CATALYST DIALOGUE ON GLOBAL HEALTH ARCHITECTURE

Towards a global health architecture that works for all

Insights from a debate on where we stand, what must change and how Germany can contribute.

Emerging suggestions

The following suggestions for German policy-makers surfaced over the course of the Catalyst Dialogue. They do not necessarily represent the views of all Dialogue participants:

- **Strengthen the role of WHO** as the 'normative pole' of global health and its coordination function, primarily by funding it 'properly'.
- **Push for better coordination between the major global health initiatives and alignment with existing country systems** by exerting political leadership on the governing boards of these institutions and by introducing follow-up mechanisms.
- **Establish meaningful mechanisms for participation of non-state actors in global health decision making**, for example, by empowering non-state actors to bring their voices into the World Health Assembly, and by giving civil society full voting rights on the major new initiatives currently emerging in global health.
- **Offer technical development cooperation to support partner countries in strengthening their regulatory and management capacity** to effectively coordinate their engagement with global health initiatives and to present their national policies and plans as the basis for donor alignment.
- **In Germany, cultivate expertise for global health** through systematic investment in academic training and in promotion of think tanks and 'public intellectuals' in the country's global health ecosystem.
- **Map and connect German actors active in global health to enable synergies**, for example, between bilateral development cooperation, private sector investment, civil society engagement and scientific or academic expertise.
- **Reduce internal fragmentation in how Germany engages in global health governance** by better coordinating and aligning positions and engagements across the multitude of German ministries and agencies with a mandate for global health.

Why a Catalyst Dialogue on global health architecture?

Eight years remain to attain 'healthy lives and promote well-being for all at all ages.' This is what the world has explicitly commited itself to achieve by 2030, as measured and tracked through the Sustainable Development Goals (SDG). But meanwhile, the devastating impact of the COVID-19 pandemic has laid bare humanity's difficulty to organise effective collective action to meet its common global health challenges.

What can be done to make the organisational and governance arrangements of global health 'work' to deliver the results the world expects?

To inform the German government's position on this question, the Global Health Hub Germany, in cooperation with Healthy DEvelopments, on behalf respectively of the German Federal Ministries of Health and of Economic Cooperation and Development, convened a high-level 'Catalyst Dialogue' among seven distinguished representatives of academia, development cooperation, foundations and the private sector, including from the Global South. Guided by the overarching question 'Which global health architecture do we need?', the participants gathered for two virtual debates and contributed individual reflections in bilateral conversations.

The objective of this paper is to share their diverse perspectives on this question. Rather than present a consensual statement, the document traces central lines of argument from this Catalyst Dialogue. It seeks to present insights into learnings, challenges and opportunities, identifying where there might be potential to work towards a global health architecture that functions for all of us.

This paper closely follows the Catalyst Dialogue discourse as it unfolded. It illustrates policy-relevant positions and presents opposing and sometimes even contradictory perspectives, all of which promise to enrich Germany's policy dialogue on global health governance.

Catalyst Dialogue participants:

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- Kate Dodson, Vice President for Global Health Strategy, United Nations Foundation
- Roland Göhde, Chair of the Board, German Health Alliance
- Anna Holzscheiter, Professor of International Politics, Technical University Dresden
- Ilona Kickbusch, Founder and Chair of the Global Health Centre, Graduate Institute of International and Development Studies in Geneva
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- Elhadj As Sy, Chair of the Board, Kofi Annan Foundation

How do Catalyst Dialogues work?

Catalyst Dialogues focus on one overarching question, combining virtual debates and individual interviews governed by the Chatham House Rule. This gives discussants the space for open and frank conversations 'on the record' while protecting the identities and affiliations of the speakers. Quotes cited in this paper are attributed to individual Dialogue participants with their express permission.

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‘Architecture’ or ‘marketplace’? The complex dynamics of global health governance

Is there a global health architecture?

