<sup>71</sup> World Bank Donates UGX 57bn to Fight COVID-19 – URN, <https://ugandaradionetwork.net/story/world-bank-donates-shs-57bn-to-fight-covid-19>





## 6. COVID-19: No visible initial progress...

Alignment, particularly in health financing, is crucial in addressing national and global health challenges, but this is not possible with parallel approaches or even competition for attention and support. At the recently concluded virtual 73<sup>rd</sup> World Health Assembly, which focused on the COVID-19 response, all these multilateral agencies nicely presented their statements on how they were assisting WHO member states to combat the pandemic. They all expressed their support for strategic preparedness and response plans of the WHO. However, there was no report on how the agencies were *collaboratively* working together to support countries in containing and mitigating the COVID-19 transmission.

Yes, there was a call for an intensified international cooperation and solidarity to collectively contain, mitigate and defeat the COVID-19 pandemic in line with the 2005 International Health Regulations on achieving international public health security, including coordinated mobilisation and utilisation of financial resources and combined efforts to improve access to necessary commodities and their distribution, such as the Access to COVID-19 Tools (ACT) accelerator. But there was no discussion in the agencies' submissions on how they were going to work in unison (i.e. in financing vaccine research and development) and avert implications of uncoordinated responses and distortion of ongoing national health programmes.

The information availed by agencies at the Assembly profoundly manifests the continued dominance of independent approaches of the agencies and shows no sign of stronger commitment to align their interventions. We are therefore not surprised that the Assembly's resolution on the COVID-19 Response<sup>72</sup> requests the WHO Director General to collaborate with the "signatory agencies of the GAP" and does not explicitly refer to the GAP as a platform for this collaboration.

COVID-19 could have been the (early) test case for the GAP - not in the sense of it already being fully implemented, but of demonstrating a stronger spirit of cooperation and alignment. The GAP agencies have failed this test.

However, the 73<sup>rd</sup> World Health Assembly is not yet over, only suspended, and will be resumed later in the year. So, there might be more to come... In a communication we received in January - before the COVID-19 pandemic grasped everyone's attention, including the GAP agencies and in

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<sup>72</sup> The WHO DG is requested "continue to work with the United Nations Secretary-General and relevant multilateral organizations, including the signatory agencies of the global action plan for healthy lives and well-being for all, on a comprehensive and coordinated response across the United Nations system to support Member States in their responses to the COVID-19 pandemic." [https://apps.who.int/gb/ebwha/pdf\\_files/WHA73/A73\\_R1-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf)



particular the WHO - the GAP Secretariat announced the release of an (informal?) update report on the GAP implementation, to be presented at the World Health Assembly.

## 7. Conclusion: “Watching the GAP”

During the past two decades, there has been a proliferation of GHIs, be it parallel alliances or partnerships in global health, working towards different goals and focusing on specific diseases and interventions. Such initiatives have shown to massively increase resources for health, but they can also disrupt policy and implementation processes in recipient countries, especially if they lack alignment and coordination between each other and with the national governments.

There are plenty of good intentions expressed in the making and adoption of the GAP, and the document itself is ideologically alright and smart. But it insufficiently addresses the reality. Agencies have to re-focus their attention on harmonisation of their internal strategies. This will call for strengthening sustainability of this partnership and coordination of the agencies. They need well-designed and elaborated mechanisms for joint financial arrangements that will facilitate pulling of agencies’ diverse public and private resources in support of the continuing transnational initiatives. This will enable these institutions to provide direct and coordinated response to a global set of priorities, such as the provision of global public goods, preventing and combating communicable diseases and addressing food security and planetary health challenges.

In conclusion, despite the promise of a new dawn of collaboration and coordination outlined in the GAP, the critical analysis done and documented in this paper indicates an environment of “business as usual”. As noted above, the GAP hinges on four core commitments and seven accelerators that will guide signatory agencies, governments and stakeholders in accelerating towards health for all.

However, the lack of clear and explicit frameworks to promote transparency, accountability and good governance between and among agencies leaves much to be desired. Additionally, participation of civil society in drafting and developing the GAP was more inclined to tokenism than meaningful and impactful participation, as their views were not fully considered or addressed. The striking similarities between the GAP and previous health initiatives spells a repetition of their shortcomings, especially in regard to national ownership, CSO engagement, and the ever-growing influence of multinational corporations in global health - all which risk to distort and influence national policies and priorities.

We commend the GAP for the positive language it exhumes considering the global mantra of inclusivity, partnerships, accountability, transparency, ownership, and good governance for health.



However, without explicit and concrete frameworks for monitoring, mutual accountability and clear and effective participation to address ever-growing power imbalances, the goal of accelerating achievement of health for all by 2030 will not be met.

We feel that our initial analysis as presented in this paper, underlines our assessment that the implementation of the GAP needs - and deserves – to be critically watched by civil society. Join us: Watch the GAP!