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A New Compact for Health Financing

From Principle to Practice

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Abstract

Global health financing is undergoing significant strain following the 2025 aid shocks, including the USAID shutdown and major reductions across European donors. The resulting decline in development assistance for health has disrupted services and amplified long-standing concerns around fragmentation, aid dependency, and weak alignment with national systems. This moment has renewed calls for reform in how health services are financed and coordinated.

Centred on evidence-informed priority setting, domestic-first financing of core services, and consolidated supplementary aid, the New Compact offers a framework to guide health financing reform. This paper examines how the New Compact for health financing can be taken from principle to practice, both as a strategic guide for global reform and as a technical framework at the country-level. We analyse implications under three scenarios for global health architecture reform: maintaining the status quo; donor policy shifts but no architectural reform; and a consolidated multilateral financing mechanism. We draw on lessons from past global and country-level coordination efforts and assess opportunities for donor policy shifts to operationalise reforms aligned with a New Compact approach. A framework for country-level drivers for success is developed to guide transition plans. Taken together with ideas for action for donors and recipient countries, this paper positions the New Compact as an approach for strengthening country ownership, improving allocation efficiency, and building more resilient health financing systems amid fiscal uncertainty.

POLICY PAPER 386 • MARCH 2026

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The UK Foreign Commonwealth and Development Office provided financial support to the Center for Global Development for this work.

Tom Drake, Anastassia Demeshko, Mizan Kiros Mirutse, Solomon Tessema Memirie, Ole F. Norheim, Miloud Kaddar, Kalipso Chalkidou, Pete Baker, and Nadia Yakhelef. 2026. "A New Compact for Health Financing: From Principle to Practice." CGD Policy Paper 386. Washington, DC: Center for Global Development. https://www.cgdev.org/publication/new-compact-health-financing-principle-practice

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Acronyms

AMC	advance market commitments
Africa CDC	Africa Centres for Disease Control and Prevention
CGD	Center for Global Development
DAH	development assistance for health
DRM	domestic resource mobilisation
EIPS	evidence-informed priority setting
EPHS	essential package of health services
FCDO	Foreign Commonwealth and Development Office
GFF	Global Financing Facility
GHIs	global health initiatives
IHP+	International Health Partnership
IDA	International Development Association
LMICs	low- and middle-income countries
MDB	multilateral development bank
MDGs	Millenium Development Goals
ODA	official development assistance
PEFA	Public Expenditure and Financial Accountability
PFM	public financial management
SDG3 GAP	Global Action Plan for Healthy Lives and Well-being for All
SDGs	Sustainable Development Goals
SWAp	sector-wide approach
UHC	universal health coverage
WHO	World Health Organization

Executive summary

Global health financing has reached a critical inflection point, triggered by the abrupt shutdown of USAID operations in 2025 and substantial budget cuts by the UK's Foreign Commonwealth and Development Office and other European donors. As we outline in **Section 1**, development assistance for health (DAH) has declined from a relatively stable US$50 billion per year in the run up to COVID-19, to an estimated US$38.4 billion in 2025. This aid shock has disrupted health services, cost lives, and brought to the surface longstanding concerns regarding aid dependency, limited national health sovereignty, DAH inefficiencies, fragmented aid, poor donor coordination, misalignment with national priorities, and weak transition planning. In response to the 2025 aid cuts a wave of initiatives sought to rethink global health financing, including a World Health Assembly resolution on health financing, the Accra Reset, and World Bank supported "National Health Compacts."

The Center for Global Development, alongside Africa Centre for Disease Control and Prevention, Bergen Centre for Ethics and Priority Setting in Health, Addis Center for Ethics and Priority Setting, and Imperial College London, have for several years been developing a proposal for a New Compact between donors and recipient countries for financing health services. In this paper, we show how the New Compact can make a vital contribution to the current global health reform agenda, and analyse the required global and national policy changes needed for implementation.

Background on the New Compact for financing health services

The New Compact comprises three pillars:

1. **Locally led, evidence-informed prioritisation,** where national institutions define a core package of high-priority health services using robust data and fair processes
2. **Domestic-first resource allocation,** ensuring governments finance this core package to promote ownership and stability
3. **Consolidated supplementary aid,** where donors collaborate to provide top-up funding for additional services, infrastructure, or crosscutting support, filling gaps where domestic capacity is limited

What fundamentally differentiates the New Compact from previous coordination initiatives is the explicit sequencing of budget formulation: domestic resources are allocated first to a defined core benefits package, while external financing is restricted to a clearly identified marginal top-up. This changes incentives for both governments and donors, and directly addresses the fragmentation observed in previous compacts and sector-wide approaches (SWAp).

As described in **Section 2**, the New Compact has application as both global strategic guidance for sectoral reform and as a technical country-level resource allocation framework. As strategic

guidance, a "Global New Compact" could be agreed between countries and donors, with a paradigm shift away from donor-driven priorities and earmarked, highly fragmented funding, towards a country-owned model that safeguards essential services against external shocks. In contrast, a "Country New Compact" would be a technical framework that can provide structure for country-level initiatives aiming to manage the complexity of external financing flows.

The impacts of the New Compact are potentially profound:

- Centring country-led, evidence-informed priority setting not only restores national sovereignty in health policymaking, but local institutions and processes previously sidestepped by external aid are strengthened to carry out their essential functions. Done well, this also means more health for the money through effective allocation of *both* domestic and external finances.
- Domestic-first financing protects core services from the volatility of external finances, reduces the risk that DAH simply displaces domestic financing, and strengthens the link between public institutions and their populations—aligning political incentives for leaders to deliver and receive credit for doing so.
- Lastly, the consolidation of donor support and stepping back from the responsibility of financing core services creates more space for donors to lean into areas of comparative advantage, including the provision of common goods for health. It also offers a refreshed narrative of aid driving self-sufficiency rather than dependency, which is vital to reengage stakeholders (including taxpayers in donor countries) amid fiscal pressures and isolationist trends.

However, the current aid architecture, as well as practical implementation challenges could undermine the above benefits. Countries may face capacity gaps in priority-setting or public financial management, potentially leading to resource misallocation. Initial implementation demands significant coordination and institutional change, and inadequate donor coordination could disrupt ongoing services during transition. If moving support on budget, donors could face reduced oversight over funds and potentially political backlash at home in the event of misappropriation.

Towards implementing the New Compact

Implementing Country New Compacts for health financing depends on macrolevel decisions about the future of the global health architecture. **Section 3** outlines three possible trajectories for global health reform:

1. **Status quo:** No significant architectural reform to defragment external financing for health services and no major donor policy shifts

2. **Donor policy shifts but no architectural reform:** Some donors or multilaterals make significant policy changes that improve external financing arrangements and facilitate implementation of Country New Compacts
3. **Consolidated multilateral financing mechanism:** Significant architecture reform, perhaps ushered in under a Global New Compact, brings a majority (though not all) external financing for health services under a single financing mechanism

Each scenario is an archetype. While a Global New Compact could catalyse a major shift towards consolidated financing, current geopolitics are perhaps more likely to lead to a mix of partial consolidation, selective donor policy adjustments, and elements of the status quo.

As such, sections 4, 5, and 6 consider incremental implementation of Country New Compacts in terms of:

1. Country-level coordination mechanisms required to reorganise fragmented health financing around a New Compact mode (Section 4)
2. Donor policy shifts that would facilitate this transition (Section 5)
3. Country capabilities that would drive successful implementation (Section 6)

Section 4 synthesises lessons from decades of health financing coordination efforts. Initiatives such as sector-wide approaches (SWAps), the International Health Partnership (IHP+) in 2007, and UHC2030 have advanced alignment and country ownership but often faltered due to inconsistent donor participation, weak accountability, donor concerns of fungibility and corruption, and unmet funding expectations. The New Compact is not a successor to these initiatives, nor would it demand an additional formal agreement. Instead it is a set of principles that could be adopted by any existing coordinating structures or formal agreements, for example to strengthen the 2025 World Bank supported national health compacts.

A mapping of key donor policies in **Section 5** highlights that, while donors' and multilaterals' expressed policies often stress the importance of health system strengthening, their resources predominantly focus on disease-specific interventions with clear direct impact. Health system strengthening is often a separate silo, with ad hoc implementation. To make Country New Compacts more feasible, donors could shift their policies and practices away from programming based on diseases and interventions and towards a focus on common goods and country partnerships. They could adopt financing instruments with more flexibility for recipients, such as envelope financing or on-budget support—while maintaining appropriate fiduciary accountability. Donors could also reconsider their narratives to include joint reporting of impact and attribution, focused on long-term sustainability and transition.

From the country perspective, success of a Country New Compact hinges on political and economic stability, strong leadership, health financing capacity, evidence-informed priority setting, robust public financial management, and donor harmonisation. A proposed readiness framework in **Section 6** assesses these drivers to guide tailored transition plans. Countries with stronger priority-setting systems, high per capita health expenditure, and low out-of-pocket reliance are better positioned, but even resource-constrained nations can phase in reforms by building domestic capabilities. Of note, a Country New Compact does not propose *how* to set priorities, or what criteria and evidence to use. This is for governments to develop based on global guidance, national values, and context and political negotiation.

In conclusion, the New Compact offers a timely, actionable response to the current health financing crisis, promising more sustainable, equitable systems. It can strategically guide the reform of the global health architecture, as well as provide a technical framework for improved country–donor partnerships in specific countries. Donors should prioritise policy reforms to align with country-led approaches, explore consolidated financing mechanisms, and invest in health system strengthening. Countries must communicate reform preferences, strengthen domestic financing, and build priority-setting capacities. By acting collaboratively, stakeholders can transform DAH cuts into an opportunity for more resilient, country-owned health financing, ultimately advancing universal health coverage, health sovereignty, and global health equity.

1. Introduction

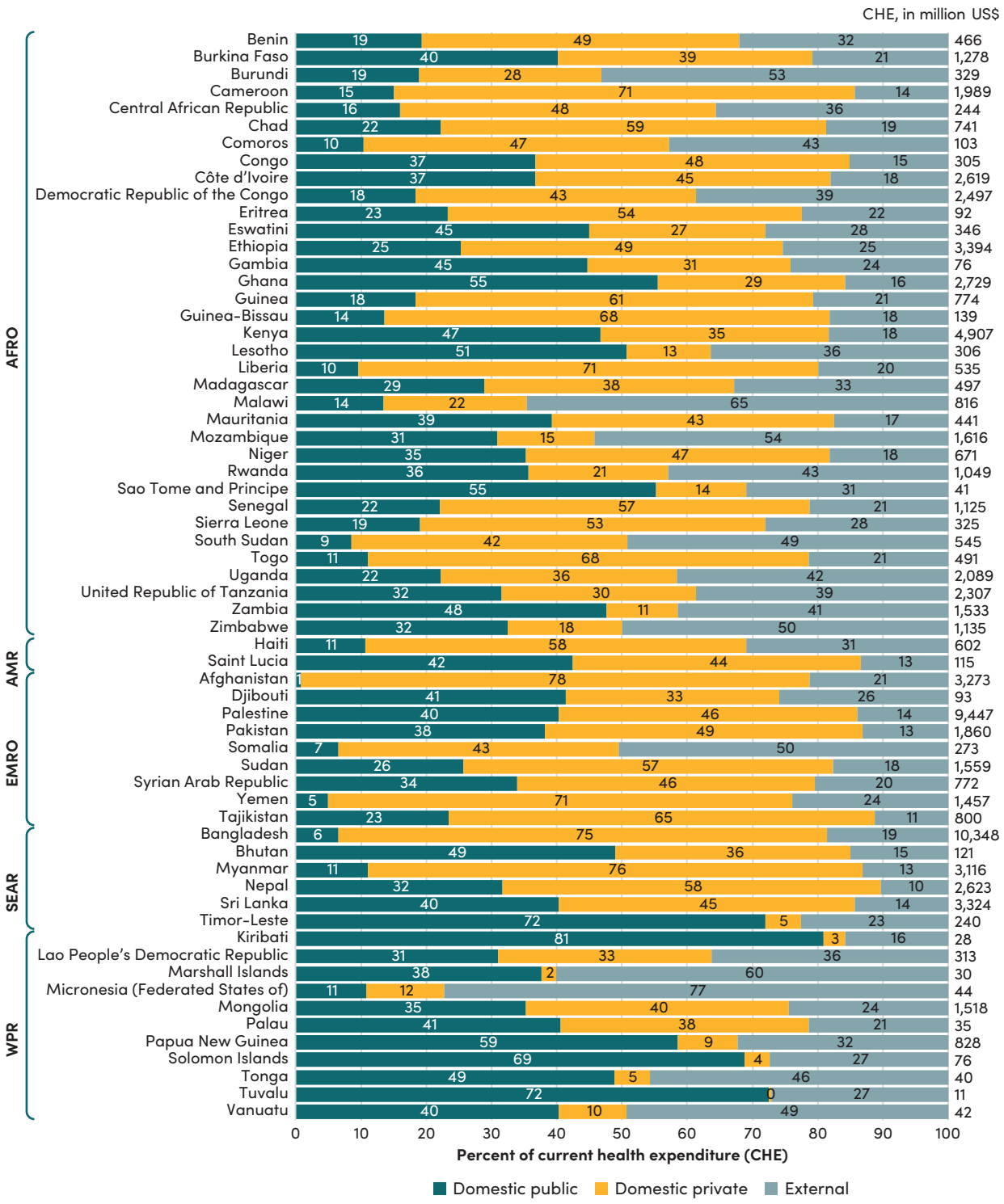
Global health financing has entered a period of heightened volatility. The convergence of major aid cuts by leading donors in 2025, persistent global economic headwinds, and heightened geopolitical uncertainty has eroded the predictability of external financing for low- and middle-income countries (LMICs). These financing shocks also reflect broader political economy dynamics, including declining political support for multilateralism, rising domestic fiscal pressures in donor countries, and increasing pressure to demonstrate short-term, attributable results from aid spending. These shocks are unfolding against an unfinished recovery from COVID-19 and a broader global polycrisis spanning economic, environmental, social, and technological domains, that continues to strain fiscal space and institutional capacity (World Bank 2025a) (World Bank 2024c). Together, these pressures threaten the sustainability of health financing and the resilience of health systems in many LMICs.

The scale of this volatility is evident in recent trends in development assistance for health (DAH). After remaining relatively stable at US$45–50 billion between 2013 to 2019, DAH rose sharply during the COVID-19 response, peaking at US$80.3 billion in 2021. In 2025, DAH was estimated to have declined to a low of US$38.4 billion—a level not seen since 2009 (Apeagyei et al. 2025). The largest reductions were seen in US bilateral aid, with significant cutbacks also announced by other major donors, including the UK and Germany. These reductions will disproportionately impact countries relying on external health financing (Figure 1), with 24 aid-recipient countries deriving over 30 percent of their total health expenditure from DAH, placing their health systems at risk. Moreover, amid a replenishment traffic jam (Madan Keller, Landers, et al. 2025), replenishment rounds for organisations like Gavi, the Vaccine Alliance (Gavi) have not met their targets among this period of sustained cuts to DAH (Gavi 2025b). Unless mitigated by increases in domestic resource mobilisation (DRM) or alternative financing mechanisms, these trends risk disrupting health service delivery and slowing progress towards improved health outcomes and universal health coverage (UHC).

Even before 2025's budget cuts, DAH was hampered by fragmentation, poor donor coordination, limited country ownership, misalignment with national priorities, displacement of domestic financing, ineffective prioritisation, and weak transition planning, all undermining LMIC health service delivery (Drake et al. 2023). At the same time, ministries of health in aid-recipient countries are contending with their own internal rising pressures of shifting disease burdens, evolving health system demands, health workforce crises, and economic downturns that constrain efforts to increase DRM for health (Kruk et al. 2018; Kodali 2023; WHO 2017).

