Rethinking the Global Health Architecture in Service of Africa's Needs

by Catherine Kyobutungi

A Perspective from the Africa Region

Recent political and financial shifts present an unprecedented challenge to global health, but also a long-awaited opportunity for significant reform. Wellcome has asked five global health thought leaders from different regions to explore what a reimagined global health architecture could look like. These five proposals are intended as a starting point to kick start regional and global conversations. The proposals are not expected to be representative, or consensus based, but to provoke discussion and debate.

Executive Summary

This paper proposes a radical transformation of the Global Health Architecture (GHA) to better serve Africa's health needs, advocating for a shift from a "saviorism" approach to one rooted in equity, self-determination, and systemic transformation.

The proposed reforms are informed by a critique of the current GHA, highlighting its origins in colonialism, its perpetuation of power disparities, and its focus on vertical, disease-specific programs that have weakened rather than strengthened African health systems. It acknowledges past successes in reducing child mortality and infectious diseases but argues these gains are unsustainable due to underinvestment in foundational health systems and an unresponsiveness to evolving health challenges like non-communicable diseases and climate change.

The paper emphasizes that the reformed GHA must be catalytic, complementary, time-bound, flexible, and rooted in equity, dignity, and solidarity. It proposes specific structural changes, including African leadership in priority setting, capacity strengthening and technology transfer, development of implementation frameworks, evidence generation, redesigning the scientific knowledge system, shaping new narratives, redesigning global health training programs, mainstreaming successes, repurposing financing mechanisms, and strengthening international coordination with a focus on African agency.

The proposed reform in the GHA envisions re-imagined African health systems that prioritize primary healthcare (PHC) as an organizing framework for health system strengthening (HSS). Key features include institutional sovereignty, knowledge-based learning systems, country-driven performance measurements, and the harnessing of indigenous knowledge. The proposed reforms are in service of the reimagined health systems and include guiding principles, the function and form of the GHA and a roadmap to reform. The roadmap includes two overlapping phases lasting five years to prepare the ground for a successful shift to HSS as a priority for Africa and an implementation/consolidation phase that hinges on the success of the first five years:

Phase A – **Redesigning Africa's health systems (2026–2030)**: This phase focuses on evidence generation to build the foundations for redesigned health systems, including reviewing and testing operational frameworks for PHC, HSS, multisectoral action, and knowledge translation. It also involves setting African health priorities to inform a new post-2030 global development framework, led by African academic/research and policy organizations with support from HIC institutions. Capacity strengthening for African institutions is a key component.

Phase B – **Reform of the Global Health Architecture (2026–2030):** This phase is a transition period where existing Global Health Initiatives (GHIs) will continue while new models are developed. It will initiate reforms in the global health research and knowledge system, including revising curricula in HIC global health institutions and reforming academic reward systems. Outputs from Phase A will inform a new post-2030 framework, and GHIs will begin structuring their strategies to incorporate HSS and earmark funds for it.

Phase C – **Implementation and Consolidation (2031 and Beyond):** This phase will focus on the full implementation and consolidation of the redesigned African health systems and the reformed GHA.

A key feature of the re-imagined African health systems is a robust knowledge system to develop the necessary global and operational frameworks for HSS, guide country-specific priority setting to inform the necessary GHA reform, provide assurances to all GHA players about the potential impact of the shift to HSS and later systematically provide evidence for decision makers within countries.

While the reformed GHA will have the same players, the role of international organizations and other HIC-based institutions will be primarily capacity strengthening and skills transfer to African institutions. Existing structures in the African knowledge ecosystem will be strengthened through training for individuals and interventions to build strong institutions including establishing well-resourced policy units to lead the continent's health system transformation.

