Insights on global health reform discussions, trends and perspectives

November 2026



CENTER FOR RESILIENT HEALTH

Partnership for International Politics and Diplomacy for Health

Karolinska Institutet

Contents

Our reflections and analysis 3

Moving from diagnosis to accountability will take time 3

Reform processes in tandem 4

Redistribution of power 4

A summary of ongoing reform discussions, trends and perspectives 5

Accra Reset 5

WHO-hosted reform process 6

WHO Director-General nominees at WHS 7

MOPAN 7

Insights on global health institutions 8

Relevant publications and expert comments 9

About us 13

This is the seventh in a series of Insights papers summarising our understanding and analysis of global health reform discussions, trends and perspectives. Previous papers in this series are available here.

We will continue to share regular updates and analyses around key issues and decisions shaping the future of health.

To keep up with the latest information, follow our LinkedIn page.

Our reflections and analysis

This section summarises our reflections on developments around reforms of the international system for health since September's Insights Paper, offering an analysis of the latest discussions.

Moving from diagnosis to accountability will take time

To much anticipation, the Accra Reset High-Level Panel Report was launched by President Mahama on the margins of the 81st United Nations General Assembly (UNGA) in September 2026. The task for the High-Level Panel was to translate the political momentum around global health reforms into a practical bold and people-centered reform agenda. The 10 recommendations and the accompanying five political shifts are the Panel's response to this challenge. A call was made to the Global North during the launch event, inviting cross-regional collaboration and addressing the need for engagement by development partners.

Many official and informal conversations on global health at UNGA81 and WHS in Berlin appeared supportive of the Panel's proposals and the Accra Reset's broader sovereignty agenda. Among the recommendations that gained particular traction are the One-Stop Country Compact, and the transformation of the 'big five' global health institutions through the so-called 4Cs pathway: Commit, Collaborate, Consolidate, and Close. The High-Level Panel makes the point that country-level reform alone will not suffice, and that improvements in countries are inseparable from reforms in global health governance. Therefore, these two recommendations can be seen as two sides of the same coin.

Even though the public endorsement of the recommendations is encouraging, their practical uptake and impact will take time to materialize. Many institutional leaders have praised the recommendations but at the same time continue to argue for the continued importance of their own institution in the reformed ecosystem, demonstrating the tension between talking about reform and enacting reform. The central question for implementing structural change is *who is willing to give up power over priorities, budgets, funding, and the final say in decision-making*. Instead of waiting for a universal reform blueprint, coalitions of the willing will need to coalesce around specific recommendations.

President Mahama's incoming Chairmanship of the African Union provides a platform to continue strengthening political support for the Accra Reset and delivering on the High-Level Panel's recommendations. There is an opportunity to discuss the report at the next AU-EU summit.

Reform processes in tandem

The Accra Reset and the WHO-hosted reform process are distinct initiatives with different leadership, scope, and timelines, and thus different strengths.

The bold and ambitious Accra Reset meaningfully challenges the status quo but may risk weak implementation as stakeholders hesitate; institutions may prioritise self-preservations while governments remain cautious about backing possibly controversial recommendations. In contrast, the WHO-hosted process has both the legitimacy and mandate to facilitate broader agreement around key principles and recommendations, using evidence from other ongoing processes, such as the High-Level Panel's Report and MOPAN's upcoming analysis. These other processes and reports do not strive for UN-style consensus but help ensure that the reform agenda does not lose sight of the more 'uncomfortable' options.

The WHO Joint Task Force's interim report will reveal which reform pathways have been the most palatable. Considering the representation of Global Health Initiatives (GHIs) on the Task Force, it will be particularly revealing to see how the Task Force operationalises the recommendations around mandates and functions. It will also be interesting to see how the report defines Global Public Goods, and how country ownership is conceptualised.

Redistribution of power

Waiting first for the Accra Reset High-Level Panel Report and now for the WHO Joint Task Force interim report risks extending diagnosis and prolonging inaction. While broad support matters, the expectation that everyone must be on board can become a reason to delay, particularly when reform requires powerful actors to relinquish authority, resources and institutional roles. Coalitions of the willing may offer a practical route forward, provided they have credible backing from the countries and communities reform is meant to serve. Yet greater country representation and responsibility will achieve little if donors retain control over funding and final decisions, or if organisational leaders, secretariats and interconnected governing bodies continue to protect existing mandates. True progress on the reform agenda will be reflected in a genuine redistribution of power.

A summary of ongoing reform discussions, trends and perspectives

Building on *past Insights papers*, this section provides an overview of processes and voices shaping the reform discourse and a synthesis of the key discussions.