Yet, in crisis there is also opportunity. Reform to address the long-term needs of aid recipient countries has gained momentum in recent years, and the financing crises will undoubtedly shake up a system with deeply entrenched flaws. The Lusaka Agenda outlined critical shifts needed to accelerate the evolution of global health initiatives (GHIs) (Future of Global Health Initiatives 2023). A 2025 World Health Assembly resolution also called on member states to strengthen equitable health financing systems by elevating domestic public resources, fostering collaboration between health and finance authorities, and enhancing capacity building, to accelerate progress towards UHC by 2030 (WHO 2025e). African leaders have been at the forefront of calls for reform. As part of the Accra reset, Pate et al. called for "transforming the global health ecosystem" and the Africa Centres for Disease Control and Prevention's (Africa CDC) "Health Financing in a New Era" sets out plans to strengthen African health financing and mitigate the impact of decreases in official development assistance (ODA) (Pate et al. 2026; Africa Centres for Disease Control and Prevention 2025). In alignment, the Center for Global Development (CGD) has produced a range of work on global health architecture reform, including a proposal to reimagine health aid through a New Compact for health financing (Drake et al. 2023).

FIGURE 1. Current health expenditure by funding source of aid-recipient countries that have greater than 10 percent of their health expenditure as external financing, 2022



Notes: AFRO: African Region; AMR: Region of the Americas; EMRO: Eastern Mediterranean Region; SEAR: South-East Asian Region; WPR: Western Pacific Region; CHE: current health expenditure.

Source: WHO Global Health Expenditure Database (WHO 2025a).

In this paper, we describe how countries and donors can move from idea to implementation of a New Compact. We first reintroduce and refine the New Compact proposal, then consider broad future global health architecture scenarios within which implementation could take place. We then provide detailed analysis on three topics: (1) country-level coordination mechanisms, (2) donor policy shifts required, and (3) country capabilities needed for New Compact success. In developing this paper, we benefited from consultation with various global health stakeholders, including a virtual roundtable with health leaders across Africa in February 2025 (Demeshko, Memirie, et al. 2025) and an in-person convening with participants at the World Health Summit in October 2025.

2. The New Compact as a global strategic vision and country technical framework

The New Compact is a proposal for global health donors and recipient countries to agree a new approach to financing health services. The core principles that define the proposed compact are:

1. **Locally led evidence-informed prioritisation**, where country institutions are supported to set health priorities using available evidence
2. **Domestic-first resource allocation**, meaning countries take ownership of the core package of high priority services, including financing
3. **Consolidated supplementary aid**, which involves donors working together and with country leaders to design a top-up package, both in terms of additional health services and other crosscutting support

In previous papers, CGD and collaborators have outlined the initial concept (Drake et al. 2023), modelled its application through full and partial adoption scenarios in Ethiopia (Memirie et al. 2024), assessed the policy implications for Gavi (Morton et al. 2024), and explored consequences for public financial management (Gheorghe et al. 2024), financing of common goods for health (Drake and Demeshko 2024), the need for political economy analysis to navigate global reform (Drake and Khan 2024), and implications for donor priority setting (Drake et al. 2025). CGD has also partnered with Africa CDC to analyse what the New Compact may look like for the African region (Demeshko, Memirie, et al. 2025; Demeshko, Drake, et al. 2025).

In this policy paper, we build on these ideas to show how the New Compact can move from principle to practice, through the required global and national reforms needed for implementation. As part of this, we make a distinction between application of the New Compact principles at the global and country level.

A Global New Compact

Historically, donors have tended to support healthcare in recipient countries according to their own perception of priorities. This is enacted through earmarked funding offers, funding issue-specific international NGOs, or the creation of multilateral GHIs to support specific diseases or interventions. Domestic governments are then supposed to finance other services around this. Adopting a Global New Compact as a strategic vision for global health would require reforming the global health architecture and donor policies. This would enable a shift from a disease-specific, donor-led approach and to a model led by country priorities and domestic-first financing, with donors playing a supporting role.

The principles of the New Compact could be implemented as part of Global New Compact in different ways. A multilateral declaration could be drafted. For example, a World Health Assembly resolution, where all major donor and recipient countries come together with the ambition for a new era of global health and new principles for collaboration, with the three New Compact principles forming part of that commitment. Alternatively, it could be part of a declaration by a "coalition of the willing," in line with the proposal by Pate et al., as part of the Accra Reset (Pate et al. 2026).

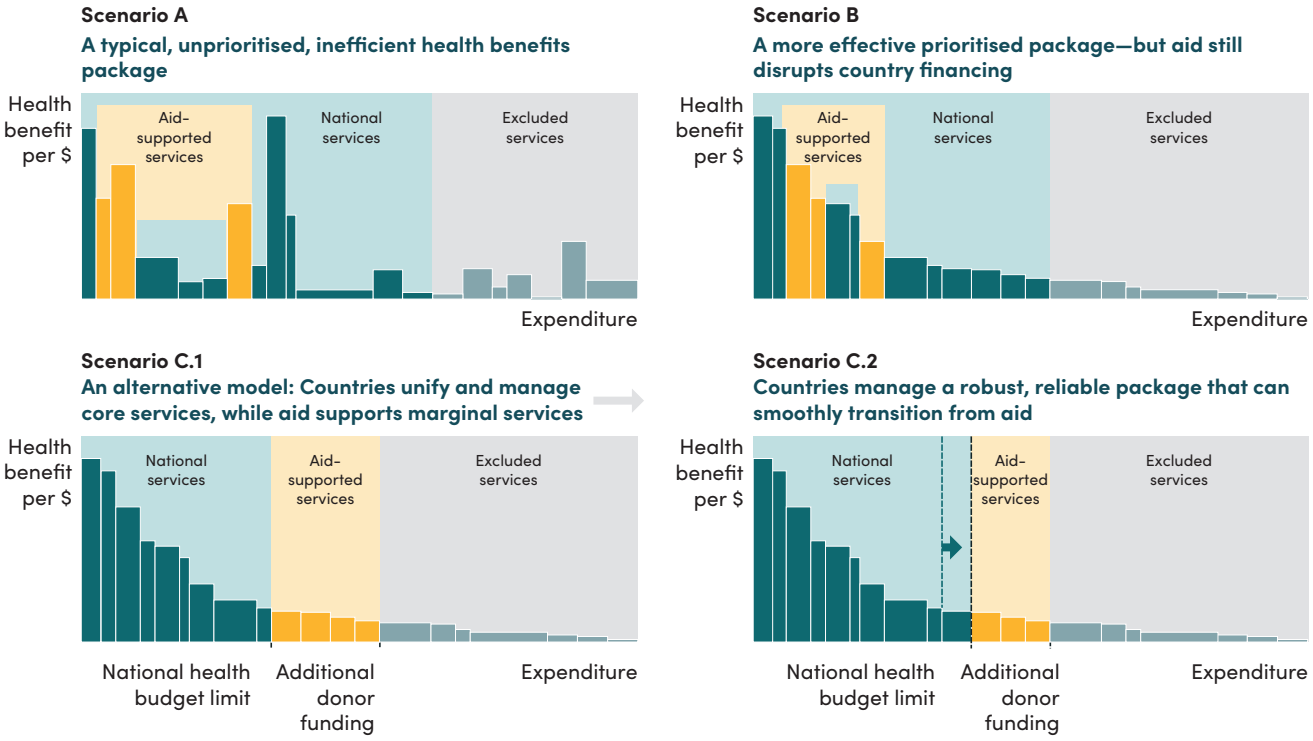
Country New Compacts

The New Compact principles can also be applied as part of an agreement between donors and a government at the country level. This Country New Compact would ideally be built around an explicit health benefits package that is designed through a locally led, evidence-informed, and fair priority-setting process. This package should be anchored to national budget formulation and medium-term expenditure frameworks.

Application of the New Compact as a country-level technical framework would likely occur through a country-level donor coordination structure (Section 6) or a new consolidated financing mechanism (Section 3). Instead of countries working out what is left for them to pick up after the various donor commitments, country planning would come first, and in the planning process countries and donors would adopt the clear principle that country financing is (at least notionally) allocated first. Financing may then be provided as on-budget support by some donors, but with added confidence in a clearer process that prioritises the most important services and clarifies that support is additional and does not displace domestic financing or duplicate other donor support. This is illustrated in Figure 2. Out-of-pocket spending would be considered as a last resort for services not covered by public, donor, or private institutional sources.

Currently, the existence of multiple external financing flows tends to make it more difficult to design and implement a clear health benefits package, therefore undermining local institutions' efforts to strengthen health systems. Adopting a New Compact approach would mean donors and recipient countries agree to centre country-led processes and design donor support around these processes, embedding a health systems strengthening approach into the way aid is provided.

FIGURE 2. Illustration of prioritised health benefits package with aid investment at the margin



Notes: Moving from Scenario A to B shows how cost-effective decisions yield more health for the same spending, but DAH still disrupts country financing. In the New Compact (Scenario C1), countries determine and fund core high-value services while donors provide a complementary top-up package. As domestic budgets grow, reliance on DAH declines (Scenario C2).

Benefits and risks of the New Compact for countries and donors

Country benefits and risks

For countries, a key benefit is the mitigation of volatility associated with external aid. By centering domestic resources on funding an essential package of services, nations are shielded from abrupt donor policy changes, political shifts, or sudden aid freezes, as we saw with USAID. This, in turn, protects the stability of core health programmes. The approach also strongly promotes local empowerment. Through locally driven, evidence-based priority setting, governments could exercise increased autonomy in managing national health priorities, which may help build stronger health institutions and increase the accountability of decision makers to local citizens. This shift away from fragmented, donor-driven assistance may equip governments to focus on system management rather than pursuing a patchwork of grants. Additionally, countries could achieve more health for the money, as the New Compact encourages improved prioritisation of health services and allocation of both domestic and donor funds. By decoupling basic care from the uncertainties of external funding, the continuity of life-saving health services may be better safeguarded.

That said, adopting the New Compact poses risks for countries. It may rapidly increase the burden on existing evidence-informed priority setting and public financial management systems, which could lead to inefficiencies or resource misallocation. Increased country autonomy may also expose systems to governance risks such as corruption or mismanagement, especially in contexts where accountability mechanisms are weak or where oversight diminishes as a result, potentially undermining donor confidence and long-term health service sustainability. Developing these systems, however, is a key aim of the New Compact and of wider health sovereignty, and so the solution to these risks is not to avoid them, but to bolster them during transition. Lastly, there is a risk that donors coordinate poorly during transition, and gaps emerge in the funding of key services.

Donor benefits and risks

For donors, the New Compact offers several advantages, particularly relevant in the shifting aid environment.

First, it supports sustainability and a reduction in long-term aid dependency by prioritising investments in national systems and institutions. By focusing on core functions, the New Compact helps build the foundations for domestic financing to progressively crowd out DAH. Importantly, it also offers a clearer and more structured pathway for transition as domestic budgets grow, helping donors avoid inadvertently entrenching dependency while continuing to support services that countries genuinely cannot yet finance themselves. It could also allow donors to better prioritise aid for countries where there are still high-value interventions that cannot be funded by governments.

Second, it could improve value for money and overall health impact by aligning donor financing with nationally defined priorities and system constraints. Rather than optimising for donor-attributed outputs and financial traceability alone, the New Compact would involve a shift towards assessing total health system results and refocus on improving the efficiency of the overall system. For example, evidence from an Ethiopia case study suggests that adopting a New Compact approach could generate an approximate 15 percent increase in total healthy life years gained at the health system level (Memirie et al. 2024). This system-level perspective supports more efficient allocation of scarce resources and could strengthen the case for impact-focused aid to LMICs.

Third, it allows donors to refocus their resources on areas of comparative advantage. As countries assume greater responsibility for routine service financing, donors could shift towards strategic, high-value functions. This could include investing in catalytic technical assistance, health system strengthening, pooled procurement, or global public goods like market shaping, pandemic prevention, and vaccine research. A Gavi case study further describes the policy shifts that might be involved for a donor under a New Compact (Morton et al. 2024). This reorientation could enable donors to maximise their strategic contribution aligned with their goals and values, within tighter fiscal envelopes.

Fourth, the New Compact provides a refreshed narrative for donor engagement that emphasises fairness and mutual responsibilities over charity. Framed effectively, this narrative can appeal across the political spectrum, resonating both with solidarity-based constituencies and with aid-sceptic audiences concerned with efficiency, value for money, and reduced long-term dependence (Schneider et al. 2021).

Finally, over time, these shifts can strengthen mutual trust and legitimacy between donor and recipient governments. By supporting nationally-led priorities, delivering demonstrable system-level gains, and clarifying pathways to transition, donor programmes may be perceived as more credible, effective, and aligned with partner country objectives.

Donors also face a set of risks with New Compact adoption. Donor governments operate within short electoral cycles, tight fiscal environments, and accountability systems that privilege visible, donor-attributable results. These incentives have historically favoured disease-specific programmes and headliner impact claims over longer-term system investments. A commonly raised risk is that shifting towards system-level financing reduces donors' ability to report simple, donor-attributable metrics such as "lives saved." This risk can be mitigated by estimating and reporting the donor-attributable portion of the impact of a countries health system, which given improvements in allocative efficiency will be higher under a New Compact approach. However, both the risk and the political importance of this risk is often overstated. A shift from *attribution* of donor impact to *contribution* towards a story of country-led progress would be a more appropriate and perhaps more compelling measure. Moreover, public understanding of aid is arguably anchored more in moral narrative (Schneider et al. 2021; Hudson et al. 2020). A fresh narrative on aid could be more influential than changes to donors' quantitative impact claims.

More binding risks arise from donor-side institutional and political constraints. Implementing a New Compact requires changes to established budgeting, reporting, and decision-making processes, as well as coordination across multiple agencies and funding streams. These shifts may encounter resistance from entrenched bureaucratic incentives, risk-averse accountability frameworks, and competing political priorities. Transition costs and early implementation errors are therefore possible, particularly where donor systems remain optimised for earmarked funding and short-term attribution rather than pooled or system-oriented approaches. Addressing these political economy risks requires making donor constraints explicit and designing compact arrangements that are compatible with domestic accountability pressures while gradually reshaping them.

Overall, the New Compact offers pathways to more sustainable, country-owned health financing, but its implementation requires risk management, careful coordination among stakeholders, and changes to entrenched donor incentives and practices.

3. New Compact high-level scenarios

Implementing a New Compact for health financing depends on macrolevel decisions about the future of the global health architecture. Here we outline three archetypical future scenarios, reflecting progressively increasing levels of change undertaken by global health stakeholders and differing implications for recipient countries.

Although a Global New Compact could, in principle, enable a transformative move towards a fully consolidated financing mechanism, a more realistic near-term outlook is a hybrid path, characterised by limited consolidation, incremental donor policy shifts, and ongoing features of the status quo. The subsequent sections of this paper unpack three key aspects to implementation in these contexts: (1) country-level donor coordination platforms, (2) donor policy shifts, and (3) country capabilities.

Scenario 1: Status quo

Under the first scenario, relatively minimal changes are made by donors (including multilateral development banks [MDBs] and global health initiatives [GHIs]) to the global health architecture or donor policy frameworks that would support New Compact–like ways of working. Some donors may express a willingness to align with country priorities, but without policy reforms, myriad constraints will make this challenging for countries. At the country level, there may be a development partners forum or a set of donors working together in sector-wide approach (SWAp) groups. But without deeper donor reforms to the complexity of who can fund what, for how long, and through which modalities, adopting a New Compact framework may be challenging. This scenario has previously been explored in more detail in a case study on Ethiopia (Memirie et al. 2024).

The advantage of this scenario is that it does not require countries to wait for donors to act first; they can initiate the transition by calling on donors to work with them under a New Compact framework. There may still be countries where a move towards a New Compact approach is worth attempting even without (or before) supportive donor reforms, and pilot implementation of the New Compact is most likely to occur in this context. However, the potential risks are that administration of a fundamental financing shift is too complex and constitutes a significant administrative burden on all stakeholders, distracting from other delivery goals. Worst case, administrative failures lead to gaps in coverage of care and the failure of the New Compact approach.

Emerging risk to the New Compact: Growing bilateralisation and politicisation of external financing for health

As DAH shifts towards bilateral deals shaped by donor countries' domestic priorities (particularly the US), funding is channelled through short-term agreements, often linked to foreign policy objectives such as security, migration, or industrial interests, rather than long-term health system needs. This accelerates fragmentation. Countries face multiple parallel agreements, each with

its own conditions and reporting requirements. Opportunities for pooled funding and joint planning shrink further.

