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Concept Note - MOPAN Insights on Multilateral Effectiveness in Global Health

Generating evidence to inform global health architecture reforms

This document presents the concept note for the MOPAN Insights study on multilateral effectiveness in global health. The purpose of the study is to generate evidence and recommendations to support decisive reform within and across multilateral health organisations in the context of a wider global health reform process. It describes the proposed scope, analytical framework, methodology, and timeline for the study.

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Concept note: MOPAN insights on multilateral effectiveness in global health

Context

Global health cooperation is entering a period of profound transition. Multilateral institutions that once expanded steadily - through new initiatives, vertical funds and layered financing mechanisms, now operate in a far more constrained and contested environment. The current global health architecture (GHA) has responded to emergencies, saved lives and reached the most vulnerable[1]. However, the system has evolved in ways that have led to fragmentation, the proliferation of parallel processes (such as funding applications) and uneven support to core global health functions. Geopolitical realignments are increasingly leading countries to reduce ODA (with bilateral health ODA projected to fall by 19–33% in 2025 against 2023 levels — a steeper cut than overall aid.[2]) and further use development and health assistance as instruments of foreign policy and domestic interest.[3] Although ODA will continue to play a role, it is unlikely that there will be a reversal in current trends. Financial and political incentives within the GHA have rewarded visibility and direct delivery. Varied financing models that include earmarked funding, have resulted in[4] evolved and overlapping mandates and action.[5] At country level, these dynamics translate into fragmentation, misaligned programmes and significant administrative burdens for national authorities. There are persistent tensions between vertical funds and the need to focus on primary health and system strengthening that is demand led by countries exposing the gap between today's architecture and what is needed to meet future burden of disease.[6] Multilateral health actors need to adjust with urgency: protect essential functions, find more effective ways of aligning their global health efforts and enable countries to assume stronger leadership and greater financial responsibility for their own health priorities. The future architecture needs to look different than it does today to meet a different set of health needs, political contexts and resource envelopes at the global, regional and country levels. The transformation of the global health system requires new thinking and leadership to promote country needs

[1] WHO (2025) Reform of the global health architecture and the UN80 Initiative: Report by the Director-General. Executive Board, 158th session, provisional agenda item 29.1. Geneva, Switzerland: World Health Organization. Link
[2] OECD (2025) *Cuts in official development assistance: OECD projections for 2025 and the near term*. OECD Policy Briefs No. 26. Paris: OECD Publishing. Link
[3] Health Policy Watch (2026) *Zambia and Zimbabwe back away from 'Prescriptive' US Health Deals,* Link
[4] Gómez, E.J., Atun, R. and Venkat Narayan, K.M. (2020) 'It's far too complicated: why fragmentation persists in global health governance', *Globalization and Health*, 16(1), p. 9
[5] IMF 2024 *How to Heal Health Financing* Link
[6] Witter, S. *et al.* (2025) 'Understanding the political economy of reforming global health initiatives', *Globalization and Health*, 21(40). Link

including greater health sovereignty, accelerated transition to more domestic financing in all contexts, and strengthened governance.

Global health reform initiatives

Although the need for systemic reform pre-dates 2025, there has been a recent proliferation of GHA reform initiatives ideas and dialogues, accelerating momentum for consolidated reforms (Annex B). Regional- and country-led processes, including the Accra Reset[7] and the wider self-reliance movement based on concepts of health sovereignty, have been crystallizing over the last several years; a reforming global health system needs to respond to demand from all countries and evolve in coordination and alignment with country and regional priorities. At the WHO's Executive Board meeting EB158/44[8], Member States requested that WHO host a Joint Process to build on and bring together current global health architecture proposals and wider UN80 reform process. Although in its early stages, the aim is to help support the development of a common framework for the global health architecture to act as a basis for future investments, priorities, and possible consolidations. This study aims to support these various reform processes by providing relevant, targeted evidence and analysis that enables more informed dialogue and decision-making. As some consensus emerges around the shape and direction of GHA reform, so too does the importance of ensuring that global level reforms are not confined to a top-down restructuring of today's system. It is critical that the demands and needs of countries drive global reform in terms of direction, pace and substance.[9] At the same time, equity goals are built into most MOPAN organisations and the needs, rights and demands of vulnerable populations – not just country governments (states) – are vital to include in the research.

Purpose, objectives and target audience

The **purpose** of the study is to collate, synthesise and analyse evidence and recommendations to support decisive reform within and across nine multilateral organisations in the global health ecosystem. The study is undertaken to contribute to a wider global health reform process.

The **objective** of the study is to assess the comparative advantage of key multilateral organisations (MOs) in delivering priority functions of a future global health architecture, interdependencies, and the implications of this for future division of labour, ways of working and collaboration. It will also identify realistic and sustainable pathways for reform, taking account of the incentives shaping current behaviour.

The **audience** of the study are MOPAN members engaged in ongoing reform efforts, multilateral health organisations, country governments (especially ministries of health) and other Global Health actors aligned closely with the WHO hosted Joint Process to support dialogue and decision-making on reform options.

[7] Accra Reset (2024) Resetting global development cooperation for a post-dependency world. Accra: Accra Reset, Link

[8] WHO EB 158 Documents Link

[9] Mosneaga, A. *et al.* (2025) 'Global health reimagined: proposed functions, structures, and forms from five regions', *The Lancet Global Health*, 13(10), Link

MOPAN's Offer

Like other MOPAN Insights, this study will build on performance evidence from relevant MOPAN assessments of multilateral organisations. Its findings will inform future MOPAN assessments of global health organisations. They will be particularly useful in analysing the enabling environment for organisational effectiveness, a prominent line of enquiry in the new MOPAN 4 methodology.

While several reform proposals have been tabled for discussion, there is a lack of evidence to guide decisions on the optimal configuration of actors, organisations and delivery pathways across the global health ecosystem. Building on MOPAN's assessments of individual global health organisations, this work will help address the evidence gap by assessing the functionality of nine multilateral organisations within the broader architecture. The study reflects MOPAN's commitment to improving the performance of the multilateral system and to producing cross-system analysis. Rather than analysing whether individual organisations are performing well in isolation, the study will examine institutional collaboration and interdependencies, how multilateral organisations are collectively positioned to deliver results efficiently in a resource-constrained and complex geopolitical environment, and what changes are required to meet future health challenges. Critically, in acknowledging the interlinkages between the global health architecture and development assistance for health, the study will aim to unpack this complexity while focusing primarily on the development aspects of the global system (see also Limitations, below).

Interviews (Annex D) and the literature review (Annex G) carried out to inform this note highlight strong demand from global health stakeholders for actionable insights into how public health needs and global public goods can be met more effectively. There was a strong request to build on other reform initiatives (Annex B) as well as to align with the ongoing WHO-hosted Joint-process.