Introduction

Koplan and colleagues (2009) define global health as: a field of **study, research,** and **practice** that prioritizes improving health and achieving equity in health for all people worldwide[11]. At its core, global health is guided by the imperative of health equity among and within nations, demanding collective responsibility and coordinated action to address shared determinants and outcomes of health. The desire to achieve equity in health outcomes has been interpreted in practice as taking actions to reduce health disparities and improve health outcomes for vulnerable populations in low- and middle-income countries (LMICs) by actors in high income countries (HICs). Over time the focus has been on improving such outcomes without any attempts to address the structural factors that create vulnerabilities in the first place. The three pillars of global health: research, study and practice are interconnected in mutually reinforcing cycles that have maintained a few health issues in the spotlight. Reforming the global health architecture (GHA) will require breaking those cycles.

The global health system is supported by a GHA comprised of: i) **international organizations** such as the UN bodies and multilaterals that set norms and standards and play a coordinating role in global health efforts; ii) **frameworks and initiatives** often negotiated and agreed upon through the UN system by member states and designed to address specific health priorities; iii) **financial actors** including bilateral and multilateral donors, development banks, international non-governmental organizations (INGOs) and philanthropic organizations which provide the financial resources to operationalize the negotiated frameworks. By design, the GHA is dominated by powerful organizations and countries, governed by processes and systems that reinforce and sustain power disparities. A study by Global Health 50/50 shows global health leadership remains heavily skewed, with the majority of global health organizations headquartered in Europe, UK and the USA[2].

Financial actors in global health provide resources in support of global health frameworks and initiatives but in line with their own policy priorities and in service of geopolitical interests. The result is support provided in ways that do not build local capacity, create dependency and have unintended consequences on the (un)sustainability of health systems in African countries. Help and support are tools of control deployed and withdrawn on the whims of the helper as recently witnessed. The tools of control extend to the outsized role played by INGOs in implementing large scale programs and their support (and control) of critical parts of the health systems like health information systems. The choice of global health priorities, with support from the global health financial architecture have resulted in vertical programs, which target specific diseases or health issues, often bypass national planning and budgeting processes, thereby limiting government control and integration of services[3]. Over time these mechanisms create "institutional substitution"—external systems that replace domestic capacity rather than build it[4]. Narratives of catastrophe from powerful actors in global health dissuade any meaningful discourse about reform.

Addressing the source of vulnerabilities including strengthening the underlying health systems has been a no-go area ostensibly because it is outside the mandate of some of the big players such as the major global health initiatives (GHIs) which have a narrow focus on specific health conditions. In addition, there are no binding global frameworks for such an approach similar to those underpinning existing GHIs. The allure of measurable tangible health outcomes like lives saved is stronger than what could be a messy Health Systems Strengthening (HSS) process where the results may not be easily measurable in a five-year funding cycle.

The crisis and opportunity

The 2025 global health financing crisis has exposed the vulnerability of aid-dependent systems and the role of global health organizations in the (dys)functioning of African health systems. It has unearthed a broken global health system characterized by power disparities – how power has been and continues to be wielded by rich and powerful countries over less wealthy and less powerful countries through actors wittingly or unwittingly acting in service of geopolitical interests. Reforming the GHA requires rebalancing the power equation but to do that, one needs to understand and disrupt the mechanisms through which power asymmetry is propagated.

Global health has roots in public health, "tropical medicine" and international health which in turn have origins in colonialism. Tropical medicine as a field grew out of the need to protect colonial administrators, their families and colonial armies from diseases in the colonized territories and to prevent diseases where they occurred and from being transmitted to other countries. In the post-colonial era, the field remained relevant since ties were maintained with former colonies. International health is concerned with health problems and challenges in LMICs linked to the protection of populations in HICs and their commercial interests and aspirations[5,6]. Global health as currently understood inherited the culture, systems and tools that center the interests of HICs and its priorities are still largely shaped by experts trained or based in HIC institutions.

Global health exists within a global political, economic and social context where narratives are formed, shaped and propagated through the education system, media, and popular culture to uphold post-colonial power structures. These narratives reinforce saviorism –the notion of countries that perpetually have problems and those that always have solutions. Interventions are based on the expertise and experience of the "savior" and not the needs and agency of the individuals being saved.