Accra Reset

The Accra Reset High-Level Panel's report, *A Sovereign Future for* Health, was launched on 21 September on the sidelines of UNGA81. During the launch event, a plethora of speakers and organisations presented 'the new global bargain'. During his speech at the launch event, President Mahama invited collaboration and close partnership between the Global South and Global North, emphasizing that resilient health systems in Africa and Asia make the world safer for all.

The report is organised around six overarching principles: Health as a key driver of development; Universal access and equity; Health-, financial-, and data sovereignty; Country agency and subsidiarity; Efficiency gains; and Accountability on every level. The report presents 10 recommendations:



The recommendations envision a system organised around country priorities, supported by stronger regional capabilities and more focused global cooperation. The first recommendation describes a unified country compact aligning international support behind one national health plan, budget and coordination framework. Recommendation 2 advocates for a sustainable financing transition grounded in

domestic resources to build health sovereignty, achieved through increased public budgets, pooled financing, and stronger financial protection. A refocus of global cooperation for global public goods, which require predictable collective funding, is described in the seventh recommendation. Recommendation 9 turns to institutional reform through 4 C's: Committing to country-led priorities, more effective Collaboration, strategic Consolidation and Closure when appropriate.

These recommendations allow debate to move from broad principles to specific changes in financing, access, and governance. They collectively advocate for five political shifts that converge around redistribution of power. With these recommendations, countries work towards practical sovereignty based on partnerships and collective benefit rather than aid. Functions are also prioritized over global health institutions, and continued existence of institutions is only justified if they deliver an enduring global function.

WHO-hosted reform process

The majority of the Task Force members was announced by mid-August, leaving slots for one regional health organisation and one UN entity to be filled. The Task Force is co-chaired by Dr Yong Feng (China) and Mr Björn Kümmel (Germany). On 31 August, Africa CDC was confirmed as a representative of regional health organisations and in early October, Serina Ng was appointed as the Head of the Secretariat.

The Task Force has been meeting monthly since mid-August and held two Member State consultations in mid-September and October. Their work is structured around three work streams:

1. **Functions, mandates, and capacities.** To examine which global health functions are essential, at what level should they be carried out (country, regional, or global), and to what extent mandates are aligned.
2. **Coordination and decision-making.** To examine how to improve collaboration, accountability, and coherence between global health actors and levels (country, regional, global)
3. **Financing**. To examine how financing can be better aligned with country-led priorities, while preserving financing for regional and global functions.

The Task Force is expected to finalise its interim report by the end of November. The report will then be reviewed by governing bodies of participating global health initiatives, UN entities, and the WHO. The final report is expected in late May for Member States' decision at WHA80.

WHO Director-General nominees at WHS

At WHA80 in May 2027, the appointment of WHO's the next Director-General will take place. There have been seven nominations thus far: **Dr. Hanan Balkhy**, WHO Regional Director for the Eastern Mediterranean Region; **Dr. Hans Henri P. Kluge**, WHO Regional Director for Europe; **Dr. Hanan Mohammed Al-Kuwari,** former Minister of Public Health, Qatar; **Dr. Song Li**, former Director-General of the Department of Women and Child Health in China's National Health Commission; **Mr. Budi Gunadi Sadikin**, Minister of Health, Indonesia; **Dr. Maria P. Neira**, WHO Director of Environment Climate Change and Health; **Dr. Gevorg Tamamyan**, CEO of Immune Oncology Research Institute.

On 11 October, Neira, Tamamyan, Al-Kuwari, and Sadikin appeared in their first public campaign appearance revolved around WHO reform. Candidates agreed reform is needed but identified different priorities. Al-Kuwari proposed an independent review to reduce duplication and increase accountability within the Organization. Sadikin argued the WHO should return to its core functions: norm-setting and convening. Tamamyan proposed WHO should focus on health outcomes and be willing to act outside its formal mandate when necessary. Neira framed reform primarily around prioritizing prevention and environmental determinants of health.

In a reflection by Health Policy Watch, Former Global Fund Executive Director Michel Kazatchkine described the event as 'high-level warm-up' but criticised candidates for avoiding difficult organisational questions, such as relationships between headquarters and regional offices, appointment of regional directors, and structure of WHO leadership teams.

James Campbell and Jocalyn Clark argue in a BMJ editorial that the next WHO leadership election will test governments' willingness to share power and cooperate on global health. According to the authors, to effectively address health needs, this election requires four mindset shifts: abandon expectations that one person can fix all problems, address WHOs entrenched budget constraints, give civil society greater voice, and hold Member countries on the executive board accountable.

MOPAN

Expected on 3 December, MOPAN's upcoming report 'Comparative Advantage in the Multilateral Health Ecosystem' aims to present reform pathways that strengthen country ownership and preserve essential functions. The report will assess how nine multilateral organisations can best deliver prioritized health functions and improve their division of labour. It will examine mandates, capabilities, and the incentives that enable reform.