The evidence will therefore be presented in a way that supports the on-going dialogue in various quarters that collectively aims to advance global reform while preserving the strengths of each organisation, reducing duplication, and enhancing alignment. To the extent possible, the analysis will be sensitive to the subsidiarity principle given the growing focus on regionalisation in both global health and development assistance for health as a pathway for efficient delivery of global health priorities and functions across diverse country contexts. During the preliminary phase ahead of the initial mapping, the team will explore options to present information in ways that highlight where and how global, regional and country operations interact with one another.

Guiding questions

The study is guided by three overarching research questions:

Q1. What relative comparative advantages do key multilateral health organisations have in delivering the priority functions of a future global health architecture[10]?

Q2. What are the implications for future division of labour, ways of working and collaboration across multilateral organisations?

[10] We align our definition of global health architecture with that of WHO. GHA refers to the combination of actors, frameworks and processes that guide, coordinate, finance and implement efforts to improve and protect health globally. WHO (2025) Reform of the global health architecture and the UN80 Initiative: Report by the Director-General. Executive Board, 158th session, provisional agenda item 29.1. Geneva, Switzerland: World Health Organization. Link

Q3. What operationally feasible and sustainable reform is needed and what are the incentives and disincentives for change?

For this study 'comparative advantage' considers multilateral organisations' relative mandates and organisational attributes in order to leverage a more effective global health ecosystem that fosters better coordination, collaboration and coherence.

The following lines of enquiry will guide the analysis:

- **L1 Mandates:** Examine multilateral organisations' health mandates as defined in their constitutional documents and assess how these mandates have evolved in practice. Map mandates against future priority health functions (see Scope: Functions and institutions below) to identify gaps, interdependencies, overlaps, and areas requiring clearer role delineation across the ecosystem[11]. The analysis will start with historical mandates but will look carefully at how these have evolved in practice as a result of UN resolutions, board decisions and other developments. Furthermore, following the Covid-19 pandemic, and since the Lusaka Agenda was endorsed, many organisations have been evolving and sometimes expanding their mandates and are reshaping their roles. These aspects of mandate evolution will be researched directly with individual organisations and included in the mapping.
- **L2 Organisational attributes:** Assess whether organisational attributes (funding models, operational modalities, governance and accountability structures) are fit to deliver future roles, including interdependencies and the ability to collaborate effectively across institutions. This assessment will cover capacities, capabilities and reach at global, regional, and country levels.
- **L3 Comparative advantage:** Integrate findings from mandate and organisational-attribute analyses to determine each organisation's comparative advantage in relation to future priority health functions. Identify implications for an optimal division of labour and collaboration across the GHA.
- **L4 Incentives:** Analyse how incentives shape the interaction between mandates and organisational attributes, and the extent to which they support or hinder effective allocation and delivery of functions within and across organisations. Consider how incentive structures affect sustainability, durability, and country ownership of health outcomes including the ability of organisations to raise and distribute resources effectively
- **L5 Reform options and incentives for change:** Drawing on lines of enquiry L1-L4, propose reform pathways and identify the incentives and disincentives that would enable or impede their implementation.

Cross-cutting: across all this analysis, the study will provide illustrative insights on how multilateral comparative advantage differs across geopolitical contexts. Humanitarian response will be considered only insofar as it relates to Function 5: delivery in fragile and conflict-affected states (FCAS) – see below.

Outputs

Within the time and resources available, the study will deliver the following products:

1. A concise brief (≤10 pages, excluding annexes) summarising the **mapping of organisational mandates against future priority functions**, to be delivered by end-April, in time for WHA.

2. A concise brief (≤10 pages, excluding annexes) presenting the **comparative advantage analysis** including an analysis of collaboration among different organisations by September, in time for UNGA.
3. A **narrative report addressing the Guiding Questions**, accompanied by an executive summary and all supporting annexes, by December 2026.
4. A full and summary **PowerPoint presentation tailored** for key dissemination moments in the Joint Process, with timing to be defined at the World Health Assembly in May 2026. The dissemination strategy will be agreed with the Advisory Group (Annex E).

Scope: Functions and institutions

Priority functions

The WHO-hosted Joint Process has identified priority functions for the future GHA:

1. Norms and standards: Evidence-based norms, guidelines, classifications, regulatory standards, and global
2. National Health Ownership & Priorities: Strengthening countries' leadership with one plan, one budget, and one monitoring with aligned domestic and international financing public goods
3. Product R&D innovation market shaping, manufacturing regulation access: Equitable development and delivery of health products and technologies
4. Data, surveillance & Health security
5. Health Emergencies & Humanitarian Action: Preparedness, response, recovery across outbreaks, conflict and for vulnerable communities
6. Coordination, Impact, Accountability of GHA: Cross-cutting coordination: mandate alignment, shared impact frameworks, transparency with mutual responsibility and accountability

The development of these functions has highlighted the need to form a distinction between these six global health functions and – for example – the range of thematic priorities for development assistance for health (DAH) that are central to MOPAN's donor-focused mandate.[12] While these two frameworks overlap, (the global health system concerns all countries while DAH concerns a subset of countries), they are not coterminous and capturing that complexity is essential to the usefulness of the study. The mapping exercise will seek to define and compare both sets of categories, not only to provide a reference framework for the comparative advantage analysis, but to reveal where convergence and divergence between the two architectures is driving the duplication and perverse financing incentives that most affect country recipients.

The definitions and sub-functions for each global health function are expected to be developed as part of the WHO-hosted Joint Process and as a result the mapping may not delve into sub-functions extensively. It is anticipated there will be considerable overlap between global health functions and development assistance for health thematic priorities and to enable the study to capture and explore these overlaps with granularity, several spotlight analyses will be undertaken. While the decision on spotlights will be made

[12] The EU and Like-minded Donor reflection process identified thematic areas for development assistance for health: Normative guidance and standards; health security; market shaping, commodity procurement, and fostering equitable access to healthcare products; health financing and resource mobilisation; data analytics, surveillance and early warning; research and development, technology, and innovation; health workforce knowledge exchange and technical collaboration; advocacy, community engagement and inclusion. Link

during the early weeks of the study, examples include: UHC/PHC, technical assistance, advocacy for equity and inclusion.

A glossary will be included in each MOPAN deliverable to ensure clarity around terminology especially where that differs from MOPAN's existing functional classifications. The glossary will also make more explicit the way that some terms are currently used to incorporate a number of quite different elements (for example, the term 'market shaping' which needs tighter definition). Where relevant, the glossary will be reviewed with organisations themselves to ensure clarity and transparency.