State of play: wins in global health–progress amidst imperfection

The current global health system has had successes over the last two or so decades. Remarkable progress has been made in reducing infant and childhood mortality, largely driven by advances in the prevention and management of the commonest childhood illnesses and infectious diseases in adults[7]. These have resulted in significant gains in life expectancy across many countries on the African continent. Success has been driven by concerted efforts at the global level grounded in the MDGs and later the SDG frameworks around which resource mobilization, investment in large scale service delivery programs, reductions in the cost of technologies and investments in data systems for accountability at the global level were done. Recent analyses have shown a slowing down of the rate of decline in indicators for maternal, newborn and child health and a realization that many African countries are off track in meeting the SGD targets by 2030[8]. This raises questions about the long-term sustainability and impact of this approach.

State of play: failures of the global health system

The speed at which COVID-19 vaccines were developed—within a year of the virus' emergence—demonstrated the power of scientific innovation, global collaboration, and rapid mobilization when political will aligns with public health urgency. This achievement, although marred by vaccine hoarding and inequitable access, proved that coordination across borders, sectors, and institutions is not only possible but effective. Similarly, the swift containment and response to Mpox in HICs revealed that when threats affect powerful actors, resources, attention, and action follow quickly. Thus, the GHA has repeatedly replicated colonial legacies, enabled epistemic violence, and privileged HICs institutions in agenda setting.

The health gains witnessed in the last two decades have been achieved within increasingly weaker healthcare systems with gaps in finance, staffing, or supplies and infrastructure. The success of highly visible vertical programs has continued to mask these failures.

Investments in healthcare systems have remained low often because of conditionalities to access loans from international lending institutions such as recruitment bans in the face of health workforce shortages. As a result, performance on health workforce adequacy has remained woefully poor and targets seem unattainable even in the next fifty years at current rates of change[9].

Inefficiency: The involvement of multiple funders in the health system—often with overlapping mandates and uncoordinated efforts—**create inefficiencies,** strain local management capacity and establish parallel procurement, accounting and reporting systems. A common feature of such programs is the repeated training of the few healthcare professionals in the system, imparting skills required to execute tasks within specific projects, or to roll out tools and guidelines within projects. Such training is rarely mainstreamed into pre-service curricula for healthcare professionals.

The **health system is also unresponsive to shifting local and global trends.** Guided by global health frameworks and initiatives, funders influence which health programs are prioritized and impose metrics aligned with their agendas, limiting recipient countries' policy autonomy[10]. This "structural dependence" constrains African governments' ability to define health priorities independently[11]. The continent is grappling with a quadruple burden of infectious diseases and MNCH conditions, Non-Communicable Diseases (NCDs), mental ill health, and unintentional injuries. The well documented epidemiological and other transitions and worsening quadruple burden remain overshadowed by the handful of health conditions prioritised at the global level. There have been no significant global health initiatives developed despite some of these conditions featuring in frameworks like the SDGs. Investments have remained low and policy documents have not been operationalized to address a looming public health disaster.

Amid these failures are **emerging issues and trends** like climate change, misinformation and disinformation, rapid population growth in the context of global population decline and the use of AI and related technologies. African health systems are unprepared to deal with these major trends.

Long-standing failures of global public health

Global health emerged as a defined field around 1990 partly in response to the HIV/AIDS pandemic and the concept gained prominence from the early 2000's through the first 15 years of the new millennium as the world grappled with successive threats from emerging infectious diseases[5]. Over the last 20 years, global health has become one of the most important areas of foreign, development and security policy. Due to its origins, the field has grown in parallel to other frameworks such as **primary health care (PHC)** and over time diminished their relevance.

The Alma Ata declaration of 1978 focused the world's attention on PHC as the key to achieving an acceptable level of health throughout the world by the year 2000. The declaration had elements critical to the proposed reforms. These are: i) the role of **multiple sectors,** in addition to the health sector, in the realization of this goal; inclusion: the right and duty of people to **participate** individually and collectively in the planning and implementation of their health care and; iii) the place of **PHC** – essential health services accessible to everyone, affordable, and promoting self-reliance. There is little progress in actualizing these tenets of the declaration.