Insights on global health institutions

Global Fund

On 28 of October, the Global Fund Board appointed Mark Dybul as Executive Director. Having served as a member of the Accra Reset High-Level Panel and previously as Executive Director for the Global Fund from 2013 to 2017, Dybul is expected to take office in early 2027. This coincides with a new leadership of the board, with Erna Solberg as Chair and Javier Hourcade Bellocq as the Vice Chair.

Gavi

Gavi named Mozambique as the first Leap Champion for health system reforms, recognising its leadership in health system reform, country ownership, and sustained investment in public health. Mozambique is the first country to implement Gavi's new approach of unified immunisation budgeting aligned with national health priorities.

UNITAID

Announced in July, Luis Pizarro was appointed as the new Executive Director of UNITAID and will take office towards the end of 2026.

On 23 September, UNITAID published a news article that celebrated its 20th anniversary and argued that ongoing reforms of Global Health Architecture should prioritise equitable access to health innovations. Specifically, the article advocates for reduced delays between access in high- and low-income countries and for protection of mechanisms that ensure accessibility, such as market shaping and strategic partnerships for innovation.

UNAIDS

The UNAIDS Programme Coordinating Board Working Group's final report recommends transforming rather than closing UNAIDS, aiming to save costs while preserving core functions. It proposes technical implementation would shift to UN Cosponsors and national institutions, while a central hub would retain strategic leadership, coordination and accountability.

UNFPA & UN Women

A UK parliamentary answer on 28 September states that the UK remains open to merger and non-merger options for UNFPA and UN Women but considers the evidence insufficient to justify a merger at that time, putting emphasis on protecting existing mandates, a robust evidence base and meaningful civil-society consultation.

Relevant publications and expert comments

Principles to practice

In October, the Partnership for International Politics and Diplomacy for Health published a policy brief discussing Global Public Goods. The brief distinguishes global functions, i.e. what international institutions do, from global public goods (GPGs), defined as outcomes that are non-rival and non-excludable, and are sometimes produced by global functions. It proposes a continuum from pure to partial GPGs to help determine which activities require global cooperation and which belong at national or regional levels. Importantly, the brief underscores that this is a political choice, and that boundaries should be negotiated transparently, rather than used to justify existing mandates. GPGs should receive dedicated financing, with contributions based on ability to pay and decision-making rights independent of financial contributions.

In a comment in Nature Medicine, Rasanathan et al argue for a simpler global health system that puts countries central, is oriented around global public goods, and is served by a leaner set of global and regional institutions. They advocate stronger domestic financing with continued targeted support for vulnerable countries, clearer responsibilities for regional institutions, and a focus on shared challenges for global institutions. In a Wellcome post, John-Arne Røttingen, one of the co-authors, states that "*we need to engage with the practical choice, trade-offs and implementation challenges that meaningful reform will require*", underscoring that the focus needs to shift from 'what' to 'how and when'.

Similarly, a Think Global Health review of 67 publications in early September identified a growing agreement on country-led reform and pointed to unresolved questions about how financing and responsibilities should be redistributed.



William Menson and Jirair Ratevosian argue in a PLOS opinion piece that the Accra Reset and America First Global Health Strategy share an ambition for greater country ownership, but that transferring responsibility only works if countries have the resources and institutional capacity to sustain care. Bilateral agreements can clarify commitments yet must be complemented by regional cooperation on procurement and manufacturing. Menson and Ratevosian explain the importance of predictable funding, realistic transition timelines and public accountability for both governments and donors as a goal, rather than how many agreements have been signed.

Redistribution of power

In a Devex opinion piece, Ebere Okereke poses that global health institutions broadly agree countries should be in charge, but that this requires institutions to surrender control over budgets, funding, and decisions. She argues that greater country representation and responsibility alone will not shift power sufficiently if financial authority and ultimate decision-making power remains with donors. In the Lancet, Richard Horton complements this discussion by cautioning that reform processes risk achieving little for people's health if underlying power imbalances remain unchanged.

In a PLOS opinion piece, Filipa Alpeza and Afifah Rahman-Shepherd make the case that global health reform hinges on an understanding of the interests and internal dynamics of the organizations expected to change. Governments may set the political direction, but organisational leaders, secretariats and members actively shape reform and have incentives to protect their mandates and influence. Major organisations' interconnected governing structures reinforce their power, while civil society and affected communities remain poorly represented in formal reform processes. Alpeza and Rahman-Shepherd call for closer attention to those dynamics, transparency around organisational interests, and independent accountability mechanisms.

