

## **Insights on global health reform discussions, trends and perspectives**

2 March 2026

This is the third in a **series of *Insights papers*** summarising our understanding and analysis of global health reform discussions, trends and perspectives. It follows the **first** and **second** Insights papers, published in November 2025 and January 2026, respectively.

**We will continue to share regular updates and analyses around key issues and decisions in what will be a critical 12 months for shaping the future of global health.**

### **Our reflections and analysis**

*This section summarises our reflections on developments around reforms of the international system for health since the January Insights paper, offering an analysis of the latest discussions. Descriptions of specific processes and events we have been following are provided in the main text of the paper.*

Boundaries between what initially emerged as siloed global health reform initiatives are softening, with greater awareness and exchange across different conversations<sup>1</sup>. While it is vital to continue pursuing alignment, it needs to occur at a productive and pragmatic level. This requires mobilising sufficiently large, diverse groups of stakeholders and actors to influence political processes, while retaining agility and avoiding cumbersome bureaucracies. South-led discussion and processes are emerging as crucial in this regard.

Cost-cutting efforts across global health institutions are acknowledged as necessary to maintain core functions. However, there is equal recognition that such measures do not constitute the deeper structural reforms required, and there is widespread doubt that transformation will be driven from within existing governance structures alone. Different appetites for change and conflicting funder priorities may impede reform proposals that depend on closer interorganisational collaboration, as illustrated by the marginal progress of joint work by Gavi and the Global Fund. Moreover, less has been said so far about reforms of other global health financing institutions and funds as well as disease-specific partnerships, all of which contribute to the current fragmented landscape. Reforms at the institutional level are critical, including within Gavi and the Global Fund, but these alone will not resolve the complexity, duplication and verticalisation within the global health system – what is needed is a consolidated, coherent process that looks at the ecosystem as a whole.

Even though the WHO is recognised as one critical platform for discussing global health reforms, its ability to convene an overarching reform dialogue is contested. During the Executive Board meeting in February, member states agreed to the Secretariat developing a proposal for a joint process, but they remain wary of intergovernmental models. Moreover, there is a lack of clarity on whether the WHO has the bandwidth and legitimacy to bring together the full range of relevant actors and stakeholders, including GHIs, civil society, the private sector, finance ministries, and, not least, the US government. The WHO Secretariat will present a proposal on the process to the 79<sup>th</sup> World Health Assembly in May 2026.

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<sup>1</sup> Overview provided in the [first](#) and [second](#) Insights paper.

As the reform agenda takes shape, it is evident that the WHO has reached an inflection point, with its role in the international ecosystem for health being a key area of scrutiny. This raises questions about whether the Organization can credibly serve as both the host and the subject of a reform process.

In this context, South-led coalitions arguably have the best prospects for cultivating the legitimacy required to drive global health reform. The Accra Reset stands out in this regard, having secured high-level international backing, though the exact governance arrangements remain somewhat ambiguous. The initiative is framed as a reset of global development cooperation, starting with, but not limited to, global health. However, it is uncertain whether this broader scope will ultimately strengthen or dilute its perceived relevance for reforming the global health ecosystem. Additionally, it is worth considering how the Accra Reset – launched by Ghanaian President John Dramani Mahama – and Lusaka Agenda relate to one another. The Lusaka Agenda has successfully accumulated notable political attention and sits closer to the comfort zone of key stakeholders; however, it arguably comes across as less transformational, with President Mahama’s messaging moving the conversation from aid efficiency to aid redundancy.

Despite the attention Accra Reset has received in the Global North and in several multilateral fora, its success hinges upon sustained and unified backing from African leadership, which is not guaranteed. The Reset's ability to make an impact on the global health architecture may be questioned if it fails to foster regional cohesion.

There is also a risk of reform fatigue. Many of the pledges, frameworks and commitments that have emerged in recent months resemble earlier efforts which failed to materialise. Belief that current momentum is fundamentally different and has the potential to deliver transformative change will be tested without visible progress in the months ahead.