The first failure is that most countries haven't operationalized the concept of **PHC** with a few exceptions. Ethiopia has successfully integrated NCD prevention, treatment, and care into its decentralized PHC system since 2014[12,13]. Rwanda has achieved near-universal health coverage through community-based, locally managed health insurance and service delivery[14]. There has also been little progress in developing new tools for health promotion and except for HIV, practical frameworks for multisectoral action. As a result, the potential and promise of PHC has never been fully realized and the concept has been overshadowed by global health whose foundations and tenets are at odds with the concept of PHC.

The second failure is the absence of practical approaches for holistic health **systems strengthening (HSS).** The WHO building blocks for HSS is a widely known framework but not easily actionable when designing HSS programs or research projects. HSS programs and research rarely look at the whole system and often focus on one or two of the building blocks. Some intangible components of a health system such as values and culture or how the building blocks interact are not well studied or seen as entry points for interventions. There is added complexity when one considers how the health systems interact with other health-producing systems. Consequently, even the most promising HSS programs may not translate into sustainable change.

"The purpose of knowledge is action, not knowledge"
– Aristotle

The third long-standing failure is weak or absent frameworks for knowledge translation, uptake and use in decision making across different levels of the health system. The GHA facilitates a uni-directional knowledge system that caters to the needs of decision makers at global level but not those at progressively lower levels of decision making. There is a disconnect between the knowledge system resident in academic and research institutions both in HICs and LMICs and the decision-making processes in government agencies relevant to the production and promotion of health. This is because the global health knowledge system consistently sidelines African scientists, rewards scientific production over knowledge translation and use, and is not set up to address the needs of decision makers. Research funding mechanisms do not support relationship building and meaningful engagement between knowledge producers and users. Lastly, the absence of knowledge uptake frameworks (policies, guidelines, laws) within countries impedes systematic uptake and use of scientific evidence.

The New Global Health Architecture (GHA)

The reformed GHA should be in service of re-imagined African health systems with the features described below. Global health as a field needs to refocus on its goal of achieving equity in health outcomes for all people worldwide – but not from a saviorism lens. The global health community must contribute to building systems that last, solving health problems decisively and acting in service of people and communities. The reform efforts should focus on shifting power, specifically the power to make decisions about what is most important for countries, from the global to local levels.

Re-imagined African Health Systems

There is a need to re-imagine Africa's health systems by leveraging the systems, processes and infrastructure that has driven the observed successes in achieving health improvements, addressing the failures of the current global health system and tackling its long-standing failures as outlined above. Central to the re-imagined African health systems is the sovereignty and agency of Africans at all levels. At the heart of re-imagined health systems is **institutional sovereignty** whereby domestic institutions control priority-setting and resource allocation and where external support reinforces rather than replaces national capacity. The reform process for African health systems will require a stepwise approach grounded in scientific evidence.

The immediate actions for reform therefore revolve around **generating new knowledge** to guide actions by different players in the GHA and to progressively create confidence in the re-imagined African health systems.

These health systems must **prioritize PHC as an organizing framework for HSS:** The global health system is at odds, and in competition, with the concept of PHC, which has the potential to deliver more health gains than the current approach. Prioritising PHC is aligned with recommendations in the Lusaka Agenda that calls for GHIs to play a role in HSS through integrated health services and aligning funding with national health plans[15]. Africa's health systems need solutions that will deliver health outcomes at the least cost. Apart from being potentially more cost-effective in the long term, PHC also aligns very well with the vision of agency and self-determination. It also offers standard scaffolding and a framework around which HSS models can be built, and for country-specific priority setting based on the local epidemiological, cultural, social, economic and political factors.

In line with the PHC framework, Africa needs **health systems that serve and work for everyone.** Country health systems should be built based on local epidemiological profiles and considering other long-term trends. Related to this is the need to develop practical models for connecting the health system with other health-generating systems, taking a **whole-of-government approach** to health by developing mechanisms through which all sectors can play a role in generating and maintaining health.