For governments, long-term planning becomes extremely difficult. Budgeting becomes reactive, and core services are increasingly exposed to political shifts in donor capitals. External resources tend to follow what is politically visible for donors, rather than what is most urgent locally. This undermines evidence-based priority setting and domestic-first financing. It also destabilises donor efforts to align with country systems, making it difficult to advance sector-wide coherence, integrate donor resources into national budget processes, or strengthen joint performance frameworks—all key for phased adoption of a New Compact. The New Compact becomes harder to implement, but also more necessary. Countries may increasingly use it as a defensive coordination tool to protect core services and reassert national leadership.

Scenario 2: Donor policy shifts but no architectural reform

The second scenario considers a future without fundamental changes to the global health architecture in the sense of financing flows, but where donors (including MDBs and GHIs) take significant steps to adapt their policy frameworks in line with the Lusaka Agenda. That is, at the country level, the number of donor development partners does not materially change, but they are better able to adapt to harmonise—through a SWAp or similar coordinating platform—and align behind country-led priority setting and domestic-first financing. For example, Gavi may adopt a more flexible co-financing policy or a "New Compact Envelope Financing" mechanism (Morton et al. 2024; Madan Keller, Bonnifield, et al. 2025b), and donors may create less rigid bilateral funding mechanisms (see Section 5). Other important policy reforms could include alignment of funding cycles and transitioning towards on-budget support, as was the case for pooled funding in Ethiopia that CGD previously explored in more detail (Memirie et al. 2024). In this scenario, financing remains fragmented, but donors are better equipped to respond to countries' calls to at least partially align with a New Compact model.

The advantage of this scenario of meaningful donor policy reform is better country-level New Compact harmonisation and less administrative burden on countries to deal with a wide array of fixed donor constraints. Moreover, there is some benefit to a plurality of financing flows; if one fails, the others are still in place (and with domestic-first financing, the most essential services are not at risk). However, there is still significant work required, both by countries and by donors to manage this country-level complexity.

Scenario 3: Consolidating financing into a single multilateral channel

This third scenario imagines that the vast majority of multilateral and bilateral country-level financing support is replaced by a single multilateral facility that provides external financing for

health services. This mechanism would likely be targeted to stable LMICs. Fragile and conflict-affected states are likely to need more tailored support, and upper-middle-income countries are unlikely to represent value for money for impact at the margin. Bilateral and philanthropic donors may still provide financial support for capital or crosscutting investments, as well as other global health functions such as the provision of common goods for health. However, with some exceptions, donors would agree to a single pooled multilateral platform for financing support for health services and step back from providing bilateral financing to reduce fragmentation and complexity.

There are two broad options for a consolidated financing channel.

1. **A health services financing mechanism within (or closely associated with) the MDBs:** The MDBs use of on-budget financing, disease-agnostic approach, ability to blend loans and grants, and trusted due diligence processes make them well placed to take a New Compact approach, and to align external financing behind country-led priorities. The World Bank, by far the largest MDB contributor to the health sector, has experience with a range of mechanisms for health financing, including the Pandemic Fund, the Global Financing Facility (GFF), and the International Development Association (IDA). GFF's approach to country support is already partially aligned with New Compact principles, and the Bank's recent tranche of 15 National Health Compacts offer a valuable starting point, provided it shifts the Compacts towards becoming genuine deals between donors and governments, and if GFF can overcome implementation challenges (Musuva et al. 2025; Demeshko and Baker 2025).
2. **A dedicated GHI:** An alternative model for a consolidated health services financing mechanism would be a dedicated multilateral initiative. In the current political climate, there would likely be very limited appetite for creating a new additional GHI, so it is more likely this would be created by radically consolidating the existing initiatives (see (Pate et al. 2026) for an example). The two most likely options would be the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and/or Gavi. Gavi has recently published a statement on its approach to global health architecture reform including a commitment to "explore radical options with respect to Gavi and the Global Fund" (Future of Global Health Initiatives 2023; Witter et al. 2025; Gavi 2025a). 'A Global Fund for Health Services' (or similar) would align funding behind a country-led, sector-wide budget formulation process to expand a core package of health services through public systems rather than parallel programmes. Governance, planning, and management of the funds at country-level would shift from the current parallel approaches to the government ministries that manage domestic budgets.

All else being equal, the consolidation of financing flows would present a significant improvement for recipient countries, reducing administrative burden, and creating space for national institutions to function effectively. Moreover, pooled financing reduces and spreads the risk of volatility in upstream donor contributions. The main drawback of consolidated funds is the work required by

donors and other global health stakeholders not only to create such a function but to reform or dismantle the currently existing structures it would replace. Also, compared with scenarios 1 and 2, there is a monoculture risk to using only, or mainly, one channel to provide financing. In addition, if for some reason the partnership breaks down, the implications are more catastrophic than if a single bilateral funder or GHI withdraws.

There are some potential advantages to the MDB option. Their constitution as a bank means the initial grants provided by upstream donors can be leveraged to provide increased volumes of financing as concessional loans—though there is some debate about the suitability of using debt financing for recurrent service provision obligations, as opposed to capital investments. That said, there are also drawbacks to the MDB option, particularly the limited accountability of governance structures (Musuva et al. 2025).

Consolidation of the GHIs and adoption of a New Compact approach has the potential to address most of the challenges associated with GHIs (Witter et al. 2025). This approach would be particularly strong if it worked in partnership with the MDBs, enabling it to leverage their on-budget financing. However, given the extensive work required to realise such reforms, there would need to be a strong rationale for why a multilateral financing function for health services would be better as an independent institution rather than a facility within the MDBs. It may be more practical to refocus and strengthen the GHIs on other areas of comparative advantage, such as market shaping and pooled procurement. Countries could then voluntarily use their own resources, boosted by multilateral funds, to procure through the GHIs to gain access to better prices and quality (CGD 2025).

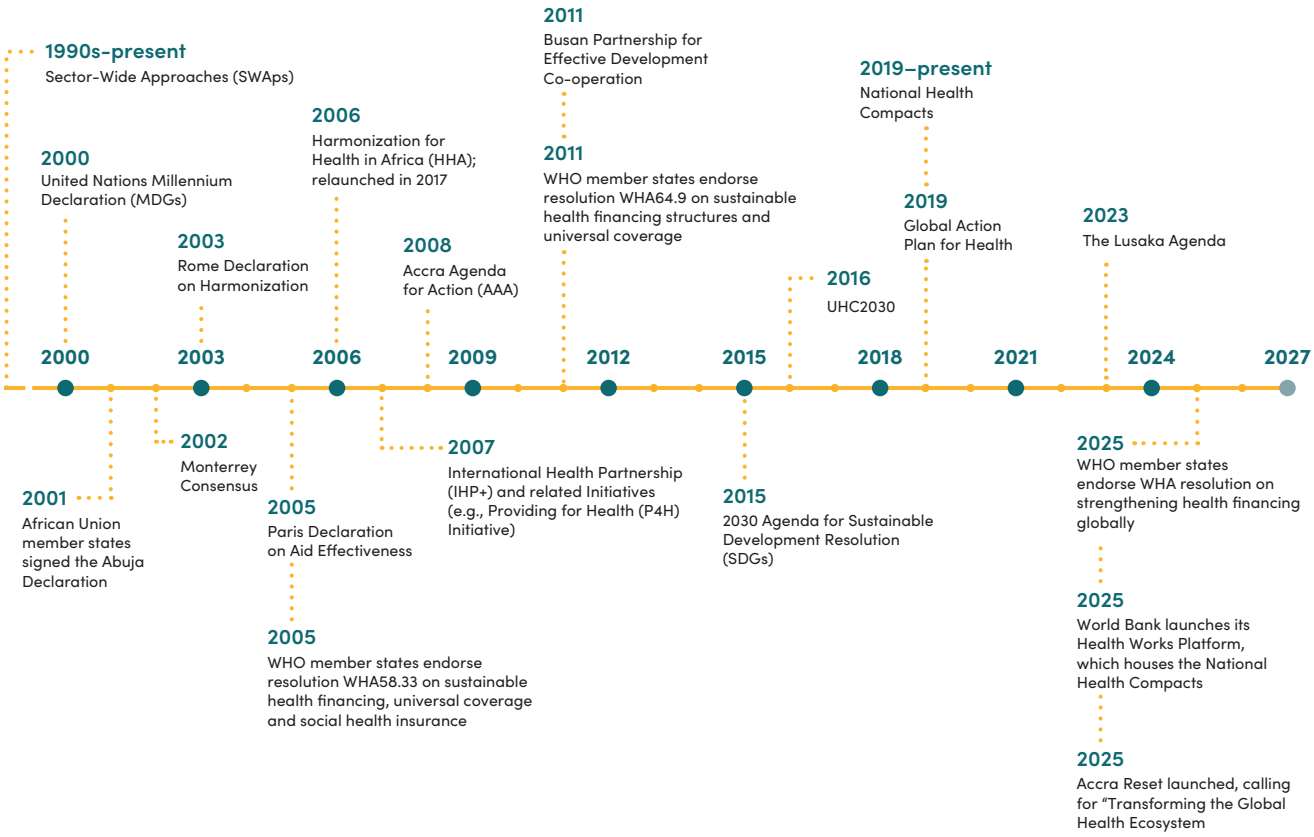
4. The landscape of health financing coordination initiatives

Efforts to harmonise global health financing have evolved over several decades, shaped by the persistent challenges of aid fragmentation, volatility, and limited country ownership. Key milestones in the movement towards coordinated, country-led approaches to health financing have aimed to address these recurring issues.

Figure 3 outlines a timeline of the recent history. It begins with the introduction of SWAps in the early 1990s (WHO 2006), followed by the establishment of the global principles of aid alignment, coordination, and accountability in agreements such as the Monterrey Consensus (United Nations 2002); Rome Declaration on Harmonization (United Nations Development Group 2003a, 2003b); the Paris Declaration (OECD 2005); the Accra Agenda for Action (OECD 2008); the Busan Partnership for Effective Development Co-operation (EU Capacity4dev 2011); and for African Union members, the Abuja Declaration (African Union 2001). These principles were operationalised through compacts and mechanisms for mutual accountability, notably the International Health Partnership and related initiatives (IHP+) ('The International Health Partnership and Related Initiatives (IHP+)' 2009)

including the Providing for Health (P4H) Network (P4H Network 2023; UHC2030 2025b). The IHP+ scope later broadened under UHC2030 (UHC2030 2025b), through which national health compacts (UHC2030 2025a) were developed and endorsed. In parallel, major global commitments such as the Millenium Development Goals (MDGs) (WHO 2018), later succeeded by the Sustainable Development Goals (SDGs) (United Nations 2015), shaped the health diplomacy landscape aimed at improving health outcomes. More recently, the Global Action Plan for Health Lives and Well-being for All (WHO 2025f) (SDG3 GAP) and the Lusaka Agenda (Future of Global Health Initiatives 2023) continued efforts to align stakeholders and progress towards the SDGs or UHC. In 2025, the World Health Assembly (WHA) resolution on strengthening health financing globally was endorsed by member states (WHO 2025e) and the World Bank launched its Health Works platform (World Bank 2025b), and supported 15 countries to launch National Health Compacts (Demeshko and Baker 2025).

FIGURE 3. Timeline of key global health financing coordination initiatives, 1990s–2025



Success factors and common weaknesses of past initiatives

Various mutual success factors and reoccurring challenges have emerged across the donor coordination initiatives (these initiatives are further detailed in Tables A1 and A2 of Appendix 1). In summary, the donor coordination initiatives have, to some extent, contributed to progress on alignment with national strategies, improved dialogue among stakeholders, and the development of

shared tools and frameworks. Success factors commonly included steps towards country leadership, inclusive planning processes, and mechanisms to promote mutual accountability. However, these gains were often tempered by significant limitations. These included inconsistent donor or government participation in coordination efforts; sustained donor dominance or lack of compliance despite agreements; unclear or overly broad objectives; uneven or incoherent inclusion of country partners; weak monitoring, reporting, and accountability systems; and unmet expectations around financing.

In reality, these initiatives did not fall short because of a lack of ambition, but because of how they were designed. Most relied on voluntary alignment, without binding financial commitments, which quickly undermined their credibility. Ministries of finance were often only marginally involved, meaning these processes sometimes failed to shape budget decisions. At the same time, accountability frameworks were weak, with broad objectives, lack of appropriate incentives, and limited monitoring. Finally, few initiatives articulated clear pathways for transitioning away from external financing, leaving countries and donors in a state of prolonged uncertainty.

Evaluations of initiatives like IHP+ (Shorten and Conway 2015; Ofosu et al. 2016), SWAps (Foster et al. 1999; Vaillancourt 2009), country compacts (Taylor and Dolea 2012), and the SDG3 GAP (WHO 2025c) reveal mixed outcomes. For instance, the SDG3 GAP achieved early partner buy-in but struggled with uneven country ownership and poor contextualisation due to limited incentives for GHIs to engage and the coordination mechanism's lack of authority and resources (WHO 2025c; Susa Sparkes et al. 2025). Despite some being evaluated, it is unclear how each initiative has contributed to overall change in harmonisation efforts, due to limitations in measuring attribution or lack of systemic evaluation. It is also uncertain why multiple global compacts continue to emerge—such as the IHP+ and UHC2030 Global Compact (UK Government 2007), World Bank's Knowledge Compact for Action (World Bank 2024d) and its leadership on National Health Compacts through its Health Works platform (World Bank 2025b), and the New Global Financing Pact under the Health Impact Investment Platform (WHO 2025b)—especially given concerns about limited progress and weak transparency in reporting results (Labonte and Marriott 2010; WHO 2025c; Witter et al. 2025). While a comprehensive assessment of the effectiveness of all compact-like initiatives is beyond the scope of this paper, a deeper examination of coordination efforts, signed compacts, and their impact, may be a valuable area for future research.

More broadly, the trajectory of the health financing donor coordination initiatives has been shaped by wider political and institutional dynamics. This includes shifting global development priorities, such as the emergence of SDGs from MDGs; changing aid modalities; and the influence of landmark agreements such as the Paris Declaration on Aid Effectiveness (OECD 2005). A fluctuating tension between focusing on vertical and often siloed programmes, versus horizonal, systems-strengthening approaches created challenges in advancing coordination efforts and sustaining momentum. Taken together with the strengths and weaknesses of past initiatives, these lessons

point to the importance of both technical design and attention to the evolving political and institutional context in shaping the effectiveness and sustainability of coordination mechanisms. Overall, there is evidence of piecemeal efforts by donors to align with national priorities and to increase countries' ownership of health coordination mechanisms (WHO 2025c), and learning from what works and does not is key. Given the current climate of widespread funding cuts in 2025, optimising coordinated and effective funding allocation is all the more important.

What does the New Compact add to existing coordination initiatives?

The New Compact complements past initiatives, offering an approach that can be integrated with existing coordination efforts to enhance their effectiveness both at the country and global levels. It is not an alternative or replacement to SWAps or National Health Compacts.

As a strategic vision, the Global New Compact complements recent multilateral calls for change, particularly the Lusaka Agenda, the Accra Reset, and the 2025 WHA resolution on health financing (Future of Global Health Initiatives 2023; Pate et al. 2026; WHO 2025e). The Lusaka Agenda calls on global health initiatives to make five key shifts that include greater attention to health systems and increased emphasis on domestic spending, but it does not provide specific reform recommendations. To complement this, the WHA resolution contains relevant recommendations for reforms. For example, member states are urged "to focus domestic resources on an affordable package of essential health benefits, based on evidence and developed through inclusive and transparent processes" and "to design and streamline processes to transition smoothly and sustainably from external assistance for health to sufficiently robust domestic financing for health, including through progressive integration of vertical funding flows into domestic public financial management and procurement systems, using instruments such as sector-wide approaches and health compacts" (WHO 2025e).

As a technical framework, the Country New Compact can be adopted by country-level coordination initiatives, such as SWAps, as guiding principles for aligning behind an explicit health benefits package, led by country institutions, and adopting a notional "domestic-first" principle in budget formulation. Importantly, it is not an alternative to a SWAp and in its principles, it is most like 'One Plan, One Budget, One Report.' Shifts towards adopting a New Compact as a country-level technical framework will depend on a range of other factors, which are explored further in Section 6.

5. Donor policy frameworks and strategies for health services financing

To assess the potential for donors to implement the New Compact, we examined policy frameworks and strategies guiding the health financing decisions for leading bilateral and multilateral actors. (More details of this review can be found in Table A3, Appendix 2.)