For each function, the study will ultimately aim to produce a comparative advantage analysis to identify where each organisation's strengths and weaknesses lie based on evidence of organisational effectiveness, where coordination or role realignment could improve effectiveness, where there are significant gaps or overlaps, and where radical reform options should be considered.

Institutions

The study will focus on an agreed sub-set of multilateral organisations selected because, together, they deliver most of the priority functions above. Provisionally these are:

- United Nations Organisations: United Nations Children's Fund (UNICEF), United Nations Population Fund[13](UNFPA), the World Health Organisation.
- Multilateral development banks: World Bank (and its linked programme, the Global Financing Facility (GFF).
- Global partnerships: Gavi, the Vaccine Alliance, Global Fund to fight AIDS, TB and Malaria.
- Other multilateral partnerships to be included: Pandemic Fund and Unitaid.

Other actors, such as bilateral donors and philanthropies and regional institutions, will be considered to the extent that they influence multilateral behaviour and performance in the contexts of interest. Some organisations have been excluded from scope. UNAIDS has been omitted in light of plans to sunset the entity and the forward-looking ambition of this study. Others like UNDP, GPEI and CEPI have also been excluded from the full list although there is a possibility that organisations may be brought into the study for specific spotlight issues. A decision on this will be taken ahead of the second deliverable date in September.

Analytical approach

Approach to comparative advantage

At the heart of this study is the assessment of comparative advantage. Within the UN system the concept of comparative advantage is often invoked as key to strengthening multilateral coordination, collaboration and coherence. As evidenced by MOPAN, its significance as a unifying concept for promoting effectiveness and efficiency has been minimised by diverging definitions, poor operationalising and deeper

[13] UNFPA is included because of its current circumstances and context which may throw up some important ideas and lessons. It is likely to be merged with UN Women under the UN80 reform process. In the wake of USAID's demise, UNFPA is the main (only significant) global agency providing sexual and reproductive health commodities and technical support to the 54 poorest countries and is an essential bulwark against the global SRHR pushback. Lastly, the UNFPA Supplies Partnership is working innovatively with its partner countries using a co-financing approach and match funding model to support domestic resource mobilisation. There is much to learn here.

structural constraints.[14] The study's analytical approach builds on the work of two recent MOPAN studies on the UN mandate-results gap and comparative advantage and collaboration.[15] [16]

The study will explore MOPAN's revised, relational understanding of comparative advantage[17], one that assesses each organization's strengths in relation to others across the system, rather than in isolation. MOPAN's analysis of the UN mandate-results gap[18] highlights how financial incentives (including tightly earmarked funding) have systematically pushed UN agencies toward service delivery and short-term projects and hints at the challenges involved in strengthening normative and policy functions they were created to perform. Reform decisions must look beyond mandates or current capabilities alone, and account for how incentives (including perverse incentives) have reshaped each and have led to duplication in roles, functions and resources.

Because of how multilateral organisations operate, some overlap in their work is inevitable — particularly as they engage closely with country systems. Organisations cannot always avoid shared areas of work; strengthening health systems for mothers and newborns, or addressing maternal health alongside HIV, TB and malaria, will naturally involve more than one actor. The core challenge is therefore not simply delivering on comparative advantage but also coordinating and adapting across contexts to maximise it.

In this context, the analysis will include 4 dimensions to explore comparative advantage:

- The **Evolution of mandates**: Comparative advantage is not static. The analysis will identify:
    1) **Original mandates** based on what organisations were created to do as well as evolving mandates as they have been shaped over time (for example, as a result of UN resolutions, board decisions and other sources).
    2) **Capabilities established through accrued knowledge, expertise and operational experience**, which may diverge significantly from original mandates (accrued advantage), assessed at global, regional and country levels.
    3) **Prospective advantages given the structural changes now under way,** particularly the funding reductions forcing organizations to shed capabilities and reprioritise.
    4) **Lessons learned to mitigate against mandate creep** for a reformed architecture, as well as where mandate agility has brought benefits, and what this might mean for future division of labour and collaboration.
- **Organisational attributes in practice:** to examine the financing, operational, governance and accountability systems that underpin each organisation in practice and which together, enable or restrict their ability to operate fully to their comparative advantage both independently and while working with other organisations**.** This dimension will draw on evaluation evidence and other sources to explore whether and how a multilateral organisation's systems support its comparative advantage and enable or prevent it from delivering its mandate.

[14] MOPAN (2026). Beyond Overlaps Leveraging Comparative Advantage for Multilateral Collaboration, Multilateral Effectiveness in a Shifting Landscape. Link

[15] MOPAN (2025). Closing the UN Mandate-Results Gap: Realigning Incentives for Lasting Impact, Multilateral Effectiveness in a Shifting Landscape. Link

[16] MOPAN (2026). Beyond Overlaps Leveraging Comparative Advantage for Multilateral Collaboration, Multilateral Effectiveness in a Shifting Landscape. Link

[17] Ibid.

[18] MOPAN (2025). Closing the UN Mandate-Results Gap: Realigning Incentives for Lasting Impact, Multilateral Effectiveness in a Shifting Landscape. Link

- **The shape of the emerging global health architecture:** The study situates comparative advantage for multilateral organisations against how the priority global health functions are currently being delivered. This is the more forward-looking component of the study, that will allow us to better position multilateral organisations against a fast-changing landscape and guide priorities for reform.
- **Approach to subsidiarity:** The study will aim to map out mandates, organisational attributes and comparative advantage across global, regional and country levels bearing in mind the relevance of subsidiarity in the current dialogue. It is acknowledged that the institutions are not all equally present/ active at all levels while not all global health functions are equally relevant at all levels.

Using a political economy analysis approach

Political economy analysis offers an essential lens for understanding how power, incentives, and institutional interests shape the architecture of global health functions and development assistance for health, helping to explain why duplication and misaligned financing persist even when their costs to country recipients are well understood.

Through the analysis of incentives and institutional and power dynamics, (including economic systems) the study will examine the funding structures, governance and accountability systems, and reputational and competitive dynamics that drive organisational behaviour and mandate evolution. Evidence will be drawn from MOPAN assessments and the broader literature on multilateral effectiveness. The goal is to identify lessons to directly inform reform pathways. Findings will address L1 (mandate evolution) and L2 (organisational attributes).

Approach to reform options

This part of our approach is grounded in the recognition that structural reform alone does not deliver coherence if the underlying incentives and systems driving organisational behaviour remain unaddressed. The analysis will draw on results from across all five lines of enquiry to highlight reform priorities and identify lessons that can facilitate their implementation. Reform options will consider emerging needs and critical gaps and identify opportunities for action that are feasible and sustainable.

Approach to country lens: Experience across geopolitical contexts

Comparative advantage is context dependent. Strengths that organisations demonstrate in stable, reform-oriented settings may not translate to fragile or conflict-affected environments where health service delivery needs, the configuration of actors and delivery models differ significantly. The scale and nature of interaction between multilateral organisations also shift across geopolitical contexts.