The reimagined health systems must be **knowledge-based learning systems.** This entails knowledge systems that are responsive to local needs including data systems that serve national, sub-national and local levels of decision making. Greater emphasis should be put on national level accountability mechanisms as the basis for global accountability. This will require investments in the national data ecosystems with complementary roles played by different players as articulated in the African Data Revolution report[16]. Other than strengthened data systems there is a need for **systematic knowledge translation and use mechanisms** including laws, policies and guidelines which obligate data use and which will, over time, institutionalize a data use culture in the health system.

Measurements of health system performance should be country-driven and embedded in a change management strategy not to feed into distant global accountability mechanisms. With a proposed shift in focus to HSS aligned to PHC, there is a need to build measurement systems that progressively track progress in that area alongside those that measure population level health outcomes to ensure that health gains made in African countries are not reversed during the transition phase.

In the longer term, and in line with the spirit of self-determination there is also a need to develop mechanisms to harness local and indigenous knowledge in meaningful ways to inform health priorities for communities and develop solutions to local problems.

Key actions:

1) Establish a common understanding of what PHC is, whether the Alma Ata framing is still relevant and whether the concept needs to be updated to align with the current realities. There will also be a need for new knowledge about how countries can integrate PHC in their HSS strategies, potential health gains, costs and ways in which priorities of global health funders can be aligned with respective country PHC strategies.

2) Developing practical models for multisectoral action by leveraging existing theoretical frameworks and practical examples from HIV/AIDS prevention to support country level adoption and maintenance at scale. The role of the health sector needs to be clearly delineated in specific multi-sectoral actions with well-articulated mechanisms for resource allocation to various sectors and measuring outcomes and impact from all health-producing sectors.

3) Generate evidence on the potential impact of taking a whole-of-government approach compared to the status quo, the cost of taking this approach, practical ways in which this could be done, the required resources, and the systems and structures required for different phases of implementation.

4) Strengthen **national data systems** across the whole evidence value chain and delineate roles for all players in national data ecosystems including traditional data producers like academic and research institutions in strengthening health data. Establish evidence and **knowledge translation structures** within academic and research institutions linked with government agencies to drive the generation and translation of knowledge and build a strong data use culture in the health system.

5) Develop tools for aggregation and analysis of multiple data types and sources – including from other health-generating sectors, environment, administrative, among others and explore the role of new data science tools in analyzing non-traditional data to generate insights about health system strength and performance

6) Establish a coordinated continent-wide initiative to document, promote and harness indigenous knowledge including tools for measuring and quantifying African expertise based on such knowledge and lived experiences.

Reimagining the GHA for Africa Towards Equity, Self-Determination, and Systemic Transformation

This proposal is a pragmatic guide for transforming the GHA in service of Africa's health aspirations, providing pathways to equity, systemic resilience, and long-term sustainability. It calls for a reimagined GHA that is catalytic, responsive to demand, equity-centered and with greater African leadership–a just system that centers Africans' agency to define priorities, develop solutions, and lead implementation. The future GHA must be guided by the following principles:

i) Catalytic, not substantive: Global health financing actors must invest in programs catalyzing system change and not in those that become a permanent fixture providing critical health services. International organizations should support and catalyze HSS rather than substituting local institutional capacity. They should focus on innovation and catalyzing change processes that support Africa's journey to self-determination, sustainable capacity-building while leaving planning and service delivery to national and regional entities.

ii) Complementary, not competing: Interventions by actors in the GHA should be aligned with new thinking around the place of PHC as an organizing framework for HSS. Recognising the misalignment between the ideals of PHC and global health as currently practiced demands a rethink of how the latter can be reformed in support of the former. The year 2030 provides an opportunity for a new global framework developed from the bottom up that truly represents Africa's health aspirations not those imposed through existing global health mechanisms.

iii) Time-bound and flexible: The GHA must invest technical and financial resources in building new health systems with time-bound measures of progress and success. It must be responsive to changing dynamics within countries including health emergencies, political transitions, and technological shifts. Interventions must be iterative and adaptable based on new knowledge. Investing in knowledge and learning systems with strong implementation science expertise is a necessity.

iv) Rooted in equity, dignity and solidarity: At its core, global health must center equity in pursuit of justice, recognizing historical injustices and power asymmetries while actively working to redress them. Solidarity must replace saviorism, and humility must guide engagement.

The core **functions** of a re-imagined GHA will be to support Africa's journey to self-determination. It will also require building the political and diplomatic acumen on both sides for a mindset shift from saviorism to meaningful partnerships and mutual respect.

The reformed GHA will serve different but interconnected functions in the short to long term outlined below alongside the structural changes that are needed.

Table 1 functions and structural changes for the new global health architecture.

Function	Structural change needed
1) **Developing new global frameworks** aligned with a vision for sustainable HSS. Like the global frameworks that underpin current global health priorities. International organizations in the GHA have a duty to support the development of new frameworks for HSS. The impending end of the SDG era is an excellent opportunity to ensure a truly African-owned agenda towards this goal.	• Leadership by African institutions i.e. continental and regional bodies and research and policy organisations in determining African priorities – to inform a new global framework
2) **Capacity strengthening, Technology and Skills Transfer:** International organizations, academics and researchers from HICs have a role to play in skills transfer and institutional capacity strengthening for African institutions to fully own country health agendas and drive the envisaged HSS initiatives. Institutional capacity strengthening entails provision of long-term, trust-based, and flexible funding, support for strategy development and building finance, grants and governance systems. GHIs have developed tools and platforms for procurement, supply chain management, and financial accounting that should be mainstreamed into national health systems as appropriate.	• Progressive power shifting from HIC-based to African institutions. The former may lead co-created and co-designed implementation research processes with African academics, researchers, and decision makers with substantive technical roles assigned to Africans in the evidence generation and use processes. The aim is a progressive transition to African leadership in the medium term (~5 years).
3) Developing **implementation frameworks** for PHC, HSS, knowledge transfer and use and multi-sectoral action. This will require partnerships between African academic and research institutions, relevant ministries and academics and research institutions in HICs.	• Establishing research to policy and knowledge translation units within academic/research institutions in Africa to build linkages with decision makers sustainably
4) **Evidence generation:** There will be a need for evidence on numerous components of the re-imagined African health systems including the "how" of operationalizing critical frameworks like PHC, HSS and multisectoral action, potential health impacts, costs, econometric modelling comparing this approach with the status quo, incorporating new mega trends in HSS among others. This will require partnerships between global health academics and African ones.	• Dedicated funding mechanisms to facilitate relationship building, evidence needs identification and outreach
5) **Redesigning a new scientific knowledge system** where a higher proportion of research conducted is aligned with the needs of decision makers at all levels will take a concerted effort from researchers in HICs, science funders, and international organizations which use research knowledge. Beyond skills transfer and capacity strengthening for African researchers, there will be a need to develop new funding models guided by principles of localization, equitable partnerships and inclusion. This entails more funding for identification of evidence needs at different levels of decision making, sustained engagement and relationship building with decision makers and communities and mechanisms of flexibly responding to evidence needs. New knowledge is needed on prototypes and models for narrowing the translation gaps and addressing the translation crisis.	• Overhauling the reward systems in science and academia, developing and applying new metrics for assessing grant applications in translational research to incorporate potential for successful translation.
6) **Shaping new narratives:** Media, training curricula, and research must be reframed to centre African voices and realities. The dominant narratives that portray Africa as passive, dependent and perpetually in need of saving must be replaced by ones that reflect agency, innovation, and leadership. All global health actors must acknowledge and then shed the field's colonial roots	
7) **Redesigning global health training programs:** Global health needs to shed its colonial roots propagated through training programs in HICs. Current global health curricula need to be revised to eliminate concepts and narratives that perpetuate saviorism and include concepts that promote equity, justice and solidarity. The training programs need to acknowledge the field's history with an aim to develop programs that shift power from individuals in HICs to those in LMICs. At the same time, there is a need to establish training programs in global health in LMICs that elaborate on the power disparities that have plagued the field, political determinants of health and health diplomacy, while providing alternative models of engagement grounded in equity and justice, emphasizing agency, dignity and pathways to self-determination.	• HIC-based global health academic institutions to develop curricula re-imagining global health and facilitate knowledge transfer to selected regional training hubs in Africa that will coordinate training in global health on the continent
8) **Mainstreaming success:** Supported by strong measurement and learning systems within countries, multilateral agencies, academic and research institutions in HICs working in partnership with African institutions should spearhead a process of documenting success stories and mainstreaming key elements and drivers of success into national policies, legislation and pre-service training programs.	• Develop frameworks for mainstreaming success including systematic measurement, learning and documentation by program implementors, funding agencies and national academic institutions. Establish regional hubs to review success stories and facilitate development of pre-service training curricula to be adapted to country contexts.