Multilateral financing

Gavi and the Global Fund are vertical programmes that have successfully targeted highly cost-effective interventions with donor resources, contradicting the New Compact approach. However, both organisations have co-financing and health system strengthening policies which offer the potential to shift towards the New Compact in four ways.

First, their policies explicitly encourage burden sharing with governments through co-financing arrangements (e.g., the Global Fund has a 15 percent co-financing incentive). However, the efficacy of these policies is disputed, and projections suggest that only one percent of the Global Fund's portfolio by disbursements will transition to domestic financing by 2040 (Pincombe et al. 2023; Gheorghe and Baker 2023). Second, both organisations have health system strengthening policies and provide resources for governments to build their health systems beyond their core remit (The Global Fund 2024b; Gavi 2022c). Third, both organisations seek to support national priority setting during their grant application process, though too often this is through mechanisms such as Gavi's national coordinating forums that may be disconnected from wider national priority setting processes such as health benefits package committees. Finally, recent policy changes open up new opportunities. Both Gavi and the Global Fund are committed to piloting reforms in pathfinder countries under the Lusaka Agenda—and piloting a New Compact approach could be a powerful option. Gavi's planned shift under its 6.0 strategy and the "Gavi Leap" to single-envelope financing for cash support offers the potential for a substantial increase in both country control over donor resources and the integration of country and donor budgets (Gavi 2024, 2026). This could be adapted to a "New Compact Envelope Financing" model if it included vaccine budgets and prioritised transitioning top priority vaccines to domestic financing (Madan Keller, Bonnifield, et al. 2025b). While both institutions increasingly refer to health systems strengthening, their governance models and incentive structures remain largely shaped by vertical, disease-specific mandates. This creates a structural tension: even when flexibility is introduced, funding decisions and performance metrics continue to prioritise disease outcomes over system-wide impact. Recognising this misalignment is essential if these institutions are to play a meaningful role in a New Compact approach.

The World Bank's financing mechanisms are intrinsically more compatible with the New Compact, since they provide broad on-budget support to national priorities. More specifically, documents related to the World Bank's health financing work highlight strategic intentions that align with New Compact principles. The GFF's health financing strategy, for example, prioritises primary healthcare, UHC, and DRM, with a strong emphasis on efficiency, equity, and resilience. It also includes measurable indicators related to resource prioritisation, alignment maturity, and financing reforms. The One Plan, One Budget, One Report agenda has also been promoted by the GFF, highlighting an intention to act on addressing donor misalignment problems with principles aligned with the New Compact (Global Financing Facility 2024). These efforts—including the latest National Health Compacts as part of the Health Works Leaders Coalition platform—reflect a strategic shift towards integrated and sustainable financing for aid-recipient countries (World Bank 2025b). However, as

with Gavi and the Global Fund, while there is strategic alignment towards integrated system strengthening, practical accounts suggests that policy documents may not always be translated into action (Salisbury et al. 2019).

Bilateral donor policies

Upstream bilateral donor strategy documents indicate potential alignment with New Compact principles. For instance, the UK's global health framework (UK Government 2023) outlines objectives to reform global health architecture and strengthen country health systems—explicitly calling for reduced reliance on vertical programmes in favour of more integrated, collaborative approaches. Germany's global health strategy (Federal Government of Germany 2020) similarly reflects alignment, emphasising support for UHC, DRM, and health system strengthening. It highlights context-specific support for national strategy development, the establishment of equitable and transparent public finance systems, and working with the SDG3 GAP. The America First Global Health Strategy gestures towards alignment by committing to multi-year bilateral agreements that require domestic co-investment and country ownership. But the strategy narrows support to a limited set of infectious diseases and health security objectives and sets overly ambitious timelines for transition to self-reliance, raising questions about breadth, predictability, and coordination with other funders (US Department of State 2025). These strategies therefore suggest there is the potential to get bilateral support for applying a New Compact approach. Of note, without careful calibration, what is framed as "integration" for donors risks becoming a transfer of financial responsibility to aid-recipient governments without adequate fiscal space. In such cases, integration may turn into cost-shifting rather than genuine health systems strengthening.

Potential donor policy shifts to facilitate New Compact implementation

Prioritise resource allocation to national priorities that are not covered by domestic financing and common goods

At the highest strategic level, donors should shift away from disease- and intervention-based donor priority setting towards two objectives: producing common goods that all can benefit from and forming long-term country partnerships to strengthen health systems. Rather than earmarking funds for specific conditions or technologies, donors could then focus on under-supplied common goods, such as disease surveillance, openly accessible health data, and new health technologies. At the same time, they could form strategic New Compact partnerships with selected countries, aligning with nationally led health services priorities while developing a cohesive agenda for system strengthening. This approach would reduce fragmentation, avoid undermining domestic health systems, and ensure that scarce resources target both collective global needs and the countries where they can have the greatest impact. Drake and colleagues further describe this policy shift in earlier work (Drake et al. 2025).

Adopt co-financing and envelope financing as a strategic bridge

Co-financing mechanisms by Gavi and the Global Fund offer a valuable entry point for the New Compact. Gavi's graduated co-financing policy and the Global Fund's increasing domestic contribution requirements suggest momentum towards shared financial responsibility and supporting DRM. Co-financing approaches can likely be readily adapted towards New Compact principles by adjusting the co-payment levels for different interventions. This convergence creates opportunities for harmonising co-financing approaches and avoiding conflicting requirements on recipient countries. It can also be a way for donors who, in the short term, are committed to subsidising commodities to adopt a partial New Compact approach by shifting co-financing away from commodities already included in the domestic package and towards subsidising interventions that would otherwise be unaffordable. This can be implemented explicitly through a tapered co-payment structure or notionally through a joint budget formulation process and envelope financing support.

A further step beyond co-financing would be envelope financing, whereby multiple funding streams can be combined into a single thematic package, giving the recipient freedom to choose how to spend (within certain constraints). Madan Keller and colleagues outline a New Compact envelope financing proposal for Gavi's 6.0 strategic period (Madan Keller, Bonnifield, et al. 2025a).

However, the risk of fragmentation remains high, with each donor maintaining separate co-financing schedules and criteria. The Global Fund's disease-specific focus and Gavi's narrow vaccine scope illustrate how co-financing can inadvertently perpetuate sectoral silos rather than promote integrated health system financing.

Move support on budget

Shifting more development assistance for health to on-budget support (where donor funds are channelled through national budgets) can reduce the fragmentation caused by parallel funding channels and strengthen countries' public financial management (PFM) and priority setting systems (Fardoust et al. 2023). On-budget support is compatible with a New Compact approach if donor funds are allocated through a country-led, evidence-informed budget formulation process that adopts a notional domestic-first financing principle, clearly distinguishing what can be afforded with domestic finances and what additional interventions external finances can enable.

Depending on the context, immediate and full transition to on-budget support may have fiduciary risks. However, these risks can be mitigated through phased implementation, strong monitoring and accountability frameworks, and targeted investment in PFM capacity (Fletcher et al. 2008). In addition, these risks must be weighed up against the risks of off-budget support. For example, this might include inefficient duplication of processes, reduced resources to build PFM capacity, lack of government oversight, and dependency on donor systems. Evidence shows that well-designed

budget support can match or exceed traditional project aid in advancing governance, policy reform, and service delivery, particularly when tailored to local institutional contexts (Fardoust et al. 2023; Fletcher et al. 2008, 5). Combining on-budget approaches with policy dialogue and selective use of complementary aid modalities during transition periods can deliver near-term results and build long-term institutional resilience and domestic ownership.

Complementary policy considerations

In addition to policy shifts to facilitate implementation of the core New Compact pillars, there are a range of adjacent policy considerations that could complement a New Compact transition.

Health system strengthening

For the New Compact to be a success, it needs a functioning health system. Yet this is potentially a catch-22. There is increasing understanding that too often, fragmented aid holds back health system functions from strengthening by either working around public systems or being a burdensome distraction. Regardless of the state of the recipient country's health system at the time of transition to a New Compact model, opportunities for improvement remain, making it essential for countries and donors to have a cohesive health system strengthening plan. Unfortunately, financing and provision of technical assistance for health system strengthening is just as complex and fragmented as financing of health services themselves. The GHIs, World Health Organization, World Bank, Africa CDC, and others all provide or finance technical assistance for health systems strengthening, and deeper work is needed to develop improved models to provide this support to countries (Hallett et al. 2025). What should be clear is that simplifying health service financing and using domestic systems is key, whether it is under the New Compact approach or broader reform efforts.

Market shaping

One concern some stakeholders have about the New Compact model is that it could undermine GHIs market-shaping ability. However, the most cost-effective services and technologies (i.e., the core package countries would fund) are often established generics, where market shaping is typically less important. In this respect, pushing the role of external aid to the margin, or the next most cost-effective technologies or services, aligns better with market shaping. Donors' role is to crowd in technologies and services that otherwise would not be affordable to countries, and this could include existing technologies or new innovations (Chalkidou, Towse, et al. 2020; Chalkidou, Claxton, et al. 2020). For example, better understanding of the marginal opportunity cost for public healthcare spending in low-income countries could help GHIs design an advance market commitment (AMC). This is a binding agreement to buy or subsidise a certain volume of a technology that does not yet exist or is not widely available, conditional on that technology meeting certain standards, for example in safety, effectiveness, and cost-effectiveness (CGD 2025).

Bringing a new technology to market through market shaping can be considered a common good and might therefore draw on separate donor funding streams and use different global health architecture. For example, like Gavi focused on market shaping for new vaccines and used an AMC to pull through new vaccine technologies (Gavi 2020). The AMC would then use donor funding to purchase or subsidise the new technology initially with domestic financing and/or country-level external aid for health financing taking over in the medium term. If new technologies are high value for money, they could be prioritised by donors in a similar manner.

Pooled procurement

Another benefit that GHIs provide is pooled procurement. The rationale for this facility is that low-income countries do not have either the purchasing power or procurement expertise to obtain good deals from manufacturers. However, the procurement function does not need to be exclusive to donor financing and could be opened to domestic financing.

Donor political economy

A central constraint on health financing reform is that donors remain powerful veto players, shaped by short electoral cycles, domestic accountability narratives for their citizens, and institutional incentives that often conflict with long-term goals of country ownership, aid consolidation, and domestic resource mobilisation for aid-recipient countries. If donor-side political constraints are left unaddressed, reforms adopting a New Compact approach risk becoming merely aspirational overlays on rebranded policies.

Addressing this requires changes not only in what donors finance, but in how financing decisions are governed. As described by Drake and Khan, 2024 (Drake and Khan 2024), donors should move towards explicit, medium-term country-donor agreements that clarify expected volumes, instruments, and reliance on nationally led priority-setting processes, with transparent conditions for renegotiation or exit. This was lacking in the World Bank National Health Compacts, where expectations for donors were not included as part of the agreements (Demeshko and Baker 2025). Major portfolio shifts, such as new vertical initiatives or abrupt funding cuts, should be accompanied by country-facing justifications linked to agreed principles of ownership, predictability, and non-displacement of domestic finance.

Reforms must also realign internal donor incentives and narratives and manage political volatility as a predictable risk. Embedding incentives for alignment with country-led, evidence-informed processes into donor performance and reporting systems, alongside protected facilities for supplementary "top-up" aid, can reduce fragmentation. In parallel, transition pathways and collective shock-absorbing mechanisms can help insulate essential services from donor political cycles, lowering the political and ethical costs of volatility for partner countries.

Shifting donor narratives

While global health professionals fret about specific measures of impact to build a narrative justifying donor financing, in general the public are not primarily convinced by statistics, but rather by a sense of fairness and duty of care (Grépin et al. 2018; Schneider et al. 2021). Public support for the current global health donor paradigm comes from a sense of injustice at the scale of poverty and health inequality, and the disproportionate disease burden experienced by many poorer populations (Grepin et al. 2012).

The New Compact adds a new dimension of *procedural* fairness to the global health narrative for external financing. This has two parts i) greater health sovereignty for recipient countries, and ii) subordinated donor responsibility and a clearer exit pathway. This new fairness narrative can appeal to political viewpoints both on the right and the left. The left are likely to support the push for greater health sovereignty and *de facto* refocusing on poorer countries, while the right may appreciate the emphasis on countries having primary responsibility for their populations with donors taking a supporting role.

Nevertheless, there are also opportunities to develop new measuring and reporting impact. Donor narratives under a New Compact could include joint reporting of impact, shifting the narrative to sustainability and greatest overall impact, with accountability tied to clearer metrics and regional oversight (e.g., by the African Union). Donors could demonstrate value-for-money under flexible financing through explicitly outlining alternative accountability mechanisms that move beyond input- or disease-specific attribution. This could include (i) system-level performance metrics (e.g., reductions in avoidable mortality, service coverage equity, global public goods, and resilience indicators) that better reflect the intent of envelope financing; (ii) cost-effectiveness at portfolio level, showing how pooled or flexible funds achieve greater health gains per dollar than fragmented vertical investments; and (iii) benchmarking against counterfactuals, comparing Compact-supported countries with similar settings that retain heavily earmarked funding. Attribution concerns could be explicitly addressed by the following pragmatic solutions, including: (i) shifting from strict attribution to contribution narratives, where donors report on their role in collective outcomes rather than claiming sole credit; (ii) agreement on shared success indicators, enabling donors to communicate clear stories of impact without overstating individual influence; and (iii) explicitly naming this trade-off would help normalise attribution loss as a necessary feature—not a flaw—of collective financing.

New approaches to accountability for donor funds

To address donor concerns about reporting and oversight, illustrative governance mechanisms could be used. These could include (i) a single, jointly agreed results framework aligned with national health strategies, with a limited set of indicators that all Compact partners report against; (ii) annual or biennial Compact performance reports, independently validated, that aggregate results

across funding sources while allowing donors to "tag" thematic priorities (e.g., maternal health, PHC strengthening); and (iii) use of existing platforms (e.g., national health accounts, routine HMIS, public expenditure reviews) rather than parallel donor-specific reporting systems.

Macroeconomic constraints and the role of international financial institutions

Today, the main constraints on health financing are no longer technical but macro-fiscal. High debt burdens, fiscal adjustment programmes, and IMF conditionalities increasingly limit what governments can realistically spend on social sectors, including health. A New Compact that ignores these constraints risks promoting unrealistic expectations around domestic financing. This makes structured engagement with ministries of finance and international financial institutions unavoidable.

6. Country-level drivers of New Compact success

For a recipient country, implementation of a Country New Compact will be more likely to be successful if local conditions and capabilities are conducive. In this section, we outline a set of six domains likely to support New Compact implementation: 1) political and economic context, 2) governance and coordination, 3) health financing, 4) evidence-informed priority setting, 5) public financial management. and 6) donor coordination. This framework (summarised in Table A4, Appendix 3, and expanded in a forthcoming paper) could be developed into a Country New Compact readiness assessment, helping country officials to understand whether to pursue a New Compact approach and identifying where leadership efforts or resources should be focused to address gaps. We have intentionally recommended the use of standardised and globally recognised indices to facilitate negotiation between countries and donors.

Political and economic context

Political stability and security are essential to ensure continuity in health sector reforms, maintain operational functionality, and attract both domestic and international investments in health. Countries experiencing prolonged instability or conflict may face significant obstacles in implementing consistent policies or managing health services effectively. Countries can use the World Bank's political stability and security index (World Bank 2025d) to assess their political environment, which can also be substantiated with experts' deliberation. More specifically, a key success-determining factor for policy reform like the New Compact is higher political will, ownership, and commitment. Countries can assess political alignment with New Compact principles by reviewing recent policy and legal framework documents, the national flagship development agenda, and trends in government budget allocation for health, both at national and subnational levels.

A sound macroeconomic environment with stable growth, effective fiscal policies, and strong institutions enables the government to sustain or increase health spending. The country's macroeconomic situation determines the feasibility of increasing or reallocating domestic resources towards essential health services. While a New Compact shift can be budget neutral, other elements of the political economy may be more challenging if resources are highly constrained. Assessing a country's macroeconomic readiness involves examining macroeconomic growth trends, budgetary allocation trends for health, efficiency of spending, and the potential for domestic revenue generation. Economic growth is key, and countries with an annual GDP per capita growth rate less than 2 to 3 percent, or no growth, have low capacity to reallocate or increase domestic health service spending.

Governance and coordination

The success of the New Compact also relies on inclusive and functional coordination and governance mechanisms for stakeholders at national and subnational levels, including public institutions, civil society organisations, community associations, academia and research institutes, private sectors, and donors. Implementation requires a series of deliberations, consensus building, alignment, joint implementation, and monitoring mechanisms among key stakeholders. Countries can measure their readiness by assessing the presence of legitimate governance platforms for each stakeholder at national and subnational levels; the level of inclusiveness, frequency, and adequacy of gathering; functionality of the platforms; and their impact in policy decision and implementation.

Health financing

Domestic resource mobilisation

Countries require a costed and politically owned strategy for DRM that is well informed by evidence, global best practices, and contextual realities, and tailored to financing high-priority health services. To achieve this, countries must adopt effective and feasible approaches for mobilising domestic resources. These include government budget allocations to health in alignment with fiscal space realities, individual or employer contributions to public health insurance schemes, and diversifying with complementary revenue sources such as health taxes.

New Compact implementation should be tailored to countries' health financing landscape and system capacity. The key parameters for assessment are the adequacy of current health spending to finance essential health services (measured as per capita total health expenditure); the level of dependence on donor funding and out-of-pocket payments (the respective shares of donor and out-of-pocket payment to total health expenditure); and government commitment to increase public health financing, as demonstrated by recent trends, the presence of a costed and evidence-informed DRM strategy, and a plan to increase budget allocations to health reflected in a medium-term expenditure framework.

Pooling and level of fragmentation

Fragmentation of financing streams can result in duplication, inefficiency, inequity, reduced bargaining power, and challenges to the core principle of channelling domestic resources first to high-priority services, thereby substantially undermining New Compact implementation. To address this, financing streams need to be organised into a higher-level pooling, either in a unified form or coordinated system that allows a strategic alignment of financing flows to ensure complementarity in financing high priority services, risk-sharing, and reduce inefficiencies. As fragmentation often reflects underlying structural and political constraints, addressing such challenges requires both technical and political interventions and can take time. Therefore, countries should prioritise coordination and alignment among financing streams while concurrently striving to establish unified pooling arrangements.

Evidence-informed priority setting

An essential package of health services (EPHS) defines which services are covered in the context of limited resources and communicates entitlements to these services to the public. EPHS development can also facilitate resource pooling across different financing schemes. It aids in assessing the performance of coverage schemes, which can lead to harmonisation of services and identification of gaps between financing and service delivery. Developing and revising an EPHS is also crucial for strategic purchasing and achieving value for money when procuring healthcare commodities. For a successful rollout, the EPHS should be aligned with broader national strategies and systems, such as budgeting, provider payment, human resources, infrastructure, treatment guidelines, essential medicines and equipment lists, and monitoring and evaluation frameworks (Chalkidou et al. 2016; WHO 2016). Of note, a Country New Compact does not propose a single method for priority setting, nor does it impose specific criteria or analytical tools. Governments retain full sovereignty to design their own processes based on national context and political negotiation. However, minimum methodological standards are necessary to ensure credibility and legitimacy. These should include cost-effectiveness analysis, budget impact assessment, and explicit consideration of equity and financial protection. The Disease Control Priorities Project (DCP4) and the international Decision Support Initiative (iDSI) provide concrete, country-tested methodologies for evidence-informed priority setting that directly operationalise the first pillar of the New Compact. Their recent syntheses demonstrate how countries have translated economic evidence, fiscal constraints, and equity objectives into real policy decisions under political and institutional constraints. These experiences show that rigorous priority setting is feasible in low-resource settings, provided that processes are institutionally embedded and politically supported (Alwan et al. 2025; Baker et al. 2023).

A well-designed EPHS is core to New Compact implementation as it allows the ministry of health to define its priorities and design the health system while ensuring adequate participation from all key stakeholders. It also facilitates the identification of top-priority health services and their financing

sources, and helps define who finances what (at least notionally, if external financing is later provided as on-budget support). Building strong country capacities to apply evidence in deciding which technologies and services to prioritise will enable donors to place greater confidence in, and defer to, recipient countries' healthcare priority-setting decisions. New Compact implementation could be an opportunity to improve a country's EPHS processes by marshalling external financing behind this critical public healthcare management framework, rather than undermining it.

Countries can use iProSE—the iDSI Progression Scale for institutionalising evidence-informed priority setting (EIPS) in healthcare—to understand how far they have progressed in institutionalising EIPS and what to improve (Gheorghe et al. 2023). Based on the self-assessment and score, EIPS institutionalisation can be categorised as foundational, breakthrough, consolidating, or mature. Moving towards the New Compact likely requires countries to be at foundational or breakthrough stages to focus on defining a prioritised list of health services and identifying financing sources and mechanisms, while simultaneously building core EIPS capacity. In contrast, countries at the consolidating or mature stages could focus on aligning priority service implementation with health system inputs and financing functions. Political ownership and commitment, a mandated and adequately resourced institution to conduct EIPS, capacity for both producing and using evidence, inclusive and meaningful stakeholder participation, alignment of priority services with fiscal space realities, and strong linkages between the defined service package and implementation mechanisms are critical for successful EIPS.

The political incentives for efficient and fair priority setting are challenging. Priority setting is as much a political process as a technical exercise, and explicit benefits packages often generate resistance when they deprioritise politically visible or high-profile services. Open and inclusive deliberative processes for benefit package design are therefore as important as technical analysis of evidence, cost-effectiveness, and distributional impact. Governments may struggle to reconcile evidence-informed priority setting with short-term political incentives, especially in settings where political capital is tied to hospital construction, specialist equipment, or tertiary care expansion rather than primary healthcare.

To better manage demand and navigate competing interest groups, open and inclusive processes are key. Recent recommendations on deliberative processes emphasise wide stakeholder participation, clarity on the distinction between technical assessment of evidence and wider societal appraisal, transparent reason-giving, hearing processes among all interest groups, and mechanisms for appeal (World Bank 2023; Baltussen et al. 2023). Ensuring transparent discussions about goals and trade-offs—where all voices are heard—can increase legitimacy and prevent political backlash. In the long run, making trade-offs explicitly rather than behind closed doors will enable social learning and political acceptability (Daniels et al. 2008).

Public financial management

Successful evidence-informed priority setting, delivery of priority health services, and transitioning to the New Compact require strong systems and institutions for managing both public and donor financing. For effective implementation of the New Compact, there must be explicit and well-costed priority services (EPHS); budget formulation and allocation must be aligned with and informed by the EPHS; the budget must be executed down to the lower tiers of the healthcare system in a flexible, predictable, and timely manner; and there must be systems to monitor that budget execution has been effective in delivering the priority services, efficient, and adhered to local rules and procedures. However, such well-functioning systems are not currently present in most LMICs, and countries need to assess their PFM capacity and implement various PFM reforms to fully encompass New Compact implementation.

Countries can assess PFM capacity using the Public Expenditure and Financial Accountability (PEFA) framework (PEFA 2025), which tracks 94 indicators across seven pillars: budget reliability, transparency, management of assets and liabilities, policy-based fiscal strategy and budgeting, predictability and control in budget execution, accounting and reporting, and external scrutiny and audit. Many countries conduct regular PEFA assessments, and this can be used as the evidence source to plan the PFM capacity building to transition towards the New Compact.

To be feasible and sustainable, the PFM reforms should be incremental rather than ambitious or radical, both within and across the PFM core functions. Most radical PFM reforms often fail. Hence, countries should aim to strengthen the basic functions before moving to advanced capabilities. There is a need to prioritise reforms based on their level of importance to enhance health service delivery, accountability, and political and administrative feasibility. Reforms should be targeted and sequential to avoid overloading the system with multiple simultaneous changes that exceed administrative capacity.

The starting priorities, and sequence of reforms vary depending on a country's PFM maturity level, the problems they want to address, political context, and administrative capacity. However, empirical evidence generally shows that budget credibility (comprehensive and realistic revenue forecasts informed by costed priority health services and predictable cash release and flow) and basic expenditure tracking and control, both at national and facility levels, need to be addressed early on as they are fundamental for other functions.

Next, strengthening budget execution capacity should be addressed. Factors that hamper effective budget execution, particularly delays in procurement, need to be resolved. Furthermore, service delivery-level PFM reforms that can enhance autonomy and flexibility to allocate and reallocate budgets to priority services, along with accountability, should be implemented. In later stages,

countries can aim to advance performance audits, align budgeting with provider payment mechanisms, link financial reporting to service delivery outputs, strengthen transparency, social and citizen accountability at facility and community levels, and introduce advanced tools that can enhance the performance of core functions. However, it is important to note the PFM reforms are not a linear process as described here, instead, the intention is to indicate the high-level sequence (WHO 2025d).

Donor alignment to PFM system and reforms

Effective implementation of the New Compact also requires a large share of donor financing to be channelled through the country's PFM system (either as on-budget support or pooled donor financing), and to use existing procurement and audit systems, rules, procedures, and institutions (Gheorghe et al. 2024).

Using countries' PFM systems could involve various risks depending on the PFM maturity level and is among the main reasons donors look for alternative solutions. However, a weak PFM system should not deter the implementation of the New Compact. Rather, it should be used to enhance local ownership and political commitment and mobilise donor support to strengthen PFM and inform the phase of New Compact implementation. This requires donors to increase their risk appetite to use and strengthen the country's PFM system while simultaneously strengthening safeguard mechanisms.

Donor coordination

Harmonising planning cycles and indicators enables coordinated support, reduces duplicative reporting requirements, and enables pooled and joint financing approaches to support core health system objectives. The key components and facilitators for harmonisation include a clear nationally owned sector policy and strategy; a medium-term expenditure programme that reflects the sector strategy; systematic arrangements for programming the resources that support the sector; a performance monitoring system that measures progress and strengthen mutual accountability; broad consultation mechanisms that involve all significant stakeholders; a formalised government-led process for aid coordination and dialogue at the sector level; and an agreed process for moving towards harmonised system for reporting, budgeting, financial management, and procurement. Additionally, strengthening and using national PFM systems such as procurement, financial reporting, and auditing reinforces country systems and institutional capacity, promotes transparency and accountability, and avoids the inefficiencies of parallel donor systems. Pooled funding of the whole sector or subcomponents can play a useful role in coordinating donors, enhancing predictability and flexibility of financing, reducing transaction costs, and promoting national ownership of health priorities. In countries where there is a significant degree of parallel service implementation, part of a Country New Compact agreement may be a roadmap towards integration of these services into the public healthcare system.

Countries can assess strategic, operational, and financial donor alignment. Strategic alignment considers the extent to which donors support national priorities and the availability of a mutually developed and endorsed sectoral plan that serve as a basis for setting priorities. Operational alignment assesses donors use of national public systems, including procedures, timelines, reporting mechanisms, and whether there is widespread participation in donor coordination groups. Financing alignment examines the degree to which donor resources flow through governments' preferred channels, such as on-budget support and/or pooled funding, their predictability and alignment with Medium Term Expenditure Frameworks, and the use of harmonised fiduciary systems such as reporting, compliance, and audit.

7. Conclusion

The New Compact is principally a framework for harmonising health services financing in countries that receive external financing support. It recommends that countries should lead an evidence-informed budget formulation process to define an essential health benefits package with domestic financing allocated to the core, highest-priority services (at high coverage) and aid designed as a top-up expanded package. This is a framework that could be adopted by any existing structures for coordinating external health financing, such as a sector-wide approach platform. The New Compact principles can also act as strategic guidance for donors to align behind country priorities and position their role as secondary to country institutions.

Successful implementation of the New Compact is likely to require policy reforms from the complex landscape of donor institutions in order to facilitate new ways of working. It would ideally be backed by a Global New Compact, which would trigger radical reforms to consolidate the majority of aid for health services financing into a single financing mechanism, likely either aligned to the multilateral development banks or evolved global health initiatives such as the Global Fund. Whilst the salience of the opportunity for global reforms creates a more enabling environment for a New Compact, its adoption should ideally be country led rather than imposed through top-down processes. In this paper we have outlined a framework for how countries might consider the drivers of success for New Compact transition.

Transition to a New Compact approach will face resistance. It will require careful consideration of the relevant political economy, assessing the potential barriers to implementation and how they could be overcome.

8. Ideas for action

For donors and multilateral institutions

- **Engage with countries to understand their priorities for adopting the New Compact.** Donors and multilaterals could support inclusive consultations with ministries of health and finance, leveraging existing platforms such as sector-wide approaches to align aid with national health strategies and enhance country ownership (Section 2).
- **Strengthen technical assistance for health systems to support New Compact implementation.** Donors and multilaterals could fund and coordinate assistance to build country capacity in priority setting and public financial management, ensuring alignment with local needs and existing global initiatives (Section 3).
- **Adapt policies to promote flexible, country-led financing approaches.** Donors and multilaterals could shift from disease-specific funding towards supporting integrated health system priorities, using tools like single-envelope financing (Section 5).
- **Explore options for a Global New Compact and consolidate health financing to improve aid effectiveness.** Donors could assess mechanisms to streamline development assistance for health, learning from past coordination efforts to reduce fragmentation while preserving flexibility for diverse country contexts (Section 6).

For recipient countries

- **Set clear health priorities, strengthen donor coordination, and make the case for a Country New Compact financing model.** Investing in evidence-informed priority-setting processes, demonstrating clear priorities for your country and assertive donor coordination can deliver results and increase the readiness of donors to support a New Compact approach (Section 6).
- **Consider conducting New Compact transition readiness assessments.** Countries can be guided by assessments to consider whether to further invest in evidence-informed planning and effective public financial management to build resilience, tailoring approaches to their economic and political contexts (Section 3).
- **Communicate health financing reform priorities to donors.** Governments could engage donors through existing coordination mechanisms to articulate needs and readiness for the New Compact, fostering inclusive dialogue with local stakeholders (Sections 4 and 6).
- **Launch and lead a Global New Compact** initiative, collaborating with other recipient countries to make the case for global health architecture reform (Section 2).

References

Africa Centres for Disease Control and Prevention. 2025. *Africa's Health Financing in a New Era*. Africa Centres for Disease Control and Prevention. https://africacdc.org/download/africas-health-financing-in-a-new-era-april-2025/.

African Union. 2001. *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*. African Union. https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf.

Alwan, Ala, Mizan Kiros Mirutse, Pakwanja Desiree Twea, and Ole F. Norheim. 2025. *Country-Led Priority Setting for Health*. Vol 1. World Bank. https://www.uib.no/sites/w3.uib.no/files/attachments/dcp-4_volume1.pdf.

Apeagyei, Angela E., Catherine Bisignano, Hans Elliott, et al. 2025. 'Tracking Development Assistance for Health, 1990–2030: Historical Trends, Recent Cuts, and Outlook'. *The Lancet* 406 (10501): 337–348. https://doi.org/10.1016/S0140-6736(25)01240-1.

Baker, Peter, Edwine Barasa, Kalipso Chalkidou, et al. 2023. 'International Partnerships to Develop Evidence-Informed Priority Setting Institutions: Ten Years of Experience from the International Decision Support Initiative (iDSI)'. *Health Systems & Reform* 9 (3): 2330112. https://doi.org/10.1080/23288604.2024.2330112.

Baltussen, Rob, Omar Mwalim, Karl Blanchet, et al. 2023. 'Decision-Making Processes for Essential Packages of Health Services: Experience from Six Countries'. *BMJ Global Health* 8 (Suppl 1): e010704. https://doi.org/10.1136/bmjgh-2022-010704.

Bundesministerium für Gesundheit, The Federal Ministry of Health. 2020. *Global Health Strategy of the German Federal Government*. Bundesministerium für Gesundheit. https://health.bmz.de/wp-content/uploads/studies/Global_Health_Strategy.pdf.

CGD. 2025. 'Making Markets for Development Innovations'. Center for Global Development. https://www.cgdev.org/markets-for-development.

Chalkidou, Kalipso, Karl Claxton, Rachel Silverman, and Prashant Yadav. 2020. 'Value-Based Tiered Pricing for Universal Health Coverage: An Idea Worth Revisiting'. *Gates Open Research* 4: 16. https://doi.org/10.12688/gatesopenres.13110.3.