This study will integrate contextual factors, including fragility, conflict and geopolitical dynamics, into its evidence synthesis, using short desk-based “spotlight” case studies to illustrate nuances. A systematic cross-country comparison is beyond the scope of this study, but a second phase could extend the global findings through structured, contexts specific case studies to assess comparative advantage more rigorously.

To incorporate geopolitical context into the framework, the study will use objective measures of economic development, stability, conflict and governance - drawing on established indices such as the Fragile States Index and World Bank Country Policy and Institutional Assessment scores to distinguish among three broad health development context:

- **Fragile and conflict-affected states (FCAS)**: where insecurity, governance collapse or protracted crisis fundamentally alter the demands placed on multilateral organisations, often requiring direct operational delivery and coordination under extreme constraint.

- **Contexts with high levels of external financing**: lower-income countries characterised by heavy reliance on external financing and limited institutional capacity, regardless of governance strength. In these settings, recent funding cuts compound already significant challenges around transition and sustainability.
- **Transitioning contexts**: settings where external financing is declining and multilateral organisations are shifting towards supporting government-led reforms, including health financing and institutional strengthening. The focus here is on how multilaterals can best support national ownership and address equity gaps that market-based or government-led approaches alone may not fully meet.

These categories are not mutually exclusive but serve as analytical lenses to ensure the study's findings are sensitive to the different conditions under which multilateral organisations operate. To the extent possible (given resource and time constraints), the study will try to capture how multilateral organisations work with non-state actors in different country contexts. Some potential country spotlights for the comparative advantage analysis are referenced in Annex C.

Methodology

The study will use an iterative, agile approach to data collection and analysis, using MOPAN evidence as its starting point. Evidence will be collected and analysed at three levels:

- **Delivery across the priority future global health functions** — to understand the emerging context and demands placed on the system.
- **Priority multilateral organisations** — to assess comparative advantage against these priority functions.
- **The multilateral system as a whole** — to capture important lessons on coordination, collaboration and alignment.

This approach will allow the study to maintain a focus on the relational dimensions of comparative advantage, situate findings for specific institutions against the fast-changing global health landscape, and incorporate critical lessons on the barriers and enablers to multilateral collaboration.

Data collection, analysis and reporting for the first output will be front-loaded to meet the deadline for the brief on organisational mandates against priority functions, due for the World Health Assembly in late April (see Table 3 for details).

Data collection: creating the evidence base

This phase involves appraising and creating our evidence base, including addressing important gaps from known data sources.

Evaluability assessment of MOPAN evidence base for selected institutions

The first activity will involve an appraisal of evidence from MOPAN assessment reviews for selected multilateral organisations, to determine which guiding questions and lines of enquiry they can help address and to what extent. This builds on the approach used in MOPAN's Insights brief on comparative advantage,[19] extending it to examine comparative advantage across the GHA.

[19] MOPAN (2026). Beyond Overlaps Leveraging Comparative Advantage for Multilateral Collaboration, Multilateral Effectiveness in a Shifting Landscape. Link

Table 1 outlines the MOPAN assessments available for the priority institutions with year of publication.

Table 1. MOPAN assessments for priority institutions

Institutions	MOPAN assessment year	Previous assessments
WHO	2024	2017-18, 2013, 2010
UNICEF	2021	2015-16
UNFPA	2025	2017-18, 2014, 2011
The World Bank	2023	2015-16, 2012, 2009
Gavi	2024	2015-16, 2012
The Global Fund	2022	2015-16

MOPAN assessment reports will be reviewed using a staged approach. An initial full-text review will be undertaken to capture overarching findings and evidence related to mandates, organisational behaviour and system dynamics. This will be followed by structured extraction at KPI level from the MOPAN 3.1 framework, to enable comparability across organisations. Where relevant, more granular analysis will draw on sub-indicators, recognising that the level of detail varies across institutions and is not consistently available at micro-indicator level. Annex E provides a guiding framework for this structured extraction.

Based on the evaluability assessment we will decide which evidence gaps to address.

Supplementary desk research on multilateral organisations and effectiveness

A desk review will be conducted to collect additional evidence in three areas:

- **Gaps identified through the evaluability assessment** — addressing areas where existing MOPAN assessments are incomplete or insufficiently current for the targeted organisations;
- **Original mandates** — as recorded in foundational and governing documents;
- **Incentives, and barriers and enablers to multilateral effectiveness and collaboration** — drawing on the broader literature, using MOPAN's published analytical work as a starting point, including their series on Multilateral Effectiveness (see Annex G).

Where no current MOPAN assessment exists, and depending on the availability of other data, new evidence may be selectively gathered through an online survey or interviews with identified multilateral representatives.

Mapping the delivery of global health functions

A desk-based review, complemented by key informant interviews, will be conducted to understand how the five priority global health functions are being delivered. The review will draw on recent relevant thematic studies by MOPAN and the broader literature, with an emphasis on recent evidence-based work for each function. Although grounded in lessons from the past, this component of the analysis will be future-oriented.

The review will identify potential gaps in the delivery of these functions and the key actors driving — and likely to drive — decisions in each area. For each identified actor, the analysis will examine their mandates and the factors shaping their incentives and comparative advantage at global, regional and national levels.

The scope of the desk-based review and the sample for key informant interviews will be determined once there is greater clarity on how the global health functions and sub-functions are defined.

Data analysis

Phase 2 will involve the thematic coding and analysis of the evidence base — documents and interview transcripts — collated in Phase 1. Evidence from activities (a) and (b) will be synthesised across the five lines of enquiry (in section on guiding questions) which will also serve as the common thread for synthesising evidence across the different sources. For MOPAN performance assessments, evidence will be extracted against the selected KPIs. A similar analytical approach will be applied to evidence on the delivery of global health functions, producing a map that captures the composition of relevant actors, their incentives and their comparative advantage.

As part of the data extraction process, evidence will also be tagged and insights extracted for the three country contexts of interest: fragile and conflict-affected states (FCAS); aid-dependent countries; and transitioning countries where external financing is declining.

Table 2 outlines how the three analytical levels relate to the evidence base, lines of enquiry and guiding questions.

Table 2. Analytical level, evidence sources and guiding questions

Analytical Level	Evidence	Lines of Inquiry	Guiding Questions
Specific organisations (selected multilateral organisations)	MOPAN assessment reports and supplementary evidence	Addressing the five lines of enquiry from the perspective of specific institutions	Q1
Multilateral system	MOPAN analytical studies and the broader literature	Broader insights and lessons to inform understanding on division on ML division labour and collaboration	Q2, Q3
Delivery of priority GH functions	KII and desk review	Understanding potential contribution/role for MOs and informing reform options	Q1-Q3

Spotlights

Across the primary and secondary evidence, examples of thematic areas (multilateral organisations working on similar health priorities), capabilities (governance, technical assistance), country/regional leadership of multilateral programmes or others will be showcased through short 'spotlights' in the analysis. Spotlights will be no more than a page in length and will be used to help illustrate concepts, contexts or complexities that arise in the analysis. Examples of potential spotlights will be identified during the evaluability assessment but are likely to evolve based on the evidence.

Reporting and validation

Reporting will be organised around the four outputs. Validation is embedded at each stage, with the Advisory Group providing feedback for the three main outputs. In discussion with the Advisory Group, we will identify milestones for engaging a broader group of experts.

Output 1: Mandate mapping brief (≤10 pages, end of April 2026) will present the mapping of organisational mandates against the five priority global health functions, identifying gaps, overlaps, and areas requiring role delineation. This output draws primarily on MOPAN assessments, organisational foundational documents and relevant contributions from the broader literature. Emerging findings will be discussed with the Advisory Group.

Output 2: Comparative advantage analysis (≤10 pages, end of August 2026) will present findings from the full comparative advantage synthesis. In addition to the institutional analysis, it will incorporate findings from the mapping of how the five priority global health functions are currently being delivered - drawing on

the KII programme and desk review completed between April and June. A draft will be shared with the Advisory Group for comment before finalisation.

Output 3: Full narrative report (December 2026)**.** This output will address all three guiding questions across the five lines of enquiry, accompanied by an executive summary and supporting annexes. It will integrate institutional findings, the functional mapping, and the incentives and reform options analyses into a consolidated evidence base. Emerging findings will be shared with the Advisory Group in September 2026 to allow for substantive input before the final report is drafted.

Output 4: Presentations (timing to be confirmed at WHA, May 2026) will include a PowerPoint with the main findings tailored to key dissemination moments in the Joint Process.

Proposed timeline

The timeline considers the timing of key global health reform debates. The design phase (scoping, initial research design, and stakeholder engagement) was completed in early 2026. The workplan shown in Table 3 is designed to produce timely interim insights for reform debates.

Table 3. Outputs against global health architecture reform movements

Month	Event
April 2026	Output 1: Mapping of organizational mandates against future priority functions
May 2026	79th World Health Assembly (WHA) *A proposal for the structure of the Joint Process will be made, based on which the timeline will be adapted*
June 2026	Global Fund Board meeting
	G7 Summit – France (G7 Presidency)
August 2026	GAVI board meeting
September 2026	Output 2: Comparative advantage analysis
October 2026	UN General Assembly
November 2026	World Health Summit, Berlin
December 2026	Output 3 and 4: Full narrative report and PPT for dissemination
January 2027	WHO Executive Board (EB159)
May 2027	80th World Health Assembly (WHA)

Table 4. Condensed timeline

Activities	Timeframe
Inception (including Advisory Group consultation, clearance and sign off)	End March
Synthesis of available evidence (MOPAN assessments)	April
Concise brief - Mapping of organizational mandates against future priority functions	End April
Dissemination (WHA, Global Fund board, G7, GAVI board)	May
Key Informant Interviews, desk research and analysis	April - June
Concise brief - Comparative advantage analysis	End of August
Dissemination (UNGA, World Health Summit)	September – October
Emerging findings and report writing	September - November
Full narrative report and PPT for dissemination	December
Dissemination (WHO EB, Joint process TBC)	January

Resources

Research team and expertise. The analysis will be carried out by a dedicated expert team combining MOPAN Secretariat analysts (including secondees from the UK), and external consultants with expertise in global health policy and organisational effectiveness. This mix ensures the integration of quantitative evidence from assessments and financial analysis with qualitative insights from interviews and case studies. Where needed, subject-matter experts will be engaged to peer review specific components.

Advisory group and quality assurance

Given the strategic importance and sensitivity of this study, clear governance and quality assurance arrangements are in place.

Advisory Group. An Advisory Group will be established, comprising representatives from MOPAN member countries and selected partners, including philanthropies, implementing countries and civil society representation (Annex E). The Advisory Group will provide strategic guidance on the study's scope, approach, and messaging, and will review key outputs (Concept note, briefs and final report) to ensure policy relevance and appropriate calibration. The MOPAN Secretariat will closely steer the work, with regular update meetings to monitor progress, address challenges, and integrate guidance from the Advisory Group. The MOPAN Secretariat will also ensure timely inputs and feedback from the relevant fora linked to the WHO-hosted Joint Process.

Quality assurance. Quality assurance will be applied throughout the process. Draft outputs will be reviewed though multiple tracks: 1) two independent experts will provide in-depth peer review of all products; 2) Advisory Group consisting of a diverse range of health experts will provide feedback; and 3) internal MOPAN processes to ensure accuracy, coherence, and consistency with existing evidence. Where appropriate, draft findings may be shared informally with organizations covered by the study to verify factual accuracy and provide context, while maintaining MOPAN's independence.

Limitations

The main limitation of this study is that it is focused on nine multilateral organisations and not the whole global health ecosystem. It is important to reiterate this in order to moderate expectations that the results of the study will identify concrete reforms. The study will mainly focus on collating, synthesising and presenting evidence. In doing this, the study will aim to promote reform pathways or areas where certain types of changes (reform) could improve how multilateral organisations work.

There are three other important limitations to identify. Firstly, the limitations created by time constraints and the reliance on (mainly) secondary data; in mitigation, the study will mine for data using AI tools (well documented) and many of these sources are expected to have been based on recent primary data collection. Secondly, there are blurry boundaries between global health functions and DAH priority areas. While the aim is to be explicit about how global health functions and priority development areas are partitioned in the study, a different set of authors might take a different approach or make different judgements. Lastly, the study will rely on analytical judgements at certain points, and every effort will be made to be as clear as possible about judgement criteria and their application to the data.

Risks and mitigation

The following table sets out the key risks associated with the study and the mitigations in place to address them.

Table 4. Risk register

Risk	Elaboration	Mitigation
Political sensitivities and institutional buy-in	Reform attempts are persistently challenged by the political economy of current structures, including organisations with established secretariats, boards and donor relationships that create strong incentives to resist change. Geopolitical realignments — including the shift toward bilateral arrangements and America First health strategies — further complicate multilateral consensus.	Constructive, system-focused framing throughout. Early and sustained engagement with GHA reform leads from key multilateral organisations, including through an informal working group. Anchor outputs as evidence to support a range of on-going reform dialogues including the WHO Joint Process and the Accra Reset to enhance value for decision-making.
Duplication with other reform initiatives	Multiple reform processes are running simultaneously — including the EU Reflection Process, Wellcome Trust regional dialogues, the Accra Reset and the UN80 process — creating a risk of duplicated effort and fragmented findings or weak findings because of fatigue. The strength and durability of reform decisions will be determined by the quality of the process, making coordination essential.	The MOPAN study is focused on collating and presenting the best possible evidence. Active mapping of and coordination with parallel reform initiatives will be undertaken from the outset. Explicit positioning of this study as complementary to, and feeding into, existing processes rather than competing with them.
Evidence gaps	WHO lacks enforcement authority and faces mission creep, and has had its own reform efforts face scrutiny and some scepticism about its ability to manage an objective GHA reform process, while many organisations have limited transparency around performance data. MOPAN assessments may be incomplete or insufficiently current for some organisations, and evidence on incentive structures and mandate evolution is often qualitative and contested.	Triangulation across MOPAN assessments, key informant interviews, desk review and the broader literature. Limitations clearly acknowledged in all outputs. Evaluability assessment conducted upfront to map gaps before data collection begins.
Scope and timeline pressures	The study spans multiple organisations, five global health functions and three country context types - creating a risk of overreach within a constrained timeline, particularly given the front-loaded deadline for the WHA brief in late April.	Detailed, staged workplan with clearly sequenced deliverables. Scope decisions on additional organisations (Pandemic Fund, CEPI, Unitaid) deferred until after the evaluability assessment. Advisory Board engaged at key milestones to maintain focus.
Uptake and influence on reform	It will be important for countries to move beyond general policy statements and play a leadership role in developing and testing new approaches but translating analytical findings into actionable reform is consistently difficult in a politically contested environment. Civil society and affected populations expect to be included in reform processes.	Findings framed around practical, operationally feasible reform options rather than abstract recommendations. Active dissemination strategy targeting key decision points in the WHO Joint Process, WHA and other reform forums. Civil society and country perspectives incorporated throughout the analysis.
Geopolitical volatility	Geopolitical shifts have permanently altered the political landscape for global health cooperation, creating a fast-moving context in which findings may need to be updated as the situation evolves.	Iterative, agile approach to data collection and analysis. Study design allows findings to be updated as the geopolitical context shifts. Geopolitical dynamics treated as an explicit interpretive lens throughout the analysis rather than a fixed background condition.

Together, these arrangements are designed to ensure that the study is delivered on time, to a high standard, and with strong credibility among key stakeholders.

Dissemination

The MOPAN Secretariat and advisory group will develop a dissemination strategy for the interim briefs and final products ensuring that findings reach key stakeholders. Key engagement moments to be aligned with other GHA reform efforts, and specifically the WHO joint-process. This is likely to include the World Health Assembly (May) and UNGA (September).

The final products may be shared as preliminary, embargoed versions, followed by a consolidated final publication incorporating design elements at a later stage. The embargoed versions are intended for limited circulation - MOPAN members and selected UN stakeholders involved in reform efforts - prior to official release.

Annex A. Design phase findings

During the design phase, the team conducted scoping interviews and a literature review of relevant MOPAN studies to inform the study's focus and methodology.

Key informant interviews

The study team conducted in-depth interviews with key informants including Member States representatives, senior officials from multilateral health agencies, global health experts, and other stakeholders – to ensure the research questions were grounded in real-world needs[20]. These exploratory interviews helped refine our focus and highlighted consistent themes about where the architecture is failing in practice. Common issues raised by stakeholders included:

- *Mandate Confusion and Overlap:* Agencies are increasingly drifting toward similar operational spaces because funding incentives reward visibility and delivery. For example, primarily normative agencies feel pressured to run country-level programs, while financing initiatives venture into technical assistance. This convergence blurs roles and fuels competition for funding. Importantly, interviewees noted this "mandate drift" is usually linked to existing incentive structures. Many multilateral organisations were created with specific historical purposes, yet donor priorities and funding patterns have shifted these mandates over time. In several cases, mandate evolution reflects attempts to compensate for perceived dysfunction elsewhere in the system. It is particularly important to examine whether current institutional configurations align with future needs, particularly for a simplified architecture focused on prioritized global public good functions.
- *Country-Level Fragmentation, Misalignment and Burden*: At the recipient country level, it has been long understood that a lack of alignment and fragmentation imposes a heavy administrative burden on ministries and national health teams. As the OECD/DAC has noted over decades, multiple parallel planning and reporting processes, misaligned policy objectives and program cycles, and numerous vertical streams are inefficient and ineffective, making it difficult for countries to implement coherent country-driven health strategies. Interviewees stressed that the resulting costs in time, transaction costs, and overall inefficiencies–are felt most acutely by recipient countries.
- *Vertical vs. Horizontal Tensions*: Many stakeholders pointed out the structural mismatch between vertical disease-focused programs and the need for integrated horizontal health systems. Donors often favour vertical programs for their measurable results, whereas countries seek to strengthen primary care and health systems as a whole. These differing incentives lead to gaps in areas that fall between vertical silos (most notably health workforce development and other health system strengthening objectives).
- *Functional Gaps and Duplication*: Beyond obvious overlaps, interviews identified that certain critical functions are either over-supplied or under-supplied in the current architecture. For instance, some functions like vaccine procurement or market shaping are supported by multiple

[20] As of design phase completion, 14 interviews had been held, which included representatives from 5 donor governments, 5 multilateral organizations, and several independent experts. This included regional representation from the Americas, Europe, Africa and the Middle East.

actors, while other functions (such as coordination in fragile states or support for health system governance) may be missing or unevenly addressed. Such imbalances indicate that the system's performance issues are systemic behaviours: emergent properties of how organisations and funding mechanisms interact rather than isolated failings of any single agency.

Stakeholders emphasised the need for usable, operational evidence that can help drive action. In particular, four areas were consistently mentioned as evidence gaps holding back productive reform debates:

1. *Functional rationalisation:* The need for clear mapping of who is best suited to do what – i.e. comparative advantage by function across the main elements of the global health architecture. Everyone agrees there is overlap, but there is little hard evidence on which organization has strengths or weaknesses in key functional areas (normative guidance, service delivery, financing, technical support, market shaping, etc.). Stakeholders want analysis that reframes conversations around functions needed and comparative advantages, rather than around historical legacy structures and mandates.
2. *Country-level operational realities:* A concrete picture of what the global health "system" looks like from the vantage point of a recipient country's health ministry. Much debate happens at headquarters level, but ministers and health officials experience the cumulative burden of fragmented processes on the ground. Stakeholders seek evidence on the extent of duplication at country to ground reform dialogue in operational facts rather than anecdotes.
3. *Financial interdependencies and incentives:* Insights into why organizations behave as they do from a financial perspective. How do funding models (earmarked donor contributions, replenishment cycles, competitive grant funding etc.) drive certain behaviours or reluctance to collaborate? Interviewees noted that unless reform discussions grapple with the underlying funding architecture and incentive structures, structural tweaks will remain superficial. Evidence is needed to illuminate these financial drivers, particularly how heavy reliance on earmarked funds might encourage mandate expansion or discourage agencies from collaborating or simply ceding roles to others.
4. *Political and governance feasibility:* Analysis of what reforms are actually implementable given current governance structures, rather than idealistic blueprints. There is fatigue with reform proposals that ignore political-economy realities, such as the independent governance of agency boards, or the divergent interests of stakeholders. Stakeholders want politically literate analysis that distinguishes between changes that look good on paper and those that could realistically gain traction. In other words, the study should help identify which barriers are due to lack of evidence and which reflect deeper political constraints.

The inputs from interviews have been fundamental in defining the role of this project. The takeaway is that MOPAN's study should provide the analytical foundation that makes ongoing reform conversations more concrete, realistic, and less driven by existing institutional positioning. The interviews affirmed that by focusing on the above four areas, the study will address the most pressing information needs of those leading or influencing reform efforts.

Literature and evidence review

In parallel with interviews, the design phase included a preliminary literature review and a synthesis of existing evidence (including MOPAN's own assessments) to "map the gap" in knowledge. Over 70 key documents were reviewed spanning academic studies, policy reports, recent global commission findings, and 14 past MOPAN institutional assessments and papers. This was to situate this study in the context of what is already known.

The challenges identified by stakeholders are well documented in existing literature. Issues like inter-agency competition, misalignment and fragmentation, overlapping mandates, high coordination costs for countries, accountability gaps, and power imbalances between global and local needs have been analysed in numerous studies over the past decade.

Many of the coordination and fragmentation challenges currently facing the global health architecture are not new. They reflect long-standing tensions in the broader aid system that have been recognised for over two decades. The principles of the Paris Declaration on Aid Effectiveness and subsequent global agreements emphasized country ownership, alignment with national systems, harmonization among donors and mutual accountability. Yet persistent incentives for visibility, earmarking and vertical delivery have limited progress toward these goals. The global health sector illustrates how structural drivers of fragmentation can endure despite repeated reform commitments. Recognising this historical continuity is important.

The persistence of these problems suggests that previous reform efforts often addressed symptoms rather than root causes. Today's architecture debates are part of a longer trajectory in aid effectiveness, and that meaningful reform requires addressing incentive structures that have proven resistant to change rather than assuming that coordination problems are temporary or technical in nature.

The review of MOPAN's own assessment findings reinforced these points with concrete examples. Across multiple organisational assessments, common systemic issues emerged: unclear division of labor in health issue areas, duplication of efforts in countries, slow collective responses to emerging challenges, and misaligned funding that complicates collaboration. For instance, MOPAN assessments of UN agencies and global funds have frequently noted mandate overlaps and coordination shortfalls, which echo the wider literature and interview feedback. These patterns confirm that many weaknesses observed at the institutional level are symptomatic of broader system dynamics.

Critically, the literature review highlighted a gap in actionable, cross-cutting analysis. While many reports diagnose problems, few provide the kind of operational evidence or comparative perspective that decision-makers need to weigh trade-offs and drive consensus for change. There is a recognised need to go beyond listing issues and instead explain *why* the system behaves as it does and *what options* might realistically address it. This finding validated MOPAN's intended value-added: namely, applying a political-economy lens to connect performance evidence with the political and financial realities that shape it. In summary, the design phase consultations and reviews confirmed the relevance of the study and sharpened its focus. They underscored that MOPAN's comparative advantage lies in leveraging operational evidence from its assessments and new case studies, to illuminate system-level dysfunctions in a way that purely conceptual reform blueprints cannot. The early findings also stressed that the study's ambition should be clarity, not comprehensiveness: rather than attempting to cover every aspect of global health, the goal is to make invisible or tacit system dynamics visible and explicit and provide concrete evidence on key pain points. These principles have guided the final scope and research framework described below.

Annex B. Mapping of global health reform initiatives

Table A B.1. Mapping

Initiative	Focus
Lusaka Agenda / Friends of Lusaka Agenda	Aims to transform global health financing and the role of global health initiatives, like Gavi and the Global Fund, in the global health architecture. It aims to shift power and decision-making towards the countries themselves, ensuring that national health priorities lead the way to accelerate progress toward Universal Health Care (UHC), promoting equity and sustainability in health systems, whilst addressing fragmentation and inefficiencies. The five shifts of the Lusaka Agenda: 1. Integrated primary health care; 2. Domestic financing transition; 3. Equity; 4. Strategic and operational coherence; 5. Market shaping, local manufacturing and R&D.
Accra Initiative / Accra Reset	A framework for transforming global development (with Health as a subset). It focuses on health governance and sovereignty and seeks to establish a new global health order that empowers nations to lead resilient and self-sustaining health responses less reliant on aid. • Key feature is the SUSTAIN Initiative: a toolkit to support countries to move towards domestically financed / led health systems • Endorsement of the Accra Compact, articulating Africa's vision for health sovereignty and a more equitable global health order. • The Accra Roadmap is a blueprint for embedding sovereignty into health and development system The Accra Reset follows from the Initiative, and expands on it to reshape global development, governance and financing models. It is more operational, moving from promises to action by the taskforce set up by President Mahama of Ghana.
UN80	The UN's ambitious, system-wide reform effort. The UN80 taskforce is looking at: • Efficiencies and improvements: in the UN Secretariat and the system as a whole; • Implementation review: a comprehensive review of over 4,000 resolutions and other mandate source documents to streamline delivery, reduce duplication and enhance impact; and • Potential structural changes and programme realignments: of programmes across entities to ensure optimal coherence, resource, and impact.
EU & Like-Minded Donors Reflection Process on Global Health Reform	To support donors to strengthen alignment around a clear vision for global health and development; map out the architecture needed to deliver functions and priorities; and set out practical options for advancing reforms in the GHA. • This process will support the development of shared vision around functions and map the architecture needed to delivery functions. • A harmonized roadmap for the way forward to guide advancing reforms will be developed.
Seville Platform for Action	A UN backed delivery mechanism that will accelerate the implementation of the Sevilla Commitment on Financing for Development, with the overarching aim to close the SDG funding gap to get them back on track by 2030. It looks at debt challenges and support architecture reform: • The Platform acts as a concrete mechanism to turn global pledges into tangible results with built in systems for tracking progress and ensuring accountability for approved commitments
Wellcome Dialogues	Wellcome commissioned bold proposals from five thought leaders from different regions for a reimagined global health architecture. These proposals are intended to be used as a starting point, to kickstart ambitious and inclusive conversations on a reimagined global health architecture.
WHO-hosted Joint process	WHO has proposed to take on a convening role to facilitate structured dialogue among Member States on the future of the global health architecture. WHO's role is framed as that of a neutral convener, providing a platform for Member States to exchange views, articulate reform priorities, and explore options for greater coherence and effectiveness. This is a recent initiative the scope of which is still unclear.