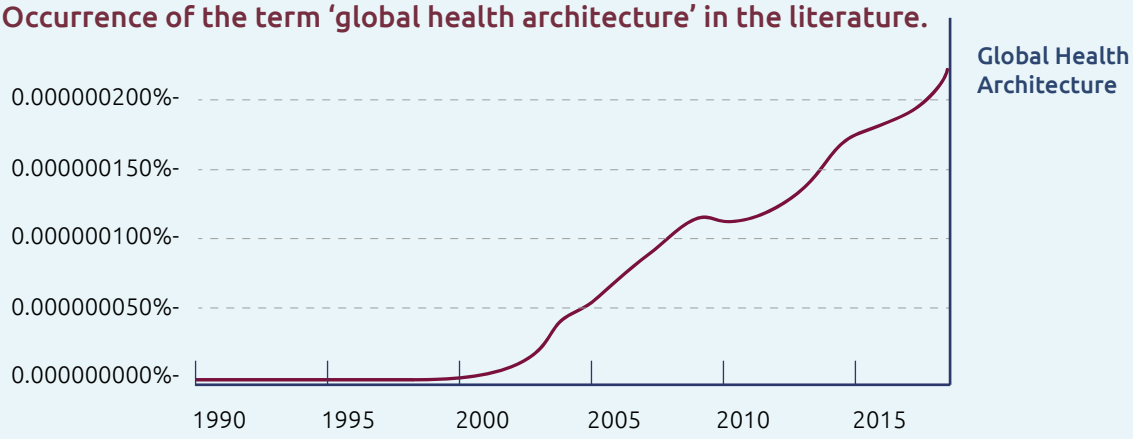
Many people have an intuitive, albeit vague, understanding of what might be meant by ‘global health architecture’, a term which has gained prominence since the late 1990s. ‘Architecture’ carries normative expectations of purposive design, order, rules and compliance. The ‘global health architecture’ is broadly thought of as the world’s endeavour to organise itself in health-related matters that go beyond individual state boundaries. In short, it pertains to issues of global health governance with political, financial, technical and operational implications.

In practice, however, we do not observe the orderly coordination, collaboration and decision-making in the domain of global health that would correspond to the notion of ‘architecture’.

The landscape of actors, institutions and their interrelationships has evolved over time and has become ever more complex. The World Health Organization (WHO) continues to occupy a central role since its founding in 1948, but everything around it appears to have changed. The 1990s and early 2000s saw a proliferation not only of international and intergovernmental initiatives, such as UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria (‘Global Fund’ for short) or Unitaid, but also an immeasurable number of public and private campaigns, partnerships, foundations and organisations ranging from the local to the global level.

> *“Working in Tanzania in the 1980s and early 1990s, the “architecture” at the time was mainly WHO and UNICEF with whom we engaged through the Ministry of Health. Occasionally we maybe turned to bilateral partners and some international NGOs. This was later complemented by many other global players.’*
>
> Christoph Benn

Occurrence of the term ‘global health architecture’ in the literature.



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> *Global health is a peculiar field of international cooperation because there is little binding international law in this area, especially when compared to climate or the environment.'*
>
> Anna Holzscheiter

Today, a multitude of organisations representing a vast range of interests, mandates and approaches vie for attention, funding and influence. At the same time, global health is one of the least regulated international arenas, given the absence of binding international law. The Framework Convention on Tobacco Control and the International Health Regulations are notable exceptions.

The emergence of a competitive global marketplace

The configuration of the actors, funding flows and decision-making processes in today's global health ecosystem resembles a competitive marketplace. Rather than following a grand design, the current set-up has emerged over time as the result of countless individual measures.

> *Looking at it historically, it's definitely not an architecture. I think it's a dynamic marketplace.'*
>
> Ilona Kickbusch

Most organisations that make up and shape the global health space were created in response to specific challenges, for example, the Global Fund as a 'war chest' to finance the fight against AIDS, tuberculosis and malaria, or the Coalition for Epidemic Preparedness Innovations (CEPI) in reaction to the Ebola epidemic.

Several Catalyst Dialogue participants pointed to the fact that institutions, once created, become 'sticky', meaning they tend to stay around. They might even modify their original mandate to justify their continued existence, an effect referred to as 'mission creep'.