Chalkidou, Kalipso, Amanda Glassman, Robert Marten, et al. 2016. 'Priority-Setting for Achieving Universal Health Coverage'. *Bulletin of the World Health Organization* 94 (6): 462–67. https://doi.org/10.2471/BLT.15.155721.

Chalkidou, Kalipso, Adrian Towse, and Rachel Silverman. 2020. *Unpacking the Black Box of Payer Policy: A Demand-Side Approach for Equitable Uptake of Cost-Effective Health Innovation*. Center for Global Development.

Daniels, Norman, James E. Sabin, Norman Daniels, and James E. Sabin. 2008. *Setting Limits Fairly: Can We Learn to Share Medical Resources?* Oxford University Press.

Demeshko, Anastassia, and Pete Baker. 2025. 'One-Sided Compacts: Why the World Bank's National Health Compacts Need to Be a Two-Way Deal'. Center for Global Development. https://www.cgdev.org/blog/one-sided-compacts-why-world-banks-national-health-compacts-need-be-two-way-deal.

Demeshko, Anastassia, Tom Drake, and Nadia Yakhelef. 2025. *A New Era for Global Health: Can African Countries Agree a New Compact with External Donors?* March 27. https://www.cgdev.org/publication/new-era-global-health-can-african-countries-agree-new-compact-external-donors.

Demeshko, Anastassia, Solomon Tessema Memirie, and Tom Drake. 2025. *A New Compact for Health Financing: Insights from Policymakers Across Africa*. February 7. https://www.cgdev.org/publication/new-compact-health-financing-insights-policymakers-across-africa.

Drake, Tom, and Anastassia Demeshko. 2024. *Putting Aid in Its Place: Financing Common Goods*. September 11. https://www.cgdev.org/publication/putting-aid-its-place-financing-common-goods.

Drake, Tom, and Mishel Khan. 2024. 'A New Compact for Health Financing: The Global Political Economy of Reform'. Center for Global Development. https://www.cgdev.org/blog/new-compact-health-financing-global-political-economy-reform.

Drake, Tom, Jessica Ochalek, Witold Więcek, Nadia Yakhelef, and Rachel Bonnifield. 2025. *A New Compact for Health Financing: Donor Priority Setting*. June 30. https://www.cgdev.org/publication/new-compact-health-financing-donor-priority-setting.

Drake, Tom, Lydia Regan, and Pete Baker. 2023. *Reimagining Global Health Financing: How Refocusing Health Aid at the Margin Could Strengthen Health Systems and Futureproof Aid Financial Flows*. February 27. https://www.cgdev.org/publication/reimagining-global-health-financing-how-refocusing-health-aid-margin-could-strengthen.

EU Capacity4dev. 2011. 'Busan Partnership for Effective Development Co-Operation'. https://capacity4dev.europa.eu/groups/public-fragility/info/busan-partnership-effective-development-co-operation_en.

Fardoust, Shahrokh, Stefan G. Koeberle, Moritz Piatti-Fünfkirchen, et al. 2023. *Retooling Development Aid in the 21st Century: The Importance of Budget Support*. Oxford University Press.

Federal Government of Germany. 2020. *Global Health Strategy of the German Federal Government*. The Federal Ministry of Health, Global Health Unit. https://health.bmz.de/wp-content/uploads/studies/Global_Health_Strategy.pdf.

Fletcher, Kevin, Sanjeev Gupta, Duncan P. Last, et al. 2008. 'CHAPTER 5. Strengthening Institutions to Promote Effective Utilization of Aid'. In *Fiscal Management of Scaled-Up Aid*. International Monetary Fund. https://www.elibrary.imf.org/display/book/9781589067035/ch005.xml.

Foster, Mick, Adrienne Brown, and Tim Conway. 1999. *Sector-Wide Approaches for Health Development: A Review of Experience*. WHO. https://iris.who.int/bitstream/handle/10665/66468/WHO_GPE_00.1.pdf?sequence=1.

Future of Global Health Initiatives. 2023. *The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process – FGHI*. Future of Global Health Initiatives. https://futureofghis.org/final-outputs/lusaka-agenda/.

Gavi. 2020. *Advance Market Commitment for Pneumococcal Vaccines - Annual Report 2020*. Gavi. https://www.gavi.org/sites/default/files/document/2021/2020-PCV-AMC-Annual-Report.pdf.

Gavi. 2022a. *Gavi Alliance Co-Financing Policy Version 3.0*. Gavi. https://www.gavi.org/sites/default/files/about/governance/corporate-policies/01-Gavi-Co-financing-Policy.pdf.

Gavi. 2022b. *Gavi Alliance Eligibility and Transition Policy Version 4.0*. Gavi. https://www.gavi.org/sites/default/files/about/governance/corporate-policies/02-Gavi-Eligibility-and-Transition-Policy.pdf.

Gavi. 2022c. *Gavi Alliance Health Systems and Immunisation Strengthening Policy Version 1.0*. Gavi. https://www.gavi.org/sites/default/files/about/governance/corporate-policies/07-Gavi-Health-Systems-and-Immunisation-Strengthening-Policy.pdf.

Gavi. 2024. *Gavi 6.0—Phase 6 (2026–2030)*. Strategy No. 6. Gavi. https://www.gavi.org/our-alliance/strategy/phase-6-2026-2030.

Gavi. 2025a. 'Gavi Statement on the Global Health Architecture'. August 19. https://www.gavi.org/news/media-room/gavi-statement-global-health-architecture.

Gavi. 2025b. 'World Leaders Recommit to Immunisation amid Global Funding Shortfall'. August 6. https://www.gavi.org/news/media-room/world-leaders-recommit-immunisation-amid-global-funding-shortfall.

Gavi. 2026. 'The Gavi Leap'. Gavi, February. https://www.gavi.org/our-work/gavi-leap.

Gheorghe, Adrian, and Pete Baker. 2023. *Country Transition Projections up to 2040: Gavi, the Global Fund, and the World Bank's IDA*. October 11. https://www.cgdev.org/publication/country-transition-projections-2040-gavi-global-fund-and-world-banks-ida.

Gheorghe, Adrian, Pete Baker, Javier Guzman, and Tom Drake. 2024. *A New Compact for Health Aid: Integrating Evidence-Informed Priority-Setting and Public Financial Management*. September 9. https://www.cgdev.org/publication/new-compact-health-aid-integrating-evidence-informed-priority-setting-and-public.

Gheorghe, Adrian, Sophie Gulliver, Abha Mehndiratta, Javier Guzman, and Peter Baker. 2023. *iProSE: A Scale for Assessing Progress on Institutional Use of Evidence to Inform Priority-Setting in Health*.

Global Financing Facility. 2023. *Delivering on the GFF Promise: Protecting and Promoting the Health and Well-Being of Women, Children and Adolescents | Global Financing Facility*. World Bank. https://www.globalfinancingfacility.org/resource/delivering-gff-promise-protecting-and-promoting-health-and-well-being-women-children-and.

Global Financing Facility. 2024. 'From Slogans to Action: Realizing the One Plan, One Budget and One Report Agenda | Global Financing Facility'. https://www.globalfinancingfacility.org/events/slogans-action-realizing-one-plan-one-budget-and-one-report-agenda.

Grepin, K. A., K. Leach-Kemon, M. Schneider, and D. Sridhar. 2012. 'How to Do (or Not to Do) … Tracking Data on Development Assistance for Health'. *Health Policy and Planning* 27 (6): 527–34. https://doi.org/10.1093/heapol/czr076.

Grépin, Karen A., Crossley B. Pinkstaff, Arne Risa Hole, et al. 2018. 'Allocating External Financing for Health: A Discrete Choice Experiment of Stakeholder Preferences'. *Health Policy and Planning* 33 (suppl_1): i24–30. https://doi.org/10.1093/heapol/czx017.

Hallett, Timothy B., Tara D. Mangal, Asif U. Tamuri, et al. 2025. 'Estimates of Resource Use in the Public-Sector Health-Care System and the Effect of Strengthening Health-Care Services in Malawi during 2015–19: A Modelling Study (Thanzi La Onse)'. *The Lancet Global Health* 13 (1): e28–37. https://doi.org/10.1016/S2214-109X(24)00413-3.

hera. 2024. 'Enhancing Universal Health Coverage: Piloting of Innovative Tools for the Evaluation of the P4H Network (P4H)'. Hera—Right to Health and Development. https://www.hera.eu/news/innovative-tools-monitoring-evaluation-p4h-network.

Hudson, Jennifer, David Hudson, Paolo Morini, Harold Clarke, and Marianne C. Stewart. 2020. 'Not One, but Many "Publics": Public Engagement with Global Development in France, Germany, Great Britain, and the United States'. *Development in Practice* 30 (6): 795–808. https://doi.org/10.1080/09614524.2020.1801594.

Institute for Health Metrics and Evaluation. 2023. 'Financing Global Health'. Institute for Health Metrics and Evaluation. http://vizhub.healthdata.org/fgh/.

Institute for Health Metrics and Evaluation (IHME). 2023. 'Financing Global Health'. October 10.

Kodali, Prakash Babu. 2023. 'Achieving Universal Health Coverage in Low- and Middle-Income Countries: Challenges for Policy Post-Pandemic and Beyond'. *Risk Management and Healthcare Policy* 16 (April): 607–21. https://doi.org/10.2147/RMHP.S366759.

Kruk, Margaret E., Anna D. Gage, Catherine Arsenault, et al. 2018. 'High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution'. *The Lancet Global Health* 6 (11): e1196–252. https://doi.org/10.1016/S2214-109X(18)30386-3.

Labonte, Ronald, and Anna Marriott. 2010. 'IHP+: Little Progress in Accountability or Just Little Progress?' *The Lancet* 375 (9725): 1505–7. https://doi.org/10.1016/S0140-6736(10)60625-3.

Madan Keller, Janeen, Rachel Bonnifield, Tom Drake, Pete Baker, and Orin Levine. 2025a. *How Gavi 6.0 Can Take a Bigger Leap*. July 18. https://www.cgdev.org/publication/how-gavi-60-can-take-bigger-leap.

Madan Keller, Janeen, Rachel Bonnifield, Tom Drake, Pete Baker, and Orin Levine. 2025b. *How Gavi 6.0 Can Take a Bigger Leap*. Center for Global Development. https://www.cgdev.org/publication/how-gavi-60-can-take-bigger-leap.

Madan Keller, Janeen, Clemence Landers, Nico Martinez, and Rosie Eldridge. 2025. 'The 2024–2025 Replenishment Traffic Jam'. *The 2024–2025 Replenishment Traffic Jam*. https://www.cgdev.org/media/2024-2025-replenishment-traffic-jam.

Memirie, Solomon Tessema, Anastassia Demeshko, Mizan Habtemichael, et al. 2024. *A New Compact for Financing Health Services: Ethiopia Case Study*. September 9. https://www.cgdev.org/publication/new-compact-financing-health-services-ethiopia-case-study.

Morton, Alec, Jamaica Briones, Anastassia Demeshko, Pete Baker, and Tom Drake. 2024. *A New Compact for Financing Health Services: Opportunities for Gavi and Partner Countries*. September 9. https://www.cgdev.org/publication/new-compact-financing-health-services-opportunities-gavi-and-partner-countries.

Musuva, Anne, Marie-Jeanne Offosse, and Aloysius Ssennyonjo. 2025. 'Advancing the Lusaka Agenda: The Global Financing Facility's Missed Opportunities for Catalysing Sustainable Health Investment'. *Global Health Action* 18 (1): 2555052. https://doi.org/10.1080/16549716.2025.2555052.

OECD. 2005. *Paris Declaration on Aid Effectiveness*. OECD. https://doi.org/10.1787/9789264098084-en.

OECD. 2006. *Harmonising Donor Practices for Effective Aid Delivery*. DAC Guidelines and Reference Series. OECD Publishing. https://doi.org/10.1787/9789264035843-en.

OECD. 2008. *Accra Agenda for Action*. OECD. https://www.oecd.org/en/publications/accra-agenda-for-action_9789264098107-en.html.

Ofosu, Anthony, Louisiana Lush, Ulrika Enemark, and Esben Sonderstrup. 2016. *Rapid Independent Review of the International Health Partnership*. IHP+. https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/About_IHP_/mgt_arrangemts___docs/Core_Team/Rapid_Review_of_IHP_._Final_Report_16_DEC_2016_1.pdf.

P4H Network. 2023. 'History - The P4H Network'. P4H Network. https://p4h.world/en/who-we-are/history/.

Pate, Muhammad Ali, Donald Kaberuka, and Peter Piot. 2026. *Transforming the Global Health Ecosystem: Lessons Learned and a Vision for the Future*. Accra Reset. https://accrareset.org/publications/Transforming-the-Global-Health-Ecosystem/.

PEFA. 2025. 'Public Expenditure and Financial Accountability (PEFA)'. https://www.pefa.org/about.

Pincombe, Morgan, Pete Baker, Adrian Gheorghe, and Janeen Madan Keller. 2023. *Projections of Eligibility and Transition Trajectories up to 2040: Implications for Gavi's Next Strategic Period and Beyond*. December 14. https://www.cgdev.org/publication/projections-eligibility-and-transition-trajectories-2040-implications-gavis-next.

Regional Committee for Africa. 2008. *Harmonization for Health in Africa: Progress Report*. WHO. https://iris.who.int/bitstream/handle/10665/1774/AFR-RC58-INF-DOC-6.pdf?sequence=1&isAllowed=y.

Regional Committee for Africa. 2024. *A Decade of Transformation: Achievements and Lessons Learnt Report on the Implementation of the Transformation Agenda of the WHO Secretariat in the African Region, February 2015–February 2024*. WHO. https://iris.who.int/bitstream/handle/10665/378876/AFR-RC74-11-eng.pdf?sequence=1&isAllowed=y.

Republic of Cameroon, Ministry of Public Health. 2023. 'National Compact Between the Government of the Republic of Cameroon and its Partners of Development'. https://www.afro.who.int/sites/default/files/2025-03/Compact%20National%20ENGLISH%20-1.pdf.

Salisbury, Nicole A., Gilbert Asiimwe, Peter Waiswa, and Ashley Latimer. 2019. 'Operationalising the Global Financing Facility (GFF) Model: The Devil Is in the Detail'. *BMJ Global Health* 4 (2). https://doi.org/10.1136/bmjgh-2018-001369.

Schneider, Sebastian H., Jens Eger, and Nora Sassenhagen. 2021. 'Opinion Monitor for Development Policy 2021'. *Development Engagement Lab*. https://developmentengagementlab.org/publication/opinion-monitor-for-development-policy-2021/.

Shorten, Tim, and Shaun Conway. 2015. 'The International Health Partnership: Monitoring Transparency and Accountability'. In *Improving Aid Effectiveness in Global Health*, edited by Elvira Beracochea. Springer. https://doi.org/10.1007/978-1-4939-2721-0_18.

Sparkes, Susa, Helene Barroy, Kalipso Chalkidou, Pete Baker, and Sophie Witter. 2025. 'Money Talks: The Lusaka Agenda Financing Alignment Indicators'. Center for Global Development, January 9. https://www.cgdev.org/blog/money-talks-lusaka-agenda-financing-alignment-indicators.

Sparkes, Susan, MyMai Yungrattanachai, and Victoria Fan. 2024. 'Conditioned Domestic "Co-Financing" Policies in Global Health: A Landscape Analysis'. CGD. https://www.cgdev.org/publication/conditioned-domestic-co-financing-policies-global-health-landscape-analysis.

Taylor, Martin, and Carmen Dolea. 2012. *Developing a Country Compact: What Does It Take and What Are the Gains?* IHP+. https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Key_Issues/Country_Compacts/Developing%20a%20Country%20Compact.What%20Does%20it%20Take.Dec2012.pdf.

The Global Fund. 2024a. *The Global Fund Eligibility Policy*. The Global Fund. https://resources.theglobalfund.org/media/7443/core_eligibility_policy_en.pdf.

The Global Fund. 2024b. *The Global Fund Sustainability, Transition and Co-Financing Policy*. Geneva. https://resources.theglobalfund.org/media/14383/core_sustainability-transition-cofinancing_policy_en.pdf.

'The International Health Partnership and Related Initiatives (IHP+)'. 2009. *Global Health Europe*, July 24. https://globalhealtheurope.org/general/the-international-health-partnership-and-related-initiatives-ihp/.