Function	Structural change needed
9) Financing – resource mobilization: Current global health initiatives should repurpose their infrastructure and mechanisms to continue mobilizing financial resources from HIC governments, philanthropy in HICs and LMICs, governments in Africa and other LMICs. The next replenishment rounds will coincide with a new global framework in place of the SDGs and this gives ample time to transition to a mechanism to support HSS in Africa. Current global health initiatives need to be progressively phased out and replaced by a fund to catalyze HSS in line with the Lusaka Agenda recommendations. Within this fund countries may access resources to continue supporting existing programs based on their own prioritization in addition to accessing funds earmarked for HSS. Alongside this function should be mechanisms to mobilize domestic resources: future global health initiatives must have in-built mechanisms for African countries to transition to self-sufficiency based on measurable progress in their HSS journey – not on economic indicators like GDP.	• GHIs retain a critical role in funding global public goods and applying innovative financing mechanisms like the International Finance Facility for Immunisation (IFFIm), advance market commitments, and pooled procurement to maximize efficiency in sourcing critical technologies – applied to new priorities. Consolidating the GHIs into a single health system delivery initiative would provide greater efficiency and coordination at the global and national level. • Increased domestic investments in health by African governments supported by robust evidence on cost-effectiveness and focused on progress in HSS and whole population health outcomes. The proposed health policy units would provide the needed evidence.
10) International coordination: multilateral agencies will retain a role in addressing and mitigating global health threats through operationalizing existing frameworks such as the WHO Pandemic Agreement. Alongside this coordinating role, they should play a role in skills and capacity transfer to continental and regional institutions to take a progressively greater role in this area.	• An African-led priority setting process by African research and academic institutions, continental bodies like Africa CDC, regional health agencies like ECSA-HC and WAHO. Existing GHIs and multilaterals may provide demand-driven technical assistance for this process.
11) Priority setting: existing GHIs are well placed to coordinate a bottom-up priority setting process that is consultative and inclusive to guide their transition to a more system-wide agenda. GHIs must decenter saviorism and embrace a values-based approach grounded in equity, justice and self-determination.	

The roadmap to reform

Reform is in service of the African continent's needs and so it is important to first define those needs and develop clear frameworks through which those needs will be actualized. Secondly, the African continent therefore needs to be adequately prepared for this reform to play its rightful role within the re-imagined GHA.

The reform will be evidence driven to: provide actionable guidance to decision makers with the continent and the GHA, rationalize and justify choices in the re-imagined African health systems, provide assurances and confidence to the national governments in their choices, provide assurances and confidence to the global health players about maintaining health gains even with these choices, validate assumptions made in efficiency gains, impact and sustainability, provide assurances about the underlying theory of change for the reform. The roadmap has three phases. Conceptually these are distinct phases but practically they will overlap

A – Redesigning Africa's health systems (2026–2030)

This will be an evidence generation phase to build the foundations for the redesigned health systems on the continent. It will include reviewing, developing and testing operational frameworks such as HSS, PHC, PHC as a scaffolding for HSS, multisectoral action, and knowledge translation and use. There will be a parallel process for setting health priorities for the continent to inform the post-2030 global development framework and inform future HSS strategies within the countries and GHA. This process will involve some analytic work to create epidemiological profiles for countries/regions and models about the future scenarios that take the major trends like climate change and population growth into account. In addition, analyses will be done testing the potential impact of different policy choices e.g. a shift to HSS versus disease-specific approaches. The results from this phase will be shared with decision making bodies on the continent including Africa-CDC, AU, various regional and continental parliamentary groupings for validation and buy-in.

These processes will be led by African academic/research and policy organizations with support from HIC-based academic/research organizations and multilaterals like WHO in the first three years with overall coordination by Africa CDC.

There will be a capacity strengthening phase to prepare African institutions to play a leadership role in the future health systems. This will entail targeted training programs to build skills in critical areas to drive the analytic work in the short term and to provide systematic technical support to African governments in the medium and long term. In addition, this phase will include establishing institutions such as policy units within academic/research institutions mandated to support governments in HSS and the attendant knowledge generation and use.

INGOs, multilateral institutions, HIC-based academic/research institutions will support this process through skills transfer programs including short- and long-term training, coaching and hands-on mentoring.

Activities in this phase will need support from research funding agencies through the establishment of special funding mechanisms for research and capacity strengthening to support HSS in Africa.

B – Reform of the global health architecture (2026–2030)

This phase will include a transition period in which GHIs and other funding mechanisms will continue while building a foundation for substitution with new models – developed and refined in Phase A above. During this phase, reform in the global health research and knowledge system will commence by reforming training curricula in HIC global health institutions, developing training programs in global health on the African continent and taking the first steps towards reforming the academic reward system - led by global health research funders.

This process will be led by HIC-based research/academic institutions and research funders and will take place in the first 3 years, overlapping with the previous phase.

Outputs from Phase A will inform a new post-2030 framework, so the timing will be aligned with the global process. It is important to identify entry points as soon as possible and ensure that the African priority setting process in Phase A contributes meaningfully to the framework. Once the post-2030 framework is approved, country-specific and continental level accountability mechanisms will be developed in parallel to the global one. The policy units established in Phase A with coordination from Africa CDC and support from multilaterals will lead this process.

The end of the analytic and priority setting process in Phase A will provide information to guide the next replenishment round of the existing GHIs. As the GHIs prepare for a new role, they should structure their strategies for continuity of existing programs while incorporating HSS. The next replenishment rounds should therefore have funds earmarked for HSS and a time frame for phasing out disease-specific interventions. Financing Africa's future health systems will require domestic funding. The policy units established in Phase A will lead in-country outreach and advocacy processes to guide mobilization of funds by African governments and investment in sustainable HSS. Players in global health financing will continue playing a critical role with active engagement by African leaders, civil society and academia in aligning their priorities.

C – Full implementation and consolidation (2031 and beyond)

Reforming the GHA is a long-term undertaking and requires a well-coordinated approach. It requires a mindset shift with African institutions and individuals stepping up to take a leadership role and other players in the GHA stepping back, ceding power and seeing their role as complementary with system transformation as the goal. The first five years will lay a strong foundation on which Africa will build new health systems. The success of the proposed reforms hinges on the outcomes of interventions in the first five years and whether the global health community rallies around this vision of transformation.

In the phase beyond five years, African countries will progressively roll out their HSS strategies based on their readiness, availability of funding, presence of sufficient capacity and other contextual factors. At the beginning of this phase, African countries will start developing or will have developed the relevant policies, strategies, implementation and measurement, evaluation and learning (MEL) plans for a HSS agenda. The rollout will be closely monitored and supported by a robust MEL agenda documenting lessons and failures, replanning and course correction as necessary.

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About Catherine Kyobutungi

Catherine Kyobutungi is the Executive Director of the African Population and Health Research Center in Kenya and the Co-Director of the Consortium for Advanced Research Training in Africa.

Designed by Wellcome.

Wellcome Trust, 215 Euston Road, London NW1 2BE, United Kingdom
T +44 (0)20 7611 8888, E contact@wellcome.org, wellcome.org

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