As new initiatives continue to be launched while existing ones are unlikely to go away, the global health marketplace becomes more crowded. This has led some to infer a need for more order and coordination. However, participants agree that any attempt to impose an architectural 'superstructure' to make this configuration more orderly is unrealistic.

Complexity and diversity per se are neither positive nor negative attributes of global health governance. Such a judgement can only be made by looking at the consequences of complexity, which in turn vary depending on the level of analysis.

The pros and cons of complexity and fragmentation

A common criticism suggests that the global health marketplace has become too fragmented and unwieldy to be effective, imposing significant transaction costs on those engaging with it.

The consequences are most evident at the level of low- and lower middle-income countries. Governments – and particularly ministries of health – which want to access outside financial or technical assistance are often overwhelmed by the administrative procedures and reporting obligations they must follow. Virtually all major global health initiatives, such as the Global Fund

or Gavi, maintain separate application and due diligence processes. There is little harmonisation of approaches and requirements between organisations, and most do not align themselves with existing health budgeting and programming mechanisms in countries. This forces local decision-makers to divert scarce staff time and resources away from policy and programme planning towards navigating international donor processes. Moreover, the control over resources gives funders significant influence over the health sector agendas in many countries – because only what gets funded will get done.

> *"We tend to think of health systems strengthening as a technical process. But there can be a tension between universally agreed-upon objectives, like Universal Health Coverage, and locally grown desires. It's a political game at all levels. Ultimately, decision-makers need to see a political gain. Whether in Germany or Kyrgyzstan, it will always be more attractive to build a hospital than to invest in prevention.'*
>
> Jean-Olivier Schmidt

However, from a country's perspective, there are also strong incentives to maintain a pluralist global health landscape, because it provides access to a broader range of funding opportunities. One Catalyst Dialogue participant described the situation as follows: 'It's not only that the donors don't want to coordinate or be coordinated. It's also the countries that partly don't want that because they are afraid to lose some of the separate funds that come in'. The current global health configuration allows countries to 'play' different donors. At the same time, this issue must not be interpreted only as a 'donor-recipient' dynamic, which carries a paternalistic undertone. Health is a highly politicised area everywhere, and the political economy of health policy and financing is as evident in Germany as in any developing country. For example, investments that yield immediate and visible benefits, such as building a hospital, are easier to 'sell' than spending on prevention activities, whose added value might be measurable only much later, such as a reduction in incidence of diabetes.

On the side of funding agencies, there are powerful interests that cultivate the properties of a competitive marketplace. The diversity of actors and their offers in global health allows funders – governmental and non-governmental alike – to invest in and promote causes and approaches that are aligned with their agendas.

Participation and power in global health governance

Our intuitive perception of the 'fragmentation' of global health, owing to the sheer number of actors and processes which we cannot oversee in their entirety, changes when looking at the active players in this space.

The governing bodies of all major global initiatives and agencies with a health mandate, from the Global Fund and Gavi to UNAIDS and UNICEF, are shaped by the same handful of member states, major international NGOs and foundations that have occupied the prominent roles across the entire health ecosystem for a while.

> *'We have many inter-governmental institutions in health. They all have the same member states. The same applies to public-private partnerships. We find it's always the same NGOs, the same foundations for the pharmaceutical industry, that are represented across the board. The global health landscape doesn't seem so fragmented when looking at who is participating, who is sitting on the governing boards of these institutions.'*
>
> Anna Holzscheiter

Those with the greatest command over resources have tended to hold the greatest sway over agendas and implementation. For the most part, these have been the governments, organisations and foundations of the G7 and increasingly the G20 countries. Regional organisations like the EU have also become more integral parts of global health governance and drive decision-making.

> *'Who has the power in this system? Who legitimately intervenes in it? As a political scientist I must ask the question: Is it legitimate for the G20 to pot around in global health as much as it does, or shouldn't it leave that to the governing bodies of the WHO which includes more or less all countries in the world?'*
>
> Ilona Kickbusch

Smaller countries, let alone smaller NGOs, lack the financial resources that would give them the visibility and influence that larger players can bring to bear. They also face the more elemental constraint of not having enough staff to follow all the relevant decision-making processes in depth. A country like Germany can afford to have dedicated staff members or entire teams devoted to representing the country's interests on an organisation's board, including all the preparatory work, follow-up and backroom diplomacy required to effectively shape an agenda. In contrast, many low- and lower middle-income countries will only have a single diplomat in their Geneva mission who covers the entire global health portfolio. One and the same individual can be found rushing between civil society consultation meetings and the boardrooms of the various global health initiatives.

> *'The G7 are still seven, and the G20 are still 20. The UN General Assembly are 190 plus. We have to come back to something that is much more synergetic, for lack of a better word, to respond to the needs of all.'*
>
> Elhadj As Sy

These governing boards are the centres of power and formally 'set the rules of the game', as one Catalyst Dialogue participant put it. If one or several of the main funders on the board of an organisation were to demand greater collaboration and coordination with other agencies, this should result in practical changes.

The Global Action Plan (GAP) for Healthy Lives and Well-being for All provides an illustrative example. Launched by WHO in response to an initiative of Germany, Norway and Ghana in 2019, the GAP committed the 13 signatory agencies to coordinate and to jointly align their support and interventions around national plans and strategies that are country-owned and -led. While devised as a global plan, the GAP was meant to galvanise harmonised processes and reduce transaction costs in countries.

Three years on, little has changed in practice because the GAP has not altered the incentive structures within the signatory agencies and on their boards. The fragmentation of global health is reflected in, and partly maintained by, the funding streams that are also 'splintered', coming from a variety of donor countries and organisations. One Catalyst Dialogue participant concluded that greater coordination overall doesn't happen because it 'might reduce the power of that particular funder'. Less fragmentation means less opportunities to invest in and promote special interests.

> *"The Global Action Plan was a step in the right direction, but its weakness is that there are no consequences politically or financially if an organisation does not follow what they agreed to.'*
>
> Christoph Benn

Legitimacy, accountability and inclusiveness

The prevailing patterns of power and decision-making lead to bigger questions about the legitimacy and accountability of the institutional framework surrounding global health.

> *"The G20 and others can launch new efforts rapidly because they are powerful, dynamic and nimble enough. What they create might fill a gap in the global health ecosystem, but it is neither comprehensive nor fully inclusive.'*
>
> Kate Dodson

On the one hand, individual mechanisms and processes have become more inclusive, partly because of persistent civil society activism and in part due to new opportunities created by digital technology. For example, WHO now consults more systematically with non-state actors and increasingly uses virtual communication means to allow a greater range of stakeholders to engage with the organisation without needing to be physically present in Geneva.

> *"Global health has suffered from "promises made, promises broken, but no consequences", just looking at the Alma-Ata Declaration, the 3 by 5 Initiative, or the Abuja Declaration on health financing. We don't have an accountability framework for global health that ensures that if decisions are made, they are implemented.'*
>
> Elhadj As Sy

On the other hand, global health overall – like many other spheres of global governance – still suffers from a significant deficit in inclusive, mutual accountability. There are no systematic and comprehensive mechanisms for including and account-rendering to the people who are meant to be served. Catalyst Dialogue participants felt that 'everyday citizens, and particularly young people' are shut out of decision-making processes, and global health initiatives are mostly not answerable to a citizen constituency. This can also be observed in the extent to which different actors are bound by normative guardrails to 'play well together'. Organisations should be compelled to build synergies rather than 'duplicate and throw sharp elbows', as one Catalyst Dialogue participant put it. Unfortunately, the current configuration of the global health marketplace appears to encourage the latter rather than the former because of the way power is distributed, funding streams are organised and because accountability frameworks are missing.

Different perspectives on results

Despite all the criticism of the fragmented global health landscape, one cannot dismiss the fact that some of the current arrangements have been highly effective in producing results in specific thematic areas. For example, Gavi, the Vaccine Alliance, has helped to immunise nearly 900 million children between 2000 and 2020. The Global Fund contributed to a reduction in AIDS deaths by 65% over the same period.

However, there is another way of looking at results in global health beyond narrow, disease-specific achievements.

> *"Fragmentation is not a criterion in itself. Whether the global health architecture is functioning or not, is decided by whether it "serves the purpose" in countries, whether it contributes to better healthcare and health outcomes.'*
>
> Christoph Benn

The COVID-19 pandemic has exposed the vulnerability of health systems worldwide. Routine testing and treatment for 'old' yet pervasive diseases like tuberculosis and malaria faltered in places where health facilities had to shut down because their staff fell ill, or they were instructed or incentivised to prioritise COVID-19 over other tasks.

> *"If the best thing a country can have is a functioning health system, then we haven't done that well. Sometimes, a focus on very specific results can stand in the way of another, more holistic approach to global health.'*
>
> Ilona Kickbusch

The impacts of the pandemic have demonstrated that the world is still far from achieving Universal Health Coverage (UHC), ensuring that all people have access to the health services they need without financial hardship. UHC has officially received the highest political commitment, being one of the health-related SDGs, but making progress towards it requires broad-based, long-term investments in health systems and financial protection. Allocating funding to such systemic efforts can be seen as being difficult to 'sell', partly because advances take more time to materialise and measure. Therefore, investing in health systems strengthening is often less popular with implementing governments, global health initiatives and their funders than pursuing more specific objectives.

Given the complexity of global health governance, its numerous challenges but also positive developments, the Catalyst Dialogue participants discussed opportunities and entry points for moving the current configuration towards a more holistic and inclusive way of working that would better deliver results for all.

> *"The way funding streams, accountability and reporting work doesn't allow countries to tackle their long-term planning and capacity needs in a more integrated fashion.'*
>
> Kate Dodson

Opportunities and ideas for improving global health governance

All Catalyst Dialogue participants agreed that change is necessary, but that imposing an ideal 'architectural design' on global health governance would be unrealistic and impractical. Instead, they reflected on promising opportunities and specific ideas for how global health decision-making and funding could be organised.

> *'We aren't in a situation where we can propose something ideal. We should be pragmatic and work with what we have.'*
>
> Christoph Benn

Strengthening the central role of WHO

There is broad agreement among participants that WHO has been and must remain the 'normative pole' of global health. Its decision-making body, the World Health Assembly, brings together all member states. Therefore, WHO is uniquely legitimised to set rules, coordinate initiatives – not least in emergency situations like the COVID-19 pandemic – and to guide health policy and programmes through its important regional and country work. However, the organisation has been 'impoverished', with a meagre core budget, forcing WHO to chase after piecemeal projects and constraining its independence rather than enabling it to focus on holistic approaches.

> *'The central role of WHO must be strengthened so that it can provide the normative context for collective action that the world needs.'*
>
> Ilona Kickbusch

The obvious starting point for strengthening the role of WHO is to fund it 'properly', with a core budget of unearmarked resources commensurate with the tasks at hand. New normative functions have emerged and must be fulfilled, such as setting standards for private investments in health and determining how the area of digital health should be governed. At the 2022 World Health Assembly, the WHO member states took an important step in this direction by adopting a landmark decision to improve the organisation's financing model.

The decision was based on recommendations of a Sustainable Financing Working Group made up of member states and led by Björn Kümmel of Germany's Ministry of Health. The agreement commits member states to increase their assessed contributions – WHO's 'membership dues' – to make up 50% of core funding by the 2030–2031 budget cycle (for comparison, this figure currently stands at 16%).

> *'Under the leadership of Chancellor Merkel, Germany has started to be increasingly vocal in guiding, supporting and believing in multilateralism. This is important and I hope it will be continued.'*
>
> Elhadj As Sy

Catalyst Dialogue participants underlined that Germany has played a constructive role in supporting and strengthening the role of WHO for a long time. It is one of the organisation's biggest donors in terms of assessed and voluntary contributions. Germany has consistently voiced the need for better coordination and alignment in global health governance and is

taken seriously. This is a key asset when considering the second area where action is needed.

Managing diversity for greater coordination and alignment

Although a dynamic global health marketplace cannot be organised by rigid architectural design, participants agreed that more coordination between initiatives and greater alignment with country systems and processes are highly desirable, not only to avoid the negative consequences of complexity discussed above, but to strengthen the results orientation across the entire global health landscape.