Annex C. Candidate country spotlights

Table A C.1. Spotlights

Possible country	Context typology	Region	Health system / architecture relevance	Rationale for comparative advantage analysis
Democratic Republic of the Congo	Fragile / conflict-affected state	Sub-Saharan Africa	High humanitarian-health interface; recurrent outbreaks	Coordination and supply functions under insecurity
Somalia	Fragile / conflict-affected state	Sub-Saharan Africa	Reliance on external implementers; constrained public finance	Stress-tests roles of operational agencies and pooled financing under weak state capacity
Yemen	Fragile / conflict-affected state	Middle East	Fragmented governance; emergency operations critical	Illustrates parallel delivery burdens, commodity pipelines, and coordination constraints
Nepal	More stable with active reform	South Asia	PHC strengthening efforts; transition questions	Aligned planning, donor coordination, and transition pathways
Malawi	Low-income, high-dependency	Sub-Saharan Africa	High DAH dependence; UHC gaps	Examining domestic financing transition feasibility and GHI alignment
Ghana	More stable with active reform	Sub-Saharan Africa	Active health financing and PHC reforms; sovereignty discourse	Relevant to “health sovereignty” and transition debates; links to Accra Reset narrative
Senegal	More stable with active reform	Sub-Saharan Africa	Reform-oriented; relevant to GHI coordination literature	Enables comparison with political economy evidence from GHI reform research

Annex D. Consultations conducted in design phase

Table A D.1. Consultations

Interviewee	Role/Title	Organisation/Country
Enrico Balducci	Attaché, Global Health, Multilateral & Thematic Cooperation	Belgium
Koen Van Acoleyen	Minister Counselor at Permanent Representation of Belgium to the UN in Geneva	Belgium
Marit Viktoria Pettersen	Policy Director, Ministry of Foreign Affairs	Norway
Anna Halen	Senior Adviser in the team for Global Health at the Department for Multilateral Governance and Humanitarian Policy	Sweden
Erika Maclaughlin	Senior Policy Advisor – IFIs and Vertical Funds	MOPAN Secretariat
Jolanda Profos	Senior Policy Advisor – UN and Humanitarian Organisations	MOPAN Secretariat
Anna Seymour	FCDO – Senior Health Adviser	United Kingdom
Jo Scott-Nicholls	FCDO – Senior Health Adviser	United Kingdom
Laura Cartanya Llach	Programme Manager	European Commission
Clare Battle	Policy Lead, Future of Global Health Initiatives	Wellcome Trust
Bruce Aylward	Senior Adviser to the Director-General	WHO
Juan Pablo Uribe	Director of the Division for Central America and the Dominican Republic	World Bank
Julia Martin	Head of Strategy and Policy	Global Fund
Walid Ammar	Director of Doctorate and Research in Public Health Policy Program, Former Minister of Health	University St Joseph Bierut, Lebanon
Gerald Manthalu	Head of Division – Public Financial Management and Lusaka Agenda	Africa CDC
Rachel Bonnifield	Senior Fellow	Center for Global Development

Annex E. Advisory group members

Table A E.1. Advisory group members

Name	Role/Title	Organisation/Country
Koen Van Acoleyen	Minister Counselor at Permanent Representation of Belgium to the UN in Geneva	Belgium
Anne-Claire Amprou	Ambassador for Global Health	France
Marit Viktoria Pettersen	Policy Director, Ministry of Foreign Affairs	Norway
Karin Tegmark Wisell	Ambassador for Global Health	Sweden
Hariet Ludwig	Senior Policy Advisor Global Health and Sustainable Development	Germany
Kristen Chenier	Director of Global Health Policy and Strategy	Canada
Robert Whitby	Head of Immunisation - FCDO	United Kingdom
Cecile Billaux	Head of Unit, Directorate General for International Partnerships	European Commission
Clare Battle	Policy Lead, Future of Global Health Initiatives	Wellcome Trust
Sue Graves	Deputy Director	Gates Foundation
Walid Ammar	Director of Doctorate and Research in Public Health Policy Program, Former Minister of Health	University St Joseph Bierut, Lebanon
Gerald Manthalu	Head of Division – Public Financial Management and Lusaka Agenda	Africa CDC
Hugo López-Gatell Ramírez	Representative to the WHO, Former Deputy Minister of Health	Mexico
Suwit Wibulpolprasert	Vice Chair, International Health Policy Program	Thailand
Cedric Nininahazwe	Director of Global Advocacy, Positioning and Partnerships	GNP+
Lwazi Manzi	Head of Secretariat Global Leaders Network for Women, Children and Adolescent Health	South Africa
Belinda Nimako	Director – Policy Planning, Monitoring and Evaluation, Accra Reset	Ghana
Nana Oye Bampoe Addo	Deputy Chief of Staff for Administration, Accra Reset	Ghana

Annex F. MOPAN framework KPIs for the synthesis review with micro-indicators

Table A F.1. MOPAN framework indicators relevant for the study

Performance area	KPI with sub-indicators	Guiding questions	Lines of enquiry
Strategic Management	**KPI 1:** Organisational architecture and financial framework enable mandate implementation and achievement of expected results **1.1** Strategic plan and intended results based on a clear long-term vision and analysis of comparative advantage **1.2** Organisational architecture congruent with a clear long-term vision and associated operating model **1.3** Strategic plan supports implementation of global commitments and associated results **1.4** Financial framework supports mandate implementation	Q1, Q3	L1, L2, L3, L4
Operational Management	**KPI 3:** The operating model and human and financial resources support relevance and agility **3.2** Resource mobilisation efforts consistent with the core mandate and strategic priorities	Q3	L2, L3, L4, L5
Relationship Management	**KPI 6:** Working in coherent partnerships directed at leveraging and catalysing the use of resources **6.2** Partnerships based on an explicit statement of comparative or collaborative advantage 6.4 Strategies identify synergies with development partners to encourage leverage and avoid fragmentation	Q1, Q2, Q3	L2, L3, L4, L5
Results	**KPI 9:** Development and humanitarian objectives are achieved, and results contribute to normative and cross-cutting goals **9.1** Interventions assessed as having achieved their objectives and results	Q1	L3
	KPI 11: Results are delivered efficiently	Q1, Q3	L3, L4
	KPI 12: Results are sustainable	Q1, Q3	L3, L4, L5

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