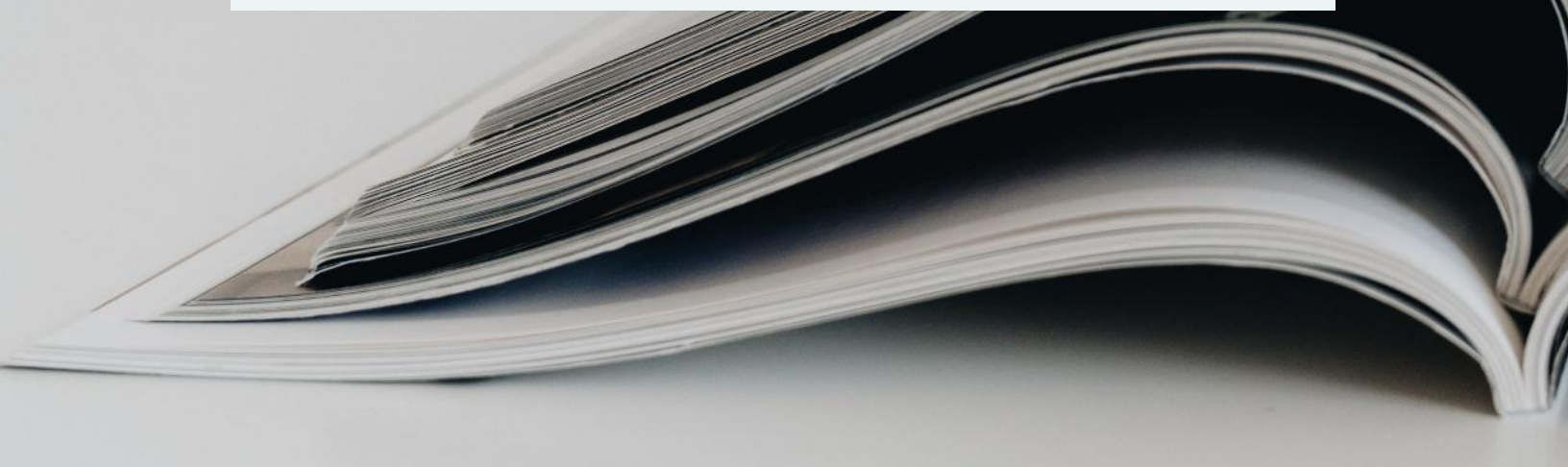


In a comment, Luchuo Engelbert Bain warns that major institutions' capacity, influence and superficial consultation could potentially reproduce existing power imbalances. He invites stronger country leadership and regional cooperation, while emphasizing that countries and communities must be able to shape recommendations and implementation. For meaningful reform to take place and to not reproduce existing power imbalance, he advocates for greater transparency and accountability to the public.

Future of financing

In September, the Partnership for International Politics and Diplomacy for Health published a policy brief on the Future of Health Financing. Using input from leading experts in the field, the brief proposes three interdependent pillars of future health financing: domestic funding as the foundation of health systems; catalytic development assistance used to transition to self-sufficiency and reserved for fragile settings; and collective financing for global public goods. It emphasizes successful transition to this future requires authority shifting to countries, expanding fiscal space through debt and financing reforms, protecting households from higher out-of-pocket expenditures, and preserving collective mechanisms such as pooled procurement.

In a blog post series, Kalipso Chalkidou and Rahul Singhal argue multilateral development banks (MDBs) as a more scalable alternative to close Africa's health financing gap. They explain most of Africa's capital is already committed or difficult to mobilise, while declining aid and philanthropy cannot close the health financing gap. Using guarantees, insurance and risk sharing, MDBs can release capital tied up against existing loans, allowing more lending while preserving strong credit ratings. Additional capacity has largely favoured climate and infrastructure, so deliberate health allocations are needed.



In a blog post, Pete Baker discussed four responses to an IDA Health Window, his earlier proposal to channel more global health aid through a dedicated World Bank fund that finances country-owned health system. The responses were broadly supportive, arguing an IDA Health Window could consolidate fragmented donor funding, channel support through national budgets, and protect health investments from being sidelines by other priorities. Its success would depend on reinforcing domestic health spending, improving donor coordination, and investing in accountability.

Physicians for Human Rights (PHR) report in a press release that the America First Global Health Strategy has damaged essential care. Drawing on its investigations and other independent evidence, PHR describes disrupted HIV testing, prevention and treatment, health worker layoffs and weakened patient follow-up and data systems, as a result of abrupt withdrawal of funding. These disproportionately affect people already facing barriers to care. In the press release, PHR calls for phased transitions, predictable multi-year funding and clear accountability to ensure the transition to country self-reliance does not come at expense of essential care.

One Data launched the Development Finance Observatory, a platform that aims to track development finance flows. It is designed as a central source for reliable development finance data and tools to understand and visualize them.



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



CENTER FOR RESILIENT HEALTH

Partnership for International Politics and Diplomacy for Health

Karolinska Institutet