> *"Architecture" gives the idea that you can put order in this system and know exactly who does what. I think that's dangerous because it takes flexibility out of this system that it desperately needs.'*
>
> Ilona Kickbusch

Participants consider it prudent to build on existing efforts. The GAP comprises 13 of the biggest, most powerful and well-resourced agencies active in global health. Although the initiative was meant to transform how the signatories work together, little has changed in practice because the incentive structures haven't changed. There are no financial or other consequences for inaction. A first step could be for countries such as Germany – the powerful funders who sit on the governing boards of all these entities – to demand that action be taken towards coordination and alignment.

However, global health governance does not stand in isolation, and it does not unfold in a depoliticised context. Whether engaging in the governing boards of the GAP signatory agencies, the WHO's World Health Assembly or 'only' trying to get two governments or a combination of state and non-state actors to work together, these are political arenas that are shaped by power, interests and trust – or the lack thereof.

> *Given the clear lack of legitimacy of some of the important decision-making bodies, can we use the current crisis to forge a system that will be more binding and inclusive?'*
>
> Christoph Benn

The current 'crisis of multilateralism' which several Catalyst Dialogue participants diagnosed, together with recent geopolitical developments, has profound implications for global health. For example, the G20 has assumed an increasingly influential role in global health governance. It is important to recognise that this is not a monolithic group but a dynamic constellation of shifting alliances. When selected G20 states coordinate to, say, vote 'against' the interests of another government on the UN security council, this behaviour may also affect how they leverage their influence on matters relating to global health.

Germany's persistent and vocal engagement in favour of multilateral approaches is an important contribution to building trust and creating space for more collective action-oriented global health governance to emerge. As a member of the powerful G7, Germany can support further, concrete steps to

manage fragmentation. For example, leading think tanks from the G7 countries have proposed to create an Inter-Agency Global Health Standing Committee to improve coordination among global health agencies' funding needs, mandates, responsibilities, and priorities.

> *"We see two kinds of multi-lateralism: The voluntary, more club-oriented multilateralism of the Global Fund, Gavi and others; and intergovernmental multilateralism that works to enhance international legal frameworks and to steer investments in global public goods. We need more of the normative multilateralism to enable the voluntary multilateral instruments to be effective.'*
>
> Kate Dodson

However, prominent initiatives by a few powerful states bring back questions of inclusion and legitimacy. Over the past two decades or so, incentives have been geared towards engagement in 'voluntary multilateralism', the kind that is embodied in the Global Fund and others. This is partly because these instruments have been able to articulate concrete results and impact, and partly because their narrower mandates and the way they are organised offer funders a way to wield influence over agendas and investments. But the world also needs a normative framework and 'rules of the road' to hold all these initiatives together. Countries like Germany have an important – albeit politically difficult – convening and facilitating role to play, drawing other actors in to cultivate the kind of binding intergovernmental multilateralism that compels coordination and alignment.

If this doesn't happen, several Catalyst Dialogue participants expressed concern that there is a risk of 'radical underinvestment in global common goods and global public goods for health'.

Country ownership and 'country-led global health'

A relatively recent development that most Catalyst Dialogue participants viewed as an opportunity for more inclusiveness is that countries of the Global South have become more proactive in engaging in global health governance. There is stronger collaboration between countries and at the regional level, both politically and in implementation. For example, governments have coordinated their messaging at the WHO World Health Assembly, found arrangements to start COVID-19 vaccine production in Africa, and established the Africa Centres for Disease Control and Prevention, an organisation which has been recognised as technically strong and adding value to global health.

> *"COVID-19 was a wake-up call. It has stimulated more assertiveness by lower- and middle-income countries and greater participation on issues regarding the legal framework to govern global health.'*
>
> Elhadj As Sy

While actions taken by a few lead actors – as with the GAP or a G7 initiative – are crucial to make the main global health governance mechanisms and players collaborate and coordinate better, the 'bottom-up' dynamic of greater engagement by low- and lower-middle-income countries should be harnessed for making the global health ecosystem more

inclusive and effective. One necessary step is for global health initiatives to become serious about harmonising their approaches and aligning their processes to existing country systems. Technical development cooperation also has a contribution to make by supporting partner countries in strengthening their regulatory and management capacity to effectively coordinate their engagement with global health initiatives.