Across the reform discussions, the point of contention is not whether health sovereignty is desirable, but whether and on what timeframe it is realistic, as well as how it is conceptualised. Proposed mechanisms for transitioning to self-sufficiency might falter not because of technical flaws or insufficient data, but due to a lack of underlying trust, both trust within countries and trust between actors across the Global North and the Global South. This includes confidence that national leaders will act in the country’s best interest, and that partners – including international institutions – will deliver on their commitments.

The prevailing dynamics may help explain growing calls for transactional and reciprocal partnerships, with equality being demonstrated through transparent articulation of benefits for all parties and ‘win-win’ arguments. In the current geopolitical environment, the multilateral system’s legacy is not necessarily its leverage; instead, it must prove its relevance and legitimacy in protecting and advancing national interests. The depletion of available resources in the global health ecosystem may prove less consequential than the

limited motivation to revitalise it. However, the very duplication and inefficiency that deter some actors from reinvigorating multilateral cooperation risk being reproduced amidst the proliferation of ‘minilateral’, ad hoc partnerships.

Alignment between Brussels and Washington, cohesion within the EU and a ubiquitous preference for multilateralism can no longer be taken for granted. Overall, there appears to be a move towards a subsidiarity-based and decentralised global health system. The remaining ODA will continue to play a role, but its framing is shifting, with greater acknowledgment that beneficiaries of development cooperation are not solely the recipient countries.

While disruptive funding cuts served as a catalyst for reforms, discussions on health financing should not be reduced to analyses of ODA trajectories, nor treat domestic resource mobilisation as merely aspirational. More clarity and further thinking are needed on how different financing approaches complement one another, and how their relative importance may evolve over time. Financing of global public goods (GPGs) is an important part of this debate; however, provision of GPGs should not be misconstrued as a potential guiding principle for optimising ODA allocation and should instead be realised from non-aid sources.

ODA is not only diminishing in LMICs’ health financing budgets; it is also gradually receding from most high-income countries’ diplomatic toolkits. The transition away from aid should therefore not be seen as a one-sided process nor a purely financial act; it is a realignment that reshapes influence, obligations, and strategic interests on all sides.

## **A summary of ongoing reform discussions, trends and perspectives**

*Building on the [November 2025](#) and [January 2026](#) papers, this section provides an overview of processes and voices shaping the current reform discourse and a synthesis of the key discussions.*

### *Updates on the Accra Reset*

On the sidelines of the 2026 World Economic Forum Annual Meeting, President Mahama of Ghana led the [first Davos convening of the Accra Reset](#). The Reset will be governed by a Presidential Council and a [Guardians Circle](#) – comprising former heads of state and government from the Global South and the Global North – aiming [to transform global development cooperation](#). Since its launch at UNGA 2025, the initiative has been positioned as a [sovereignty movement dedicated to curtailing dependency in areas beyond health](#), including technology, AI and the use of natural resources. Nevertheless, global health will be Accra Reset’s initial focus area.

In an [LSE blog](#), professors Felix Kumah-Abiwu and Jeffrey Haynes noted that Accra Reset is proactively seeking synergies with other relevant initiatives; this is exemplified by active engagement in the African Union’s Agenda 2063, which aims to address entrenched barriers to development across the continent. During the AU Summit in mid-February, [President Mahama hosted a side meeting](#) titled ‘Accra Reset’s Addis Reckoning’, which focused on establishing Pan-African payment infrastructure, strengthening mineral governance and promoting the use of local currencies. Key messages from the event were that African prosperity contributes to, not threatens prosperity in other regions, and that Africa’s forward-looking frameworks require immediate implementation. In a [BBC article](#), Accra Reset was viewed as a potential response to Trumpian international policy, provided it secures region-wide backing, which may necessitate countries to prioritise collective bargaining power over national interests.

### *The future of WHO*

Director General of the World Health Organization, Tedros Ghebreyesus, published a [world view article in Nature Health](#), reiterating that the current funding crisis offers an opportunity for countries to transition away from aid dependency and strengthen domestic health financing. He alluded to WHO’s role in facilitating this transition, though the Organization itself is undergoing a period of significant change.

On 22<sup>nd</sup> January 2026, a year after Donald Trump signed the E.O. 14155, the US officially withdrew from WHO, despite having [outstanding financial commitments](#) to the Organization. Secretary of State Rubio and Secretary of Health and Human Services Kennedy issued [a joint statement](#) condemning WHO and emphasising that the US intends to limit future multilateral cooperation in favour of bilateral partnerships. [WHO issued a statement](#) challenging the state secretaries’ critiques, particularly in regard to the COVID-

19 response. [J. Stephen Morrison and Paul Friedrichs of the US Center for Strategic and International Studies](#) commented on US' potential membership renewal once the Organization's leadership changes in 2027, and outlined why the US may have a keen interest in influencing the selection of the incoming DG. [In an article for Think Global Health](#), Peter Singer argues that US' return to WHO is subject to greater accountability and revitalised results agenda; improved ability to implement and scale innovation; and rebuilding the trust in the Organization as politically neutral.

In the lead up to the 158<sup>th</sup> session of WHO's Executive Board, Andrew Harmer published [an overview of EB documents focusing on WHO's Programme Budget](#). He highlighted that the WHO 2025 funding gap has been reduced thanks to increased assessed contributions and member states agreeing on the use of Programme Support Costs funds to finance staff salaries. Some parts of the Budget, such as preparedness for health emergencies in Africa and the Americas, continue to be underfunded, in part due to earmarked voluntary contributions not aligning with priorities set by WHO.

In an [opinion article for the BMJ](#), Ilona Kickbusch scrutinised European countries' role in WHO in light of the US leaving the Organization. She insists that Europe should act more assertively, not in order to dominate, but to advance reforms which could contribute to a more fit for purpose WHO.

Writing for the [Devex Check-up Series](#), Andrew Green pointed out that WHO's next DG will not only have to restore the Organization's budget, but also its reputation as a trustworthy global health actor. Another task will be to rekindle ties with the US and disincentivise [other member states from withdrawing](#).

WHO's [Executive Board meeting concluded with articulation of plans to streamline the Organization's governance mechanisms](#) and proceed with designing a proposal for a joint global health reform process hosted by the Organization. This will be expanded upon and further deliberated at the World Health Assembly in May. Daniel López Acuña shared his [expectations for the process](#), suggesting that appointing an independent panel of experts would be the most effective way forward.

#### *Expert comments, research insights and other developments*

In a [Lancet Comment](#), global health leaders Anders Nordström, Magda Robalo, Helen Clark, Ren Minghui, Peter Piot and Yik-Ying Teo proposed four paradigm shifts as a common framing for global health reform discussions. Specifically, the authors describe shifts in the issues affecting people's health, from infectious to non-communicable diseases; shifts in power from global institutions to regions and nations; shifts in design from a complex to a streamlined system; and shifts in financing from an aid-based paradigm to domestic funding.

In a [Viewpoint article for The Lancet](#), Sania Nishtar called for stakeholders across the global health ecosystem to align on a ‘Global Health Leap’, including agreement on reform scope and objectives, as well as processes and actors that will propel it forward. The Gavi CEO suggests that reform efforts could be advanced by convening a panel coordinated by WHO, with inclusive participation from both state and non-state actors. This publication builds on Gavi’s own transformation plan ‘Gavi Leap’, underpinned by principles of Country-centricity, Country self-reliance, Focused mandates and Finite lifespans for global institutions, which gained notable traction when it was presented in mid- and late-2025. Since then, progress on realising Gavi’s ambitious vision has been less public and closely linked to its joint work with The Global Fund, focused on exploring options for strategic alignment between the two institutions. These efforts remain complicated, not least due to the US contributing only to the Global Fund’s most recent replenishment. Although the [US congress mentioned Gavi](#) in its foreign assistance budget bill for 2026, this alone is not a guarantee that the institution will receive American funding. The requirement for [phasing out all vaccines containing thimerosal](#) and the [US losing its seat on the board](#) make near-term pledges unlikely. Further updates on Gavi’s internal reforms and positioning within the evolving global health ecosystem are expected following its Board meeting in July, now chaired by Rt Hon Helen Clark.