UHC2030. 2017a. 'Health Stakeholders Sign Country Compact in Ivory Coast'. https://www.uhc2030.org/news-and-events/news/article/health-stakeholders-sign-country-compact-in-ivory-coast-406584/.

UHC2030. 2017b. 'Liberia's Country Compact: A Common Understanding of How to Strengthen Health System'. https://www.uhc2030.org/news-and-events/news/article/liberias-country-compact-a-common-understanding-of-how-to-strengthen-health-system-426875/.

UHC2030. 2025a. 'Country Compacts—UHC2030'. https://www.uhc2030.org/what-we-do/improving-collaboration/country-compacts/.

UHC2030. 2025b. 'History—UHC2030'. https://www.uhc2030.org/who-we-are/history/.

UK FCDO. 2021. *Health Systems Strengthening for Global Health Security and Universal Health Coverage—FCDO Position Paper*. UK FCDO.

UK Government. 2007. *The International Health Partnership—A Global 'Compact' for Achieving the Health Millenium Development Goals (Signatories)*. Downing Street, London, United Kingdom. https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Home/IHP_global_compact_signatories_May%202013.pdf.

UK Government. 2023. *Global Health Framework: Working Together towards a Healthier World*. https://www.gov.uk/government/publications/global-health-framework-working-together-towards-a-healthier-world.

United Nations. 2002. 'Monterrey Consensus of the International Conference on Financing for Development'. Paper presented at International Conference on Financing for Development. https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_CONF.198_11.pdf.

United Nations. 2015. *Transforming Our World: The 2030 Agenda for Sustainable Development*. United Nations. https://sdgs.un.org/2030agenda.

United Nations Development Group. 2003a. 'Action Plan—Harmonization and Alignment to Help Achieve the MDG's'. *Rome Declaration on Harmonization* (Rome, Italy), February 25. https://www.unicef.org/executiveboard/media/27621/file/2005-JMB-Item-4-Harmonization-Action-plan-EN.pdf.

United Nations Development Group. 2003b. 'Rome Declaration on Harmonization'. *Rome Declaration on Harmonization* (Rome, Italy), February 25. https://www.instituto-camoes.pt/images/cooperacao/declaracao_roma.pdf.

US Department of State. 2025. *America First Global Health Strategy*. (Washington DC), September. https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf.

Vaillancourt, Denise. 2009. *Do Health Sector-Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries*. IEG Working Paper 2009/4. World Bank.

Waddington, Catriona, Abebe Alebachew, and Jarl Chabot. 2012. *Roadmap for Enhancing the Implementation of One Plans, One Budget, and One Report in Ethiopia*. Ethiopia. https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE__results___lessons/Ethiopia%20Roadmap%20enhancing%20one%20plan%20one%20budget%20and%20one%20report%20final.pdf.

WHO. 2006. *A Guide to WHO's Role in Sector-Wide Approaches to Health Development*. CCO/06.1. CCO/06.1. https://iris.who.int/handle/10665/69802.

WHO. 2016. 'Resource Guide on the Use of Health Technology Assessment in Health Benefit Package Design Processes'. https://www.who.int/teams/health-financing-and-economics/economic-analysis/health-technology-assessment-and-benefit-package-design/resource-guide-for-the-use-of-hta-and-hbp-design-processes.

WHO. 2017. *Domestic Resource Mobilization for Sustainable Financing for Health in Africa*. WHO. https://www.afro.who.int/sites/default/files/2017-12/WHO_Report_AFRO_20_small.pdf.

WHO. 2018. 'Millennium Development Goals (MDGs)'. https://www.who.int/news-room/fact-sheets/detail/millennium-development-goals-(mdgs).

WHO. 2024a. *Aligning for Country Impact: 2024 Progress Report on the Global Action Plan for Healthy Lives and Well-Being for All*. WHO. https://iris.who.int/bitstream/handle/10665/376857/9789240094949-eng.pdf?sequence=1.

WHO. 2024b. *Progress towards Harmonization of Partners in the WHO African Region 2023*. WHO. https://reliefweb.int/report/algeria/progress-towards-harmonization-partners-who-african-region-2023.

WHO. 2025a. 'Global Health Expenditure Database'. Global Health Expenditure Database. https://apps.who.int/nha/database/Select/Indicators/en.

WHO. 2025b. 'Health Impact Investment Platform'. https://www.who.int/about/collaboration/health-impact-investment-platform.

WHO. 2025c. *Joint Evaluation of the Global Action Plan for Health Lives and Well-Being for All*. WHO. https://cdn.who.int/media/docs/default-source/evaluation-office/report_joint-evaluation-of-sdg3-gap_final_clean_9dec.pdf?sfvrsn=4b081706_7&download=true.

WHO. 2025d. *Responding to the Health Financing Emergency: Immediate Measures and Longer-Term Shifts*. https://www.who.int/publications/i/item/9789240117587.

WHO. 2025e. *Strengthening Health Financing Globally*. Geneva. https://apps.who.int/gb/ebwha/pdf_files/EB156/B156_(16)-en.pdf.

WHO. 2025f. 'The Global Action Plan for Healthy Lives and Well-Being for All'. https://www.who.int/initiatives/sdg3-global-action-plan.

Witter, Sophie, Natasha Palmer, Rosemary Jouhaud, et al. 2025. 'Understanding the Political Economy of Reforming Global Health Initiatives—Insights from Global and Country Levels'. *Globalization and Health* 21 (1): 40. https://doi.org/10.1186/s12992-025-01129-0.

World Bank. 2023. *Open and Inclusive: Fair Processes for Financing Universal Health Coverage*. World Bank. https://doi.org/10.1596/39953.

World Bank. 2024a. *Financing Solutions for IDA-Eligible Countries*. World Bank. https://thedocs.worldbank.org/en/doc/55f0632430a178e49216c36d4ed541c4-0340012024/original/Financing-Solutions-for-IDA-Eligible-Countries.pdf.

World Bank. 2024b. 'International Development Association Financing'. https://ida.worldbank.org/en/ida-financing.

World Bank. 2024c. *Poverty, Prosperity, and Planet Report: Pathways Out of the Polycrisis*. World Bank. https://www.worldbank.org/en/publication/poverty-prosperity-and-planet.

World Bank. 2024d. *The Knowledge Compact for Action: Transforming Ideas into Development Impact*. World Bank. https://documents1.worldbank.org/curated/en/099041624093521233/pdf/BOSIB1f2e1cecb0ec184f314869b151f59d.pdf.

World Bank. 2025a. *Global Economic Prospects*. World Bank. https://www.worldbank.org/en/publication/global-economic-prospects.

World Bank. 2025b. 'Health Works—Country Compacts'. Text/HTML. World Bank. https://www.worldbank.org/en/programs/health-works/country-reform.

World Bank. 2025c. 'International Development Association Lending Terms'. https://ida.worldbank.org/en/financing/ida-lending-terms.

World Bank. 2025d. 'Political Stability and Absence of Violence/Terrorism: Percentile Rank'. https://data.worldbank.org/indicator/PV.PER.RNK.

Appendices

Appendix 1: Review of country-level coordination initiatives

To draw on lessons from the coordination initiatives, we focus on key global- and country-level efforts that have sought to improve donor coordination in health financing in Tables A1 and A2, respectively. The initiatives were selected based on their health financing focus and their intention to align funding with country-level priorities. At the global level, several initiatives aimed to embed coordination principles through broad-based partnerships, institutional alignment, and shared frameworks. The International Health Partnership (IHP+) was a seminal initiative that brought together governments and development partners to promote harmonised action on health system strengthening (HSS), largely through country compacts and shared accountability tools ('The International Health Partnership and Related Initiatives (IHP+)' 2009; UK Government 2007). It was complemented by various initiatives including the Providing for Health (P4H) Network, which focused on social health protection and health financing to advance universal health coverage (UHC), and by Harmonization for Health in Africa (HHA)(Regional Committee for Africa 2008; WHO 2024b), a regional mechanism to coordinate technical and financial support in African countries that was also relaunched in 2017 (Regional Committee for Africa 2024). With the shifting agenda from Millenium Development Goals (MDGs) to Sustainable Development Goals (SDGs), IHP+ evolved into UHC2030, still maintaining IHP+'s principles but broadening its partnerships and scope to support HSS towards the achievement of UHC and launching a renewed "Global Compact" to promote collaboration across diverse actors (UK Government 2007). The SDG3 Global Action Plan has coordinated 13 multilateral agencies to deliver joint country support and progress on thematic areas, including one on sustainable financing. These global efforts reflect an ongoing ambition to align efforts and maintain momentum in fostering collaboration across the global health ecosystem.

At the country level, compact-like initiatives have focused on enabling aid-recipient governments to lead national health financing efforts. The sector-wide approaches (SWAps), aimed to move away from fragmented donor projects towards an integrated health sector policy under government leadership that incorporates planning, budgeting, and monitoring. This model sought to align all financing for health behind a single expenditure framework. Stemming from IHP+ and UHC2030, country compacts involve formalised agreements among governments, donors, and other relevant stakeholders to align support and national plans. These compacts aimed to improve predictability, accountability, and coordination. A notable operational model is Ethiopia's One Plan, One Budget, One Report initiative, which established a shared framework for planning, monitoring, and resource mobilisation across all health sector actors. Promoted by the Global Financing Facility (GFF), the initiative is an example of how compact-like principles can be institutionalised through national systems with government leadership and donor alignment.

Together, these global- and country-level initiatives reflect a diverse but shared commitment to improve coordination, address fragmentation, and support country ownership.

TABLE A1. Lessons learned from global coordination initiatives

Initiative	Brief Description	Objectives	Achievements and Benefits	Challenges	Formal Evaluation
International Health Partnership (IHP+) ('The International Health Partnership and Related Initiatives (IHP+)' 2009; UK Government 2007)	A global initiative that promotes a horizontal approach to health systems strengthening by building the capacity of recipient country health systems and services. It encourages improved coordination among donors, governments, and other stakeholders through mechanisms like country compacts, which support harmonised and aligned action with national health strategies. The "+" signifies its role in bringing together complementary initiatives, such as P4H, HHA, RBF, Deliver Now for Women and Children, HMN, and GHWA, that collectively aimed to accelerate progress towards health-related MDGs through harmonised efforts and shared principles.	• Develop country compacts that commit partners to sustained, predictable funding and alignment with national health plans. • Increase harmonisation and coordination among donors, governments, civil society, and other stakeholders. • Generate and disseminate technical knowledge, tools, and guidance for health systems strengthening. • Enhance the efficiency and effectiveness of aid delivery for health. • Ensure mutual accountability through monitoring and performance assessment mechanisms. • Facilitate partnerships between major donors, recipient governments, and other key actors.	• Fostered accountability culture through the country compacts. • Developed harmonised planning tools. • Coordinated partnerships between major donors, the Health 8 (H8) group, recipient country governments, civil society, and other key global health institutions.	• Misalignment of donor funds. • Commitment often not sustained. • Accountability limited to signing global or national compacts but has limited resource investment and/or substantive behaviour change.	Evaluation conducted by the IHP+ Results Consortium (Labonte and Marriott 2010; Shorten and Conway 2015) in 2010; rapid independent review conducted in 2016 (Ofosu et al. 2016).
Providing for Health Network (Providing for Health) (P4H Network 2023)	A global network with a mission to promote, develop, and strengthen exchange and collaboration advancing UHC through social health protection and health financing. Launched at the 2007 G8 Summit in Heiligendamm, Germany.	• Foster high-level, multisector commitment to UHC financing, with a focus on domestic resources. • Support functional local networks to assess needs, share knowledge, and coordinate efforts. • Promote coherent, country-aligned support through joint technical assistance and global knowledge tools. • Collaborate with related UHC networks to maximise synergies. • Encourage innovation in social health protection and health financing.	• Complemented IHP+ efforts. • Supports domestic resource mobilisation and financial protection.	• Often overlaps with other initiatives. • Limited coordination at times.	Pilot evaluation in 2023–24; results were not found publicly online (hera 2024).

(Continued)

TABLE A1. (Continued)

Initiative	Brief Description	Objectives	Achievements and Benefits	Challenges	Formal Evaluation
UHC2030 (UHC2030 2025b)	In response to the shift from MDGs to SDGs in 2015, IHP+ broadened its focus to support HSS for UHC. It established UHC2030, which promotes coordination among partners and initiatives on HSS, offering practical tools and approaches to support improved collaboration. Partners sign a Global Compact to commit.	• Build and sustain political momentum around a unified global vision for UHC. • Advocate for adequate, targeted, and coordinated funding to support health systems strengthening. • Enhance accountability mechanisms to monitor progress towards UHC and SDG 3 goals. • Foster better coordination in countries receiving external aid by encouraging compliance with IHP+ principles and practices.	Not reported	Not reported	Not found
Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) (WHO 2024a)	An agreement among 13 multilateral agencies: Gavi, GFF, ILO, the Global Fund, UNAIDS, UNDP, UNFPA, UNICEF, Unitaid, UN Women, the World Bank, WFP, and WHO. It is founded on the principle that stronger collaboration among these agencies leads to improved health outcomes through more coherent and aligned support to national priorities and plans.	• Strengthen country engagement to jointly identify priorities and co-develop implementation plans. • Accelerate progress through joint action on seven thematic accelerators, including sustainable health financing. • Enhance alignment by harmonising operational and financial strategies, policies, and approaches across agencies. • Promote mutual accountability through joint progress reviews, shared learning, and transparent performance tracking.	In 2024, approach has been used in 69 countries; country case studies show increased commitment that involves closer collaboration in line with national priorities.	Existing accountability mechanisms, including the governing bodies of signatory agencies, lack the authority and incentives to drive meaningful collaboration across the broader health ecosystem, leaving GAP without real enforcement power.	Independent evaluation conducted in 2025 (WHO 2025c)
Harmonization for Health in Africa (HHA) (WHO 2024b; Regional Committee for Africa 2008)	A regional mechanism that brings together 14 bilateral and multilateral partners to coordinate technical and financial support for health systems strengthening in Africa. HHA supports country-led development efforts across key areas such as governance, health financing, human resources for health, infrastructure, ICT, pharmaceuticals, supply chains, and service delivery.	• Align partner support with country priorities while promoting harmonisation, alignment, inclusiveness, and accountability. • Strengthen health systems in line with the Paris Declaration and accelerate progress towards health-related development goals.	Supported at least 18 countries to develop or review medium-term expenditure frameworks, donor mapping, costing and budget reviews, health sector plans, SWAps, poverty reduction strategy papers, joint results frameworks, and human resources development plans.	Not reported. HHA was not clearly evaluated, and aside from mention of its relaunch in 2017 (Regional Committee for Africa 2024), its sustainability has not been described in much detail to our knowledge.	Not found

Notes: P4H: Providing for Health; HHA: Harmonization for Health in Africa; RBF: Innovative results-based financing; HMN: Health Metrics Network; GHWA: Global Health Workforce Alliance; MDG: Millenium Development Goals; UNAIDS: The Joint United Nations Programme on HIV/AIDS; UNDP: United Nations Development Program; ILO: International Labour Organization; UNFPA: United Nations Population Fund; WFP: World Food Programme.