Countries need to be empowered to establish and present their policies and plans as the basis for donor alignment. They also need the ability to recognise and manage actors and influences that aren't typically considered as belonging to the health sphere – but that wield considerable power over global and local health decisions. For example, accessing financial support from the International Monetary Fund for macroeconomic stability might require a country to adjust how much of its national budget is allocated to health.

> *"We need to strengthen governments' policy-making and regulatory capacity to be able to manage global health institutions in their own countries. Bilateral development cooperation can enable countries to "filter the noise from global health" and focus on the signals. Because this capacity tends to be weak in many countries, we must "pre-structure" the global health instruments at global level to be better aligned and coordinated in their engagement with countries.'*
>
> Jean-Olivier Schmidt

> *"The trend that needs to be better enabled is that countries are more assertive in presenting their coherent plans and policies, letting the international actors come and contribute.'*
>
> Kate Dodson

Enabling systematic and meaningful participation by non-state actors

Catalyst Dialogue participants unanimously agreed that global health governance must become more inclusive, not only to strengthen the legitimacy of decision-making but also because more diverse perspectives can enhance the quality of results. Concrete proposals exist and there are promising developments to build on.

WHO should establish meaningful mechanisms to empower non-state actors to bring their voices into the World Health Assembly, for example, by establishing a 'Committee C' (see quote). The structure would enable stakeholders who can influence global health positively or negatively to present their plans and results to the member states and to each other, thereby strengthening the consistency of global health coordination and action. Another set of concrete recommendations was developed by philanthropic organisations which joined the WHO-Civil Society Task Team, outlining a blueprint for meaningful civil society participation in global health governance.

> *'I don't think the answer to fragmentation is centralisation. We live in a networked world. But WHO has a central normative and coordinating role to play. Ten years ago, we proposed the creation of a "Committee C" that would bring global health players and organisations together in the context of the World Health Assembly while fully respecting the role of governmental delegations.'*
>
> Ilona Kickbusch

Major new initiatives currently being established in global health should lead the way in adopting participatory decision-making processes.

For example, the World Health Assembly launched a process to develop a global treaty on pandemic prevention, preparedness and response and should make this as inclusive and participatory as possible. The proposed Financial Intermediary Fund (FIF), to be hosted by the World Bank, can include civil society organisations (CSOs) with full decision-making power in its governance structure.

> *'We brought together over 120 organisations and presented recommendations on governance, finance and operating modalities for the FIF to the World Bank. Civil society should not only have a voice, but full voting rights. That's what we have in the Global Fund and Gavi, and the World Bank's legal frameworks would allow the same.'*
>
> Christoph Benn

The private sector has a constructive role to play in helping global health governance deliver results, but it must be brought in more systematically. The Health Innovation Exchange, established in 2019 and funded by UNAIDS, is a promising development because it connects funders and private sector investors to innovators and countries willing to implement new solutions that are firmly grounded in the objectives of UHC and the SDGs.

Lastly, civil society can be more proactive in contributing towards more effective global health governance – it doesn't have to wait to be invited to the table. One Catalyst Dialogue participant found that CSOs – particularly in Germany – were too focused on generic issues like demanding 'more Official Development Assistance (ODA)'. Instead, it would be more productive to question 'what should ODA deliver?' and to press governments to align their ODA with the objectives of coordinated global health governance, so as to put ODA to work for global health.

> *'The Health Innovation Exchange is a new platform that builds a truly unique bridge across innovators, investors and implementers – including especially health ministers from the Global South. How can such an approach be strengthened and scaled up at UN level and serve as a blueprint for multi- and cross-sectoral cooperation that is required for health systems strengthening?'*
>
> Roland Göhde

How can Germany become a more effective actor in global health governance?

All Catalyst Dialogue participants agreed that Germany plays a constructive role in global health governance, but that there is room to strengthen its engagement along several dimensions.

> *"Germany does what it is supposed to be doing: Being a responsible member state, the largest WHO contributor and pushing in the right direction for WHO reform, saying we need a strong and well-financed WHO.'*
>
> Elhadj As Sy

Cultivate expertise for global health

Several Catalyst Dialogue participants felt that global public health was underdeveloped as an academic discipline in Germany, particularly when compared to countries such as the United Kingdom or the Netherlands. This was attributed to Germany's not having a long tradition of engaging in global health either politically or academically. The country could strengthen its ability to contribute to the global public health discourse and to shape governance by systematically investing in academic training on the subject, to produce the 'next generation of thinkers but also decision makers' of the global health ecosystem.

In a similar vein, one participant diagnosed a scarcity of renowned think tanks and 'public intellectuals' with authority to speak on matters of public health governance. Other countries, like the United States, have many more of these which constitute a significant 'soft power' asset to shape thinking and initiatives on global health governance.

Facilitate technical development cooperation and private sector engagement

Beyond leadership and funding, Germany has other assets which it can bring to bear more effectively in global health governance. The country's technical development cooperation is well-established and GIZ has extensive experience supporting partner countries in capacity development and health systems strengthening. However, in recent years Germany has scaled back its bilateral development cooperation in health, with repercussions that extend beyond the governments and non-governmental partners that previously counted on this support.

Germany has a vibrant health private sector that commands world-class scientific expertise, innovation and capital. New partnerships and investments, particularly in lower middle-income countries, promise to yield benefits for both sides, considering market access, business opportunities and technology transfer. However, an engagement in an emerging market constitutes a significant risk, especially for small and medium-sized enterprises. Good bilateral relations between Germany and the potential partner country for investment, and the presence and activity of bilateral development cooperation, are important factors for facilitating involvement of private companies.

> *Bilateral cooperation in health needs to be embedded in multilateral engagement and has an important trigger function for private sector investments, NGO projects and research cooperation. The German government has neglected this, but it has now readjusted its strategy in the right direction. Truly systemic, coordinated implementation towards health systems strengthening requires political lead and commitment. We also need a much better, coherent mapping of the multitude of actors and initiatives to create the required linkages and synergies.'*
>
> Roland Göhde

There is room for the German government to strengthen its commitment to technical development cooperation in health and to recognise and facilitate the engagement of Germany's private sector.

Reduce internal fragmentation

Most importantly, five out of the seven voices in the Catalyst Dialogue diagnosed fragmentation not only in the global health architecture, but also in how Germany engages in global health. Multiple German ministries and agencies share responsibilities and steer many different global health instruments. For example, the Federal Ministry of Health is responsible for cooperation with WHO, UNAIDS and UNODC, while the Federal Ministry of Economic Cooperation and Development sits on the governing boards of the Global Fund, Gavi and the World Bank. The Federal Ministry of Education and Research is responsible for CEPI. 'Alignment and exchange across the German ministries with a mandate for global health is not the best and hasn't been for a long time; there are occasions when this is quite visible', said one Catalyst Dialogue participant. Several others indicated that it seemed unclear to what extent the present German government still prioritises global health.

Therefore, Germany could strengthen its own contribution to making global health governance more coordinated and holistic by 'defragmenting itself'. Although ideal solutions do not exist, there are examples from other countries considered to be more coordinated. Sweden has a Global Health Ambassador who sits in the Ministry of Foreign Affairs, but who has the authority and outreach to coordinate policy and engagement across ministries. Norway was mentioned by participants as another example for well-coordinated global health engagement, to some extent also France, and the British model before closing the Department for International Development (DFID).

> *"Germany should be a connector across global health initiatives. But with so many German ministries sharing responsibility, the extent to which the country is a **consistent** multilateral actor across the different initiatives must be questioned.'*
>
> Anna Holzscheiter

Germany's Ministry of Health and Ministry for Economic Cooperation and Development play pivotal roles for shaping the way forward. They would be well placed to lead a strategic reorientation towards less fragmentation and better coordination of Germany's engagement in global health governance. The country has already adopted a Global Health Strategy which was written before the COVID-19 pandemic. An update of the strategy could create a new dynamic for reconfiguring how Germany organises its involvement in the global health marketplace.

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