Starting in February, the Trump Administration will be applying [broader ideological restrictions on all US non-military foreign assistance](#), prohibiting allocation of funds to areas including gender identity, abortion, equity, and inclusion. The prohibitive policy will apply to NGOs, international organisations, and potentially foreign governments, such as those that [signed bilateral memoranda of understanding](#) under the America First Global Health Strategy.

David McNair [warns that talks of the ‘end of aid’ are premature](#), but notes that development cooperation is changing not only in terms of the amount of funds available, but also the narratives justifying how remaining budgets are spent. Specifically, he argues that *‘in a world now shifting back from values to interests, the instrumentalization of aid may once again become more significant’*.

In a January [interview for the Global Health Hub Germany](#), Dr Ebere Okereke openly discussed barriers to Africa’s health sovereignty, highlighting longstanding governance issues and the gap in implementing ‘innovative’ financing mechanisms. In a [piece for Think Global Health](#), Okereke suggests that the second Trump administration did not create but rather formalised the long-standing vulnerability of health systems on the African continent. She observes that global health is now less governed by multilateral norms and increasingly grounded in transactionalism, stressing the strategic importance of treating health as a matter of high politics and pointing to the fragility of a global health ecosystem *‘built on assumptions of continuity and goodwill’*.

In a report for [Nature Health](#), science writer Abdullahi Tsanni summarised some of the reflections global health experts have been sharing on the future of health financing, covering topics such as strategies for domestic resource mobilisation, burden of illicit financing flows and the changing role of global health institutions.

The CEO of World Health Summit, Carsten Schicker, discussed [global health trends to watch](#) in 2026 for Economist Impact. Schicker places UN80 at the top of that list, alongside continued work on pandemic preparedness, diffusion of power, rising role of public-private partnerships, and preservation of scientific credibility.

A [research article published in The Lancet Global Health](#) in February evaluated the impact of ODA on mortality in low-and middle-income countries from 2002 to 2021, and modelled mortality up to 2030 under three de-funding scenarios. The study findings indicate that a continuation of current downward trends in ODA funding may lead to a total of 9.4 million excess deaths by the end of this decade. Although some countries have increased domestic health spending, the authors underscore that these efforts have thus far been insufficient to compensate for ODA cuts. Additionally, they acknowledge that ODA allocations remain disproportionately centred on vertical approaches and communicable diseases and should be better aligned with evolving health needs.

In a February [brief for CGD's Tough Times, Tough Choices series](#), Janeen Madan Keller, Rachel Bonnifield and Pete Baker dissect options for 'radical simplification' within the Global Fund. Authors proposed that the Fund should direct resources to fewer countries with greatest needs; emphasise national priorities by easing disease-specific earmarks; and prioritise on-budget country-led delivery.

[Writing for Think Global Health, Vanessa Kerry](#) argued that the tension between health sovereignty and multilateralism is overstated in the current discourse on global health reform. She also stressed that countries most affected by the health financing crisis have been receiving muddled signals from prospective partners and proposed five questions to help guide decision-making and collaboration.

## About us

***The Partnership for International Politics and Diplomacy for Health*** is a collaboration between the Stockholm School of Economics and Karolinska Institutet. Our work consists of four complementary and mutually reinforcing work streams: an Executive Program for future health leaders, the Health Diplomacy Institutional Network, focused Research efforts, and Policy engagements.

Our policy work seeks to contribute to the international dialogue on what a reformed international ecosystem for global health could look like. We call this workstream ***Paradigm Shifts for Global Health - Supporting Diplomacy and Policy Pathways***. This is not a standalone initiative or process, but a means through which we engage as both originators and conveyors of ideas that could potentially assist in paving the way for a reformed international ecosystem for health.

**Read more here:** <https://globalhealthdiplomacy.se/policy-engagements>