TABLE A2. Lessons learned from country-level health financing coordination initiatives

Initiative	Brief Description	Objectives	Achievements and Benefits	Challenges	Formal Evaluation
Sector-Wide Approaches (SWAps) (WHO 2006; Foster et al. 1999; OECD 2006)	An initiative aimed at moving away from fragmented, donor-driven projects towards coordinated support for a government-led, sector-wide strategy. Its defining features include all donors and financing partners aligning behind a single sector policy and expenditure framework under government leadership, adopting harmonised approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds.	• Strengthen country ownership and leadership. • Reduce duplication and volatility in aid. • Improve aid effectiveness and harmonisation among donors.	Over 30 countries have implemented SWAps, with improved coordination and capacity in some countries.	Inconsistent donor buy-in, weak integration of vertical programmes, issues with parallel donor systems, and tendency to focus on expansion of health provision without concomitant emphasis on increased efficiency.	Review of country case studies and experiences (Foster et al. 1999; Vaillancourt 2009), but no formal independent evaluations found.
Country Compacts (UHC2030 2025a)	An initiative of IHP+, country or national compacts are a time-bound agreement that is jointly negotiated and signed by key partners, outlining their commitment to implement and support the national health priorities set out in the country's health strategy. Signatories may include government entities, civil society, the private sector, bilateral and multilateral development partners, local non-state actors, and other relevant stakeholders. Through the New Compact, all parties agree that both current and future investments will align with the national health strategy. Examples from Cameroon, Liberia, and Ivory Coast (Republic of Cameroon, Ministry of Public Health 2023; UHC2030 2017a, 2017b).	• Establish a framework to guide investments. • Increase the volume and effectiveness of health investments. • Accelerate progress towards national health priorities and objectives.	• Builds consensus and strengthens country ownership of national health strategies. • Improves coordination, dialogue, and trust among governments, stakeholders, and development partners. • Improves alignment, accountability, and focus on health results, including national and global targets. • Supports more predictable and long-term financing in some contexts. • Increases transparency and reduces transaction costs in managing development assistance. • Pre-compacts can serve as useful stepping stones towards stronger, formal agreements.	• Limited signatory participation: Key donors (e.g., GFATM, United States, and China) often do not sign, limiting effectiveness and increasing transaction costs. • Overly broad content: Compacts can be ambitious with unclear or unmeasurable objectives and indicators. • Unmet funding expectations: Some ministries expected additional funding through compacts, but this often did not materialise. • Weak reporting and indicators: Many indicators are not tracked or relevant to country priorities. • Leadership challenges: In some cases, Compacts are driven by partners rather than governments, affecting ownership and sustainability.	A synthesis review conducted in 2012 (Taylor and Dolea 2012); evaluation guidance developed by IHP+ and WHO 2025c, but no independent evaluations found.

(Continued)

TABLE A2. (Continued)

Initiative	Brief Description	Objectives	Achievements and Benefits	Challenges	Formal Evaluation
One Plan, One Budget, One Report	A harmonisation and alignment initiative originally undertaken as part of a roadmap in the health sector in Ethiopia (Waddington et al. 2012). As part of this, all stakeholders' plans and budgets aim to be reflected in one strategic plan, which is then broken down into annual plans. Implementation is then monitored using an agreed set of indicators and reporting formats.	All stakeholders work together and are aligned in planning and implementing policies, strategies, and priorities in support of results-oriented national plans and strategies.	• Alignment among all stakeholders working in the national health sector. • Countries play a more active role in designing development policies and a stronger leadership role in coordinating aid. • Creates mutual accountability and aligns efforts for better overall impact.	• Difficulties in ensuring all relevant stakeholders are at the table and agree on the one plan. • Needs to be a critical mass of people who articulate, believe, and act on the vision. • Donor commitment not often sustained.	Not found, but evaluations or reviews could be accounted under "Country Compacts."

Notes: GFATM: Global Fund to Fight AIDS, Tuberculosis, and Malaria; IHP+: International Health Partnership.

Appendix 2: Review of donor resource allocation frameworks

We purposively selected six agencies based on total funding allocation and donor type (Table A3) (Global Financing Facility 2023; Institute for Health Metrics and Evaluation 2023). US government funding in 2025 saw significant funding cuts and the total DAH remains unclear but was still included as part of the review. For each agency, we identified the latest version of relevant policy or strategy documents that described co-financing, health system strengthening, eligibility and transition, or global health financing more broadly. Policy documents were prioritised as they provide more insight into requirements for resource allocation, and when these were publicly unavailable, strategy or terms of reference documents were used. Relevance to the New Compact, opportunities, and barriers were identified based on alignment with the three core pillars, analysing whether the following principles were a focus in the document: evidence-informed priority setting or a focus on evidence and data to drive decision making; health system strengthening or universal health coverage that goes beyond vertical programming; country-first leadership and ownership of national health financing over donor-led decisions; and domestic resource mobilisation (DRM) or incentives for countries to finance core health services. Table A3 summarises relevant agency documents, overall objectives, policy relevance to the New Compact principles, and opportunities and barriers for the New Compact.

TABLE A3. Mapping key donor policy frameworks and strategy documents for resource allocation and New Compact complementarities

Donor (DAH Provided in 2023)*	Policy or Framework	Description and Objectives	Relevance to the New Compact	Opportunities and Barriers	Publication Date
Multilateral health initiatives					
Gavi (US$2.50b)	Co-financing policy (Gavi 2022a)	Outlines procedures for country co-financing of Gavi-supported vaccines, requiring all recipient countries to co-finance a share of the cost of Gavi-supported vaccines. Aims to increase country financing of Gavi-supported vaccines to enable a smooth transition out of Gavi support and strengthen national vaccine procurement processes. For countries earlier in the process, it focuses on strengthening country ownership and building procurement capacity.	Aligns with efforts to progress domestic resource mobilisation through co-financing, integrates co-financing into transition goals, and has a focus on country ownership. However, diverges from the New Compact because co-financing is not higher on higher-priority vaccines.	Opportunities: Incentivises domestic investment and complementary donor support due to co-financing and transition focus; co-payments could potentially be tapered to align with New Compact principles. Barriers: Currently asserts donor over local priorities with inflexible allocations earmarked towards Gavi-supported vaccines rather than country-led health service prioritisation; high complexity in co-financing calculations and the operationalisation of requirements.	2025
	Health System & Immunisation Strengthening (HSIS) Policy (Gavi 2022c)	Supports health system strengthening to improve immunisation coverage and equity (includes supply chains, data systems, etc.).	Aligns with systems strengthening for sustainability. Diverges if siloed from broader health priorities.	Opportunities: Integrates immunisation with HSS; principles focused on equitable, country-driven and tailored approach (emphasises reaching zero-dose children and adapting to needs of fragile contexts); considers need to strengthen PHC, not displace domestic investments or duplicate; and find synergies with other donors. Barriers: Risk of vertical programming, fragmented implementation, limited to immunisation systems.	2017–2023
	Eligibility and Transition Policy (Gavi 2022b)	Outlines the criteria that determine which countries can access Gavi support based on GNI thresholds. The policy encourages governments in Gavi-supported countries to contribute to the cost of new vaccines, fostering greater country ownership of vaccine financing. It also supports countries in planning for financially sustainable immunisation programmes as they prepare for the eventual transition away from Gavi funding.	Aligns with principles of country-driven and context-tailored financing and transition planning. Diverges in high reliance on GNI metrics.	Opportunities: Multiyear transition safeguards, allocates funding for country-led transition planning and action on top of immunisation programmes—offering opportunity to consider HSS functions. Barriers: Lacks nuance for country-level differences in their readiness for transition and capacity to finance new vaccines (e.g., fiscal constraints), focus on highest impact for Gavi funding rather than for the highest impact for financing health services as a whole.	2025

(Continued)

TABLE A3. (Continued)

Donor (DAH Provided in 2023)*	Policy or Framework	Description and Objectives	Relevance to the New Compact	Opportunities and Barriers	Publication Date
GFATM (US$5.49b)	Sustainability, Transition and Co-financing Policy (The Global Fund 2024b)	Seeks to promote domestic financing, transition readiness, and co-financing to sustain disease programmes and the health sector. Eligibility is in theory disease- and income-based. However, analysis of ratios of government-to-GFATM spending, reveals implementation of this could differ, with co-financing levels "varying idiosyncratically by country and disease program" (Susan Sparkes et al. 2024)	Aligns with transition planning, co-financing, and DRM. Diverges in disease-specific focus, weak HSS enforcement.	Opportunity: Countries lead the development of national strategies and proposals for how additional GF support could support these goals; further develop and expand on HSS funding intentions with New Compact alignment; explore intention to partner with Gavi and other donors for collaborative co-financing (principle 18g) Barrier: Disease focus on HIV/AIDS, malaria, and tuberculosis contributes to silos or fragmentation, despite intentions for compliance there is weak accountability in their reporting of allocations.	2023–2028
	Eligibility Policy (The Global Fund 2024a)	Outlines GNI and disease burden thresholds for eligibility and transition.	Aims to ensure funds are allocated to the most in need, highlighting an equity focus. Diverges in disease-specific focus and lacks evidence-informed priority setting approach.	Opportunity: Actioning on the intention for equity focus with evidence-informed priority setting. Barrier: Country eligibility largely guided by the three disease areas of focus.	2024
Multilateral development banks					
GFF, World Bank (US$2.50b)	Health Financing Strategy (Global Financing Facility 2023)	Includes aims to increase DRM efficiency and equity, emphasising PHC and UHC. Strategic direction includes bolstering country leadership, building more resilient, equitable, and sustainable health financing systems.	Aligns with PHC prioritisation and efficiency and a HSS agenda. Prioritising reforms related to DRM, efficiency, and financial protection. Includes KPIs for: evidence use in resource prioritisation as part of bolstering country leadership, donor alignment through an alignment maturity model, health financing reforms, DRM and commodity financing reforms.	Opportunities: Links financing to outcomes, promotes channelling funds to health services in line with their core principles. Use GFF's Joint Learning Agenda (JLA) on Health Financing and Universal Health Coverage to find complementarities for applying the New Compact. Barriers: Data-intensive monitoring/reporting, limited to RMNCAH-N services.	2022
IDA, World Bank, (US$2.16b)	Financing Solutions for IDA-Eligible Countries; IDA Lending Terms; IDA Terms of Reference(World Bank 2024a, 2024b, 2025c)	Describes recipient-country eligibility for IDA financing allocations based on income level, record of success, and ongoing IDA projects. Includes IDA-only, gap and blended financing options.	Blended financing arrangements differentiated based on country progress, with goals in place for smooth transition over time.	Opportunity: Identify alignments with the World Bank's Knowledge Compact for Action, and the approach for the new health target to "provide quality health services to an additional 1.5bn people over the next five years."	2024

(Continued)

TABLE A3. (Continued)

Donor (DAH Provided in 2023)*	Policy or Framework	Description and Objectives	Relevance to the New Compact	Opportunities and Barriers	Publication Date
Upstream donors					
UK FCDO (US$3.67b)	Global Health Framework (UK Government 2023)	Sets out a cross-government approach to global health, with four objectives: strengthen global health security, reform global health architecture, strengthen country health systems, and advance UK leadership in science and technology. Emphasises preparedness, collaboration, and reducing vertical programme funding. Refers to the health system strengthening position paper (UK FCDO 2021) for further detail on their stance.	Strong alignment with HSS, UHC, and DRM. Supports integrated, system-wide approaches and long-term partnerships.	Opportunity: core thematic alignment where applying the new compact framework could complement strategic aims, example of providing flexible funding to WHO could be translated to other financing initiatives. Barrier: With the many focus areas outlined in the document: ODA budget constraints, political volatility, and shifting FCDO priorities, focus on HSS and global health reforms could be diluted or not as high in priority for FCDO (including support for new compact-like efforts).	2023–2025
Germany (BMZ) (US$5.29b)	Global Health Strategy (Bundesministerium für Gesundheit, The Federal Ministry of Health 2020)	Prioritises HSS, UHC, and DRM. Focuses on health financing as a key policy area for HSS.	Aligns with HSS and DRM principles. Supports GHIs transitioning from vertical to horizontal structures and their integration into national health systems to fit country needs. Promotes the SDG3 GAP.	Opportunities: Leverage SDG GAP coordination and reliance on GHIs to deliver on their strategy. Barriers: Unclear in operational insights and how health financing will be a priority and how HSS will be implemented.	2023
US Department of State	America First Global Health Strategy (US Department of State 2025)	Redirects US global health aid from NGOs and multilaterals into time-bound bilateral deals with governments, requiring co-investment and performance benchmarks while reducing US financing over time.	Aligns with ideas on country ownership, prioritising domestic financing, and shifting from fragmented to government-led projects tied to measurable results. Diverges in focus on shifting bilateral aid away from multilateralism.	Opportunities: use the US bilateral agreements as practical vehicles through which New Compact principles could guide implementation; integrate EIPS in data and performance metrics; arrange domestic co-financing with country governments funding core services. Barriers: strong preference for bilateral over multilateral channels undercuts pooled, predictable, multi-partner financing and joint country-level priority-setting; drastic changes to the status quo but no transition period for operationalising change and integration, or for governments to absorb the costs of phased-out US support.	2025

Notes: *This table includes both donors per se (sovereign governments or philanthropic institutions that provide original development assistance) and intermediaries or agencies that allocate or manage funds on behalf of donors. US Government DAH provided is excluded due to its substantial 2025 aid cuts. Estimated total DAH spent in 2023=US$64.6b (Institute for Health Metrics and Evaluation (IHME) 2023). Of note, both bilateral donors provide funds to GFATM, Gavi, and GFF and therefore, there is expected overlap in the funds. DAH: development assistance for health; DRM: domestic resource mobilisation; GAP: Global Action Plan; GHI: global health initiatives; GFATM: Global Fund to Fight AIDS, Tuberculosis, and Malaria; GFF: Global Financing Facility; HSS: health system strengthening; PHC: primary health care; UHC: universal health coverage; MCH: maternal and child health.

Appendix 3: A framework for countries to assess drivers of successful New Compact implementation

TABLE A4. A framework for countries to assess drivers of successful New Compact implementation

Domain	Subdomain	Indicators	Data Source
Political and economic context	Political environment: a) Political stability and security	World Bank global report on political stability and security index. The index ranges from -2.5 (weak political stability) to 2.5 (strong political stability).	Worldwide Governance Indicators
	Political environment: b) Political will and commitment	Level of focus given to health in national policies, strategies, and legal frameworks.	Desk review of key national development policies and legal frameworks; qualitative assessment (key informant interview and experts' deliberations)
		Share of health budget of total government expenditure and the trend.	NHA data
	Macroeconomic environment: fiscal capacity	Annual GDP per capita growth rate and trend.	World Bank Global Development Indicator
Governance and coordination	Stakeholders engagement and coordination mechanisms	Availability of functional stakeholders coordination mechanisms and the level of participation and transparency • Public institutions • Donors and implementing partners • CSOs • Association • Private sector	Qualitative assessment (key informant interview and experts' deliberations)
Health financing	DRM tailored to financing high priority services	Availability of DRM strategy	Qualitative assessment (key informant interview and experts' deliberations)
		Per capita total health expenditure (THE)	NHA data
		Share of donor funding of THE	
		Share of government expenditure of THE	
		Share of OOP payment of THE	
	Pooling and level of fragmentation	The level of coordination in fund flows from different revenue sources (e.g., general budget, social health insurance, community-based health insurance and donor funding) and their complementarity in delivering sectoral plans and prioritised service package.	Desk review and qualitative assessment (key informant interview and experts' deliberations)

(Continued)

TABLE A4. (Continued)

Domain	Subdomain	Indicators	Data Source
Evidence-informed priority setting (EIPS)	• Governance and leadership for EIPS • Health economics evidence generation and use • Availability of adequate fund for EIPS • Stakeholder engagement	iDSI progression scale for institutionalising evidence-informed priority setting (iProSE) • Organisational structures for evidence generation • Organisational structures for evidence interpretation • Formal linkages to decision making are in place • Public funding to support these processes • Soft infrastructure to support subdomain points 1 and 2 above exists • Relevant stakeholders participate in the EIPS process	Desk review and qualitative assessment (key informant interview and experts' deliberations)
Public financial management (PFM)	• Budget formulation, execution and monitoring. • Alignment of PFM with health financing functions, service delivery and HUC goals.	• Budget reliability and predictability • Execution rate • Expenditure tracking and control • Alignment of PFM with priority health services and country UHC goals	Desk review of governmental planning and budgeting documents and other publicly available sources (e.g., PEFAs, PERs, fiduciary assessment, health sector reviews) Qualitative interview and expert deliberation WHO PFM module can be used as primary framework and can be augmented by the "World Bank's FinHealth: PFM-in-health toolkit" or "UNICEF problem-driven approach to PFM challenges in health service delivery" for in depth root cause analysis of PFM factors that hinder health service delivery
Donor coordination and transition preparedness	Donor harmonisation	• Availability of donor harmonisation frameworks and the level of joint planning, programming, and reporting • On-budget support or joint resource pooling to finance sectoral plan • Use of country system	Qualitative assessment (key informant interview and experts' deliberations)
	Donor supported programs transition preparedness	• An availability of donor transition plan • HR capacity • Supply chain management (SCM) capacity • Health information system capacity	Qualitative assessment (key informant interview and experts' deliberations)

Notes: CSO: civil society organization; DRM: domestic resource mobilisation; NHA: National Health Account; OOP: out-of-pocket.