



# From rethinking to reform: the way forward for the Global Health System

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A global synthesis across  
five regional dialogues

March 2026

## Disclaimer

This paper captures the outcomes of five regional dialogues on global health reform supported by the Wellcome Trust and led by regional partners. The views and opinions expressed throughout the dialogue are those of individual participants, and do not necessarily reflect the official policy or position of Wellcome or of regional partner organisations.

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## Acronyms

<b>AfCFTA:</b>	African Continental Free Trade Area	<b>LACHCP:</b>	Latin America and the Caribbean Health Catalytic Platform
<b>Africa CDC:</b>	Africa Centres for Disease Control and Prevention	<b>MDBs:</b>	Multilateral Development Banks
<b>AMA:</b>	African Medicines Agency	<b>M&amp;E:</b>	Monitoring and Evaluation
<b>APRM:</b>	African Peer Review Mechanism	<b>OIC:</b>	Organization of Islamic Cooperation
<b>ASEAN:</b>	Association of Southeast Asian Nations	<b>ODA:</b>	Official Development Assistance
<b>AU:</b>	African Union	<b>PAHO:</b>	Pan American Health Organization
<b>DPIs:</b>	Digital Public Infrastructures	<b>PFM:</b>	Public Financial Management
<b>GAVI:</b>	Global Alliance for Vaccines and Immunization	<b>PHC:</b>	Primary Health Care
<b>GHIs:</b>	Global Health Initiatives	<b>PDPs:</b>	Product Development Partnerships
<b>HEAR CSO:</b>	Health Architecture Reimagined Civil Society Organisations	<b>PPPs:</b>	Public–Private Partnership
<b>HTA:</b>	Health Technology Assessment	<b>REC(s):</b>	Regional Economic Community / Communities
<b>ICRC:</b>	International Committee of the Red Cross	<b>RPGs:</b>	Regional Public Goods
<b>IDA/IBRD:</b>	International Development Association / International Bank for Reconstruction and Development	<b>SIDS:</b>	Small Island Developing States
<b>IMF:</b>	International Monetary Fund	<b>UN:</b>	United Nations
<b>LAC:</b>	Latin America and the Caribbean	<b>UNGA:</b>	United Nations General Assembly
		<b>UN80:</b>	UN80 reform initiative
		<b>WHA:</b>	World Health Assembly
		<b>WHO:</b>	World Health Organization

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# Foreword

2025 was a dark year for global health. Major cuts to aid budgets internationally – most strikingly from the closure of the U.S. Agency for International Development (USAID), followed by reductions across European countries – have undermined health efforts worldwide and will cost millions of lives in the next few years.

These cuts have weakened a system that has long needed reform but was, until now, resistant to change. Over the past two decades, global health has driven enormous progress, saved lives and improved health globally. But we've also ended up with a system that has normalised inequity and ineffectiveness. Too often, global health has been something that has been done to countries rather than by or with them. Now we have an unprecedented opportunity to address this, with countries demanding change.

As one of the world's largest independent philanthropies dedicated to improving health for everyone, Wellcome has both the opportunity and responsibility to help respond to these calls. Over the past decade, we have supported new models of global cooperation, contributed to major reforms in pandemic preparedness and financing, and consistently convened diverse voices to build common ground and drive change on urgent health challenges.

There are difficult questions to be answered. With less money in the system, how do we ensure all countries can build and sustain strong, country-led health systems? How do we create a global health architecture that is relevant and responsive to all countries, regardless of income level or health needs? And how can we turn these ideas into reality?

Over the past year, Wellcome has worked with partners across the world to bring together leaders and experts from government, multilateral and global health organisations, the private sector and civil



Image credit: Vicki Couchman / Wellcome

society to begin exploring these questions and find ways forward. To start, we commissioned five thought leaders to set out their visions for reform – to show that a real reimagining of global health is possible. This is a moment for ambition, not small tweaks.

This was followed by five regional dialogues (Latin America and the Caribbean, Africa, Asia Pacific, Europe and North America and the Middle East and Central Asia) on the future of global health, shaped and led by local partners. Stakeholders from 114 countries – who came together through interviews, virtual consultations and in-person meetings – explored priority areas for change and ways reform could be realised. The ideas raised in these dialogues have been shared in five regional papers to inform regional and global deliberations.

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**John-Arne Røttingen**

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**John-Arne Røttingen**

This report brings all these reflections and recommendations together. What comes through is a clear appetite for substantive reform. Perspectives were diverse across the regions, but they share a clear message: the current global health system is strained, overly centralised and unable to meet the world's needs. Deep change is needed if we are to build a more equitable, coherent global health system genuinely shaped by the people it is meant to serve. Regions must be empowered to drive global health.

All five regions agreed on three priority areas for reform:

- **Governance:** Clarify and streamline the roles of organisations, and shift power towards regions and low- and middle-income countries (LMICs).
- **Financing:** Ensure international financing fits each country's needs, and increase national and regional investments in health.
- **Data, knowledge, products:** Build stronger regional data systems and shape markets to make sure everyone can get the health products they need.

Next, at a global convening in April, we will bring stakeholders from all five regions together to explore areas of emerging consensus for reform and, most crucially, the pathways to turn them into action. We hope this work will provide a platform for others to build on, ensuring good ideas can be translated into real change.

This work sits alongside – and we hope supports – other important reform initiatives, including the Accra Reset, the EU donor reflection process, the Lusaka Agenda follow-up, HEAR CSO, the Sevilla Platform for Action as well as the emerging World Health Organization (WHO) processes and wider UN80 reforms. The challenge for us all this year will be bringing these strands together into a coherent and powerful push for change.

If we get this right, history will mark 2026 as the beginning of a positive new era for global health. A moment of reinvention, rather than decline. The moment where collective action turned a crisis into an ambitious coordinated approach. One driven by equity, effectiveness and efficiency to deliver better health outcomes for everyone.

What happens next depends on our willingness to move forwards together – and to seize this moment to build a healthier future for all.

**John-Arne Røttingen**  
CEO, Wellcome

# Executive Summary

In 2025, Wellcome supported five regional dialogues, led by partner organisations, that brought together stakeholders from over 114 countries to consider the following questions:

- What are the key challenges with the current global health architecture and what is working well?
- What should the future function and form of the global health architecture be, and which reforms are needed to achieve this?
- What next steps need to be taken to enact these reforms, and how can they be enabled in a collective way forward?

This paper draws together the outcomes of these regional dialogues, examining where perspectives converged or diverged, and what that means for reform.

**Stakeholders across regions agreed that the current global health ecosystem has delivered clear benefits, but persistent flaws are hindering progress.**

Elements of the current ecosystem identified as being valuable include: the WHO's normative function; technical cooperation to leverage international expertise; multilateral partnerships driving financing, innovation and disease-specific progress; and sustained humanitarian presence to support health.

However, across all regions, the current global health ecosystem was seen as unfit for purpose. All dialogues attested to critical shortcomings, including: the incoherence and inefficiency of the architecture; power imbalances in decision making, agenda setting and defining the narrative; accountability and implementation gaps; external financing dependency; fragmented international health financing, distorting systems and eroding efficiency; gaps in data sovereignty and knowledge

exchange; and fragile capacity for production and supply of key commodities.

**To address these bottlenecks, participants from the five regional dialogues converged on a vision of a decentralised global health ecosystem driven by countries, anchored in regional hubs and backed by a leaner, more streamlined global architecture.**

This new global health ecosystem should work to improve health outcomes and deliver collective value for all by supporting in the delivery of regional and global public goods, providing responsive international coordination and – where needed – ensuring effective assistance aligned with country-led trajectories. This ecosystem should also be responsive to changes in disease burden and determinants, and allow for differentiated approaches based on distinct contexts and needs.

Achieving this vision requires adherence to key principles of sovereignty, subsidiarity, equity and coherence. It also requires clarity on the critical functions that will be needed at regional and global levels. Dialogues highlighted the importance of priority setting at the national level to ensure local relevance and ownership. This should be complemented at the regional level by regional priority setting to harmonise national needs and address shared challenges, technical cooperation and coordination, provision of regional public goods and mobilisation of resources. The role of the global level then becomes the setting of technical norms and standards, global stewardship and coordination, and mobilisation of coordinated finance.

**Beyond this foundational vision, dialogues across all five regions commonly identified key reforms around governance, financing, and data, knowledge and products.**

Each regional dialogue surfaced unique insights and perspective on what – practically speaking – reforms should look like. Collectively, the dialogues also outlined key next steps and established new questions to advance these common reform priorities across governance, financing, data, knowledge and products.

## **Governance**

Responding to the need to reduce duplication, competition and blurred global–regional roles, the regional dialogues converged on two priorities for mandate reform:

- Clarifying and rebalancing the global–regional division of labour.
- Streamlining mandates, especially at the global level.

Enabling regional health capacities was also seen as essential in making the global health architecture more responsive, equitable, effective and resilient. In practice, this would mean leveraging proximity and local expertise, and ensuring regional organisations can speak with a coherent, unified voice. Deepening the mandates and decision-making power of organisations that are regionally established, owned and led was also seen as depending on the strengthening of regional and sub-regional health coordination, expanding shared operational capacities and developing regional public goods.

In parallel, regional dialogues saw a shared acknowledgement that improving global health decision making would require a rebalancing of board representation to elevate the voice and authority of low- and middle-income countries and regions. The need to hardwire civil society and other nonstate actors into governance at all levels was also emphasised. Consensus also emerged on the need to make accountability mechanisms more reciprocal and increase their credibility and consequences.

## **Financing**

Regional dialogues agreed that countries must lead in increasing both the quantity and quality of domestic health financing and manage sustainable transitions. Alongside this, macro-financial constraints must also be addressed.

All regions agreed on improving the quality of international health financing. In line with the Lusaka Agenda, regions called for better aligned, simplified and more predictable external financing, alongside an evolving role for Multilateral Development Banks (MDBs). Regions also proposed bolstering regional financing mechanisms to support regional public goods.

## **Data, knowledge and products**

Stakeholders across regions agreed on the need to reinforce interoperable, regionally governed health data and knowledge systems – underpinned by strong digital infrastructure, clear data governance and structured knowledge exchange – to enable trusted evidence and stronger cooperation.

Across regions, there was also consensus that health markets must be proactively shaped to ensure equitable access, greater resilience, and increased regional sovereignty after the inequities seen during COVID19. This should include pooled procurement as well as distributed and better regulated manufacturing of health products.

This is also viewed as an opportunity to create economic benefits, aligning health and economic objectives within a shared framework.

**The implementation of reforms will require navigation of the rapidly shifting global economic and political context.**

While regional dialogues strived for consensus and the identification of specific next steps, setting out the “how” of reforms, particularly at the global level, remains a challenge. Furthermore, several reforms identified through the dialogues will depend on politically sensitive shifts and may be subject to resistance.

Realising a more equitable, effective and efficient global health ecosystem will therefore rely on several critical enablers: active leadership from LMICs and regions; alignment of ambitious technical reform proposals with high-level political authority; dynamic coalitions among stakeholders to advocate for and implement reform; and an iterative process that can deliver quick wins and sustain larger changes. It will also require partners to work together to resolve key outstanding questions, utilising upcoming regional and global health reform discussions to ensure a clear and united path forward.

**Substantive change in global health is inevitable. But successful reform of the global health ecosystem depends on working together, with all regions meaningfully engaged as co-architects.**

Governments must establish and execute a shared direction for reform. They must also strengthen and align financing behind one plan, and enable devolution where it adds value. Regional organisations must build shared systems, take on clarified functions and harmonise markets. Global organisations must become leaner and more streamlined. They must also back regional actors, align with country plans and fix financing instruments. Civil society, think tanks and academia must strengthen voice, evidence and accountability. Through a coherent and aligned effort across regions and stakeholder groups, we can seize the current window of opportunity and deliver a global health ecosystem that can match the health needs of today and tomorrow.

# Background

There is no doubt that political and financial shifts over the last 12 months have presented an unprecedented challenge to global health. Notably, these shifts have resulted in major cuts to donor aid which already cost lives and risk the compounding of global inequities. But even before these shifts, 4.6 billion people didn't have access to basic health services<sup>1</sup> and the world remained unprepared for future pandemics. While there is no easy fix and the prospect of progress is still highly uncertain, this current moment of crisis can be seen as opening a window for change. There is now a long-awaited and much-needed opportunity for transformative reform that builds a better and fairer global health system for the future.

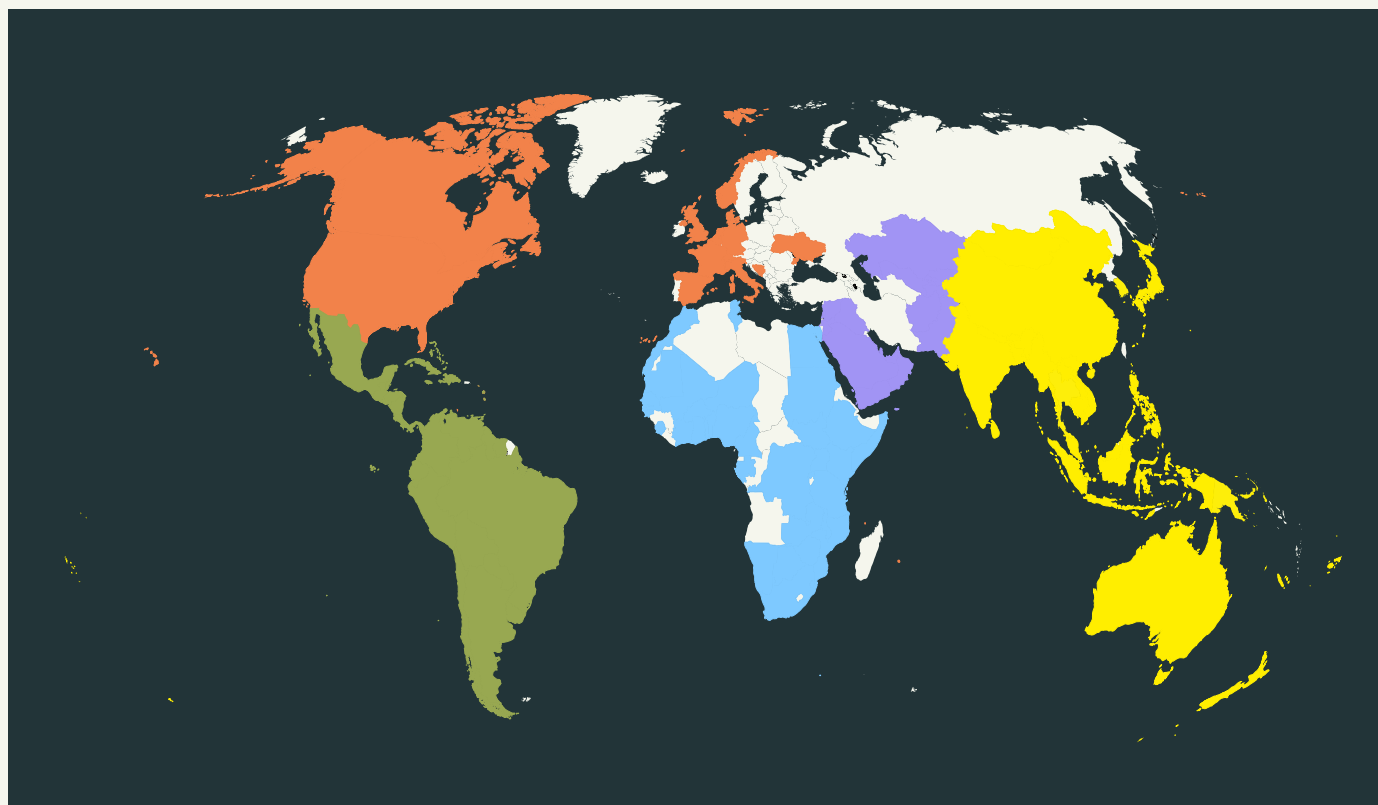
Over the past decade, initiatives such as the Lusaka Agenda and others, have been working to foster evolution in the architecture of global health<sup>2</sup>.

However, the changes needed and the changes that are possible are dramatically different in this new context.

By its nature, global health reform needs a *global* response. It cannot be decided upon by one organisation, country or region; it requires collective intelligence and decision making from around the world. In 2025, to complement other reform initiatives, Wellcome supported five regional dialogues on global health reform in Latin America and the Caribbean, Africa, Asia Pacific, Europe and North America and the Middle East and Central Asia<sup>3</sup>. These dialogues were led by partner organisations from each region, who brought together key actors for candid deliberations on what reforms to the global health architecture are needed and how these can be made possible.

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## Countries engaged across five regional dialogues on global health reform



The five dialogues drew on experience and expertise from over 114 countries, including representatives from national governments, regional organisations, the WHO and the wider UN system, MDBs, non-governmental organisations (NGOs), civil society, philanthropic foundations, the private sector, community organisations and others (see map). While each dialogue was unique, they all included a consultation phase and an in-person convening, which took place from August to November 2025 (see Box 1 for more detail on the dialogues).

### Box 1

## Overview: Regional dialogues on global health reform

### Organisations that designed, led and facilitated the dialogues in each region:

- **Latin America and the Caribbean:** Tecnológico de Monterrey (Mexico) with the Institute for Clinical Effectiveness and Health Policy (Argentina), Universidad Mayor (Chile) and University of the West Indies (Jamaica).
- **Africa:** Amref Health Africa (Kenya).
- **Asia Pacific:** The PMAC Strategic Institute with the International Health Policy Program Foundation (Thailand), the Saw Swee Hock School of Public Health, the National University of Singapore (Singapore), the Vanke School of Public Health and Tsinghua University (China).
- **Middle East and Central Asia:** The Eastern Mediterranean Public Health Network (Jordan) with the Middle East Council on Global Affairs (Qatar) and Nazarbayev University School of Medicine (Kazakhstan).
- **Europe and North America:** Panorama Strategy (USA) with SEEK Development (Germany).

### Consultation phase: Surfaced perspectives and priorities from country and regional actors, and started to identify areas of convergence and divergence. Across regions:

- A total of 1790 participants were engaged through online surveys to garner insights, test hypotheses and collect reform proposals.
- A total of 204 key informants were interviewed, exploring challenges of the current system and reform priorities.
- Many regions also conducted virtual focus group discussions or workshops at the sub-regional level.
- Consultation activities were complemented by iterative policy analysis, and synthesis by lead organisations.

### Convening phase: Developed and cemented areas of consensus, and unpacked and debated contested areas, to move towards regional convergence on priorities and concrete steps for reform.

- Authoritative and constructive groups of participants came together for frank and inclusive deliberation.
- Five convenings, in Berlin, Amman, Singapore, Kigali and Mexico City, brought together 273 stakeholders.

While the dialogues started with an assessment of the current global health architecture, their focus was forward-looking, addressing the following core questions:

- What are the key challenges with the current global health architecture and what is working well?
- What should the future function and form of the global health architecture be, and which reforms are needed to achieve this?
- What are the next steps to enact these reforms, and how can they be enabled in a collective way forward?

Drawing on the consultations and convenings, each regional dialogue produced an outcomes paper capturing participants' reflections and recommendations <sup>4, 5, 6, 7, 8</sup>. These five papers offer distinct regional insights as well as concrete proposals for reform at both the regional and global level.

This synthesis brings these regional dialogues together, examining where perspectives converge or diverge, and what that means for reform. It is intended that these lessons and priorities will complement other analysis (such as the EU and likeminded donor reflection process), and contribute to ongoing reform efforts, including the Lusaka Agenda, Accra Reset, Sevilla Platform for Action, HEAR civil society and the emerging WHO-convened process, as well as the wider UN80 process.

The paper is organised as follows: Section II takes stock of the current system; Section III outlines the vision, principles, and functions of the future ecosystem; Section IV sets out key areas for reform, proposed next steps and outstanding questions; Section V considers the collective way forward and concludes.

# Stocktake of the current system

All five regional dialogues surfaced insights on how the current global health ecosystem functions, highlighting where it has delivered clear benefits and where persistent flaws are hindering progress.

## 1. Strengths

There is agreement across regions that the global health ecosystem in its current form has contributed to vital progress. Elements of the ecosystem that are identified as being particularly beneficial include:

### 1.1. The WHO's normative function

The WHO's role in providing global technical standards and guidance is highlighted as essential, and a critical global public good. While there are calls to make guidance more responsive to country and regional realities, the WHO's normative function is seen as an important and legitimate anchor in an increasingly complex ecosystem.

### 1.2. Technical cooperation to leverage international expertise

International technical cooperation and knowledge sharing mechanisms have enabled countries to access expertise and standards they may not have the capacity to develop independently. In particular, collaboration and learning platforms have created advantages for smaller or less-resourced countries to benefit from global knowledge.

### 1.3. Multilateral partnerships driving financing, innovation and disease-specific progress

Innovative multilateral collaboration has helped several countries deliver measurable gains in priority health areas including HIV, tuberculosis, malaria and immunisation, as well as in maternal and child health. These gains were supported by multilateral partnerships, such as GAVI, the Global Fund, the Global Financing Facility and others, who are recognised for mobilising and pooling extensive international resources, market shaping mechanisms to lower prices and improve access to health products, and multistakeholder governance.

### 1.4. Sustained humanitarian presence to support health

The Middle East and Central Asia dialogue highlights the critical role that neutral actors such as the International Committee of the Red Cross (ICRC) and humanitarian NGOs continue to play to maintain access to essential health services and complement broader health system efforts in fragile and conflict-affected contexts.

Despite these successes, all regions view the current global health ecosystem as unfit for purpose. More specifically, shortcomings in governance, financing, knowledge exchange and product supply are highlighted as undermining efficiency, effectiveness and sustainability.

## 2. Weaknesses

### 2.1. Outdated narrative

Global health still operates on an “aid-first” narrative that shapes the ecosystem, casting countries and regions – especially in the Global South – as recipients, not co-architects. In this outdated approach, decision making and technical authority sit with external organisations, shaping priorities from the outside and reinforcing dependency. Success is framed in terms of donor compliance and implementation of vertical programs, rather than joint contribution to public goods, building domestic leadership and delivering long-term system strengthening at national, regional and global levels.

### 2.2. Incoherence and inefficiency

The global health architecture is extensive but lacks coherence, exacerbated by the lack of a common vision of success. Roles are blurred between global organisations, as well as between global and regional organisations. Mandates overlap and actors frequently compete rather than complement each other. Institutional responsibilities are unclear and parallel initiatives proliferate – instead of coordinate – around country priorities. This fragmentation and lack of system-wide decision making hampers the ecosystem’s effectiveness.

### 2.3. Power imbalances

Health governance remains dominated by high income actors and regions, and is overly centralised at the global level. Four out of five regions – Africa, Latin America and the Caribbean, Asia Pacific, and the Middle East and Central Asia – emphasised in their dialogues that their region does not have sufficient authority in global health decision-making structures – for example, on boards and in the governance processes of global health organisations. This reinforces dependency and inequity, with LMIC governments and civil society under represented and less influential in priority setting, program design and oversight. It also leads to some actors feeling “at the margins” of a system conceived, financed and governed from the Global North, which does not adequately incorporate country and regional needs, expertise and ownership.

### 2.4. Accountability gaps

The absence of effective accountability mechanisms in global health leads to a persistent gap in the implementation of commitments. Without more binding mechanisms or incentive systems, collective commitments to providing global public goods are seen as aspirational. Several dialogues also highlighted the one-way nature of global health monitoring, tracking country performance against donor targets. In contrast, equivalent mechanisms to track donor alignment with country priorities are either weak or absent – this perpetuates power imbalances and undermines trust.

### 2.5. Continued external financing dependency

Insufficient domestic health investment and the overreliance of some countries on external finance not only constrains country ownership and health sovereignty at the national level, but also undermines their agency in the global health ecosystem. A lack of adequate mechanisms to build domestic financing capacity and plan for a responsible transition from external financing is a key gap in the current ecosystem. This is exacerbated by macro-financial constraints, in particular unsustainable debt burdens, inequitable borrowing costs and illicit financial flows, which restrict countries’ fiscal space.

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The current architecture does not promote synergies among global, regional, and national levels. Instead of complementing existing capacities, many international actors operate in parallel, creating duplication and displacing functions that could be more effectively carried out by local or regional institutions

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**Latin America and the Caribbean Dialogue Outcome Report**

## **2.6. Fragmented international health financing**

The proliferation of siloed, disease-specific financing streams undermines coherence and imposes an unnecessary administrative burden on countries. Such funding often bypasses national processes for planning and budgeting, which neglects the need to develop sustainable country-owned systems, undermines public financial management and works against the integrated delivery of primary health care (PHC).

## **2.7. Gaps in data sovereignty and knowledge exchange**

Many countries contribute large amounts of data to global research efforts but lack ownership and reciprocal access to data, knowledge and health products. A lack of interoperable data systems along with limited regional knowledge exchange and technical cooperation also constrain the use of data and expertise for evidence based decision making and rapid health emergency responses.

## **2.8. Fragile and inequitable production and supply of health commodities**

The COVID-19 pandemic highlighted the fragility of the concentrated global systems for production and supply as well as the continued inequities in access to vital health products. Opportunities for local and regional manufacturing, supply chains and harmonised regulatory processes are often underused, perpetuating reliance on external markets rather than fostering autonomy and resilience within the global health ecosystem.

This stocktake shows that while stakeholders across regions acknowledge the achievements and assets of today's global health ecosystem, they are clear that these strengths coexist with deep shortcomings that are holding back progress. Today's global health ecosystem has become fragmented, top heavy and misaligned with the priorities of regions and countries. This diagnosis forms the basis for a shared view that meaningful reform must be transformative and guided by a clear common vision.

# Vision, principles and functions for the future ecosystem

## 1. Vision

Taken together, the five regional dialogues envisage a global health ecosystem that can improve health outcomes and deliver collective value for all by supporting in the delivery of regional and global public goods, providing responsive international coordination, and – where needed – ensuring effective assistance is aligned with country-led trajectories. This system is responsive to changes in disease burden and determinants, and it allows for differentiated approaches based on distinct contexts and needs. It is a decentralised system driven by countries, anchored in regional hubs and backed by a leaner and more streamlined global architecture.

Achieving this vision requires adherence to key principles.

## 2. Principles

- **Sovereignty** – Countries exercise authority over their health priorities and systems, enhancing self-reliance. The global health ecosystem is shaped by sovereign national actors, in partnership with regional bodies and non-state actors, driving multilateral collaboration grounded in ownership, trust and legitimacy.
- **Subsidiarity** – Decisions are made and implemented as closely as possible to those they affect, allowing for flexible, differentiated approaches that respond to diverse and evolving country and regional realities, anchored in devolved power.

International coordination and external financial and technical support are provided when and where critical, reinforcing national and regional agency within a shared global framework.

- **Equity** – The global health ecosystem catalyses progress towards equitable health outcomes within and between countries. Fair processes, partnerships, governance and financing mechanisms actively rebalance power asymmetries and disparities between actors at national, regional and global levels.
- **Coherence** – Functions at each level of the system are clear and complementary, matched by a clarity of organisational roles. Efficiency is maximised by ensuring existing structures and systems are strengthened and utilised, rather than creating new or parallel structures. Streamlined global organisations with clearer – less overlapping – mandates and responsibilities respect, complement and support what exists locally and regionally, connecting these systems into an aligned global ecosystem shaped by networked cooperation instead of competition.

### 3. Functions

The national level remains without doubt the primary locus for providing and protecting health. But progress towards a transformed global health ecosystem also requires greater clarity on the functions that will be needed at the regional and global levels (the focus of this paper).

Most dialogues identified the following functions for the **regional level**:

- **Set regional health priorities**, agendas and strategies based on countries' distinct health needs and shared priorities, and strengthen regional, cross-country accountability mechanisms.
- **Lead technical health cooperation and coordination across countries in the region**, and where requested, provide context-specific support to countries' implementation of programs.
- **Provide regional public goods for health**, such as surveillance and outbreak response capacity, shared data and knowledge architectures, regulatory harmonisation standards, and others.
- **Mobilise and link resources** – both financial and technical – in line with country and regional health priorities for regional public goods and other forms of cooperation and support.

To be complemented by the following functions at the **global level**:

- **Set global technical norms and standards and support and coordinate delivery of global public goods** for health – such as research and development, regulatory guidance, clinical and policy guidance, global disease surveillance systems, and others.
- **Provide global stewardship and coordination** to manage global threats and externalities, such as global health emergencies, and facilitate information-sharing and the alignment of actors across regions in a shared global framework.
- **Mobilise coordinated financing** for global public goods, as well as for assistance to countries transitioning to domestic health financing, and in humanitarian settings, where needed.

This list of functions is not exhaustive but draws on those most commonly highlighted across the dialogues to provide an outline for the future division of labour across different levels of the health ecosystem. It will require further collective deliberation to ensure a comprehensive mapping of functions (recognising that the kind of support and engagement wanted will vary with country context), and to consider the appropriate pathways in regions whose capacity, structures and readiness to carry out such functions varies considerably. Reflections on the steps needed to realise this differentiation of functions are outlined in the following section.

# Key areas for reform

Each regional dialogue surfaced unique insights and perspectives on what reforms are needed to accelerate progress towards the transformed global health ecosystem envisaged above.

There was variation in the focus, emphasis and depth of discussions and proposals across regions. Despite this, dialogues across all five regions converged on common areas of reform, responding to commonly identified weaknesses set out in the stocktake above. Taken together, the dialogues proposed key reforms in governance and financing as well as data, knowledge and products. Many echo existing priorities and shifts set out in the Lusaka Agenda<sup>9</sup>, highlighting the need to draw on existing principles and commitments to joint action as we move forward. The proposed next steps and outstanding questions for advancing reforms are based directly on the proposals from all the dialogues, as well as on the synthesis of shared priorities.

## 1. Governance

### 1.1. Differentiate and streamline mandates to improve coherence and efficiency

Responding to the duplication, competition and blurred global–regional roles set out in Section II, the regional dialogues converged on two priorities for mandate reform: differentiating and rebalancing the global–regional division of labour, and streamlining mandates within levels.

#### 1.1.1. Differentiate and rebalance functions and mandates between global and regional levels

Shifting more functions from the global to regional level comes through as a key reform priority across Latin America and the Caribbean, Asia Pacific, Africa, and the Middle East and Central Asia. It is driven by a shared vision of credible regional hubs that directly respond to their countries' distinct needs while, at the same time, connecting to and shaping the global system.

While focused on the global system, stakeholders from Europe and North America also voiced significant support for re-calibrating roles and responsibilities between global and regional levels, enabling greater regional ownership of health while clarifying which functions should remain global.

Most dialogues highlighted the need for the WHO to recentre on its core mandate of setting global norms and standards, with regional organisations taking a more defined role in contextual adaptation, technical cooperation and implementation support. Asia Pacific and Latin America and the Caribbean also highlighted the need for mandate reform among international financial organisations, including the International Monetary Fund (IMF), the World Bank, and regional development banks to better coordinate financing for global and regional public goods (see sub-section 2.2).

However, there was also agreement that the complexity of such a rebalancing of functions from global to regional levels should not be underestimated. Considerable support will be needed to enable regional health organisations to absorb and deliver additional functions, recognising variations in capacity and maturity levels across regions (see sub-section 1.2). Clear governance and accountability arrangements – including between regional organisations – will also be essential to ensuring such shifts do not exacerbate fragmentation. All regions also agreed that greater regionalisation, through joined-up and shared frameworks, must ensure global alignment.

### 1.1.2. Clarify and streamline mandates within levels, especially at the global level

In addition to any rebalancing functions and mandates between global and regional levels, there was strong consensus in the dialogues that the mandates of the current global health organisations should also be clarified and streamlined to reduce fragmentation and inefficiencies.

#### Proposed next steps:

- Global and regional health organisations introduce or improve accountability and coordination protocols with oversight from member state governments, including formal mechanisms for joint planning and information sharing to promote collective action and incentive structures that prioritise collaboration and synergy over competition.
- Governments authorise an independent, system-wide review of the individual mandates and differentiated functions of global and regional health organisations, identifying opportunities for re-calibration to address duplications, gaps and inefficiencies and to ensure delivery of the key functions set out in section III. Such a process would be inclusive and transparent, involving both global (such as the WHO, UNICEF, UNFPA, and others, Global Health Initiatives like Gavi, the Global Fund, GFF, Unitaid, CEPI, and the Pandemic Fund, and different partnerships) as well as regional actors (such as Africa CDC and others).
- In line with the findings of this review, governments and partners work with global health organisations to progressively devolve agreed roles and responsibilities, while also supporting and enabling regional health organisations to absorb these. This devolution should be phased and predictable to enhance confidence in the reform process and reinforce governance credibility.
- Governments and partners work with global health organisations, within and beyond the UN system, to streamline their mandates through appropriate governance mechanisms while avoiding the creation of new organisations.

Despite broad agreement in principle, the level of ambition, the sense of how to do this and the support for different options remained less defined. Proposals included better harmonisation of mandates across global health organisations, including the WHO, GAVI and the Global Fund (highlighted by the Middle East and Central Asia and Europe and North America); re-focusing organisations on their core mandates and functions where they hold a comparative advantage (Latin America and the Caribbean, Europe and North America and Asia Pacific); and actively unifying mandates to reduce duplications across organisations (Africa).

#### Outstanding questions and trade-offs:

- Given wide variety in regional capacity and integration, how can reforms toward regionalisation be best navigated, while also maintaining alignment and coherence at the global level?
- How can collective deliberation more precisely determine the balance of functions between global and regional levels, while considering associated trade offs?
- Which actors have the authority and impartiality to lead a system wide review of roles, duplications and mandates at the global level – and how would recommendations be adopted across governance bodies?
- How can such deliberations ensure adequate consideration of the different needs of different countries (considering factors like income status and fragility)?
- How can institutional resistance to substantive mandate shifts be constructively addressed?
- How can gaps in global health functions be avoided during transitions of mandates, especially if roles shift faster than financing or technical capacity?

## 1.2. Enable regional health architecture

Across dialogues, enabling regional health capacities is seen as essential in making the architecture of global health more responsive, equitable, effective and resilient by leveraging proximity and local expertise. There was strong consensus across Latin America and the Caribbean, the Middle East and Central Asia, Africa and Asia Pacific that their respective global influence depends on credible, coherent regional organisations that speak with a unified voice.

Deepening the mandates and decision-making power of regional organisations will require strengthening regional and sub-regional health coordination, expanding shared operational capacities and strengthening support for the delivery of regional public goods. Due to the heterogeneity of regions, there is no one-size-fits-all approach to achieve this. Still, two common mechanisms emerged.

### 1.2.1. Strengthen regional policy coordination platforms

Strengthened multilateral, multi-stakeholder regional and sub-regional platforms should serve as hubs to develop and endorse shared health priorities, agendas and regional strategies as well as to coordinate actions. This would allow countries to mobilise collective resources and harmonise efforts to influence decision making and policy at the global level. They should be driven by, and be accountable to, national, sub-regional and regional actors to solve regional health problems, while also sustaining links to global mechanisms.

There are already regionally-owned actors that can exercise or provide the foundation for such coordination and leadership, although in most cases the current configuration is imperfect. Participants in the Middle East and Central Asia dialogue highlighted that organisations such as EMPHNET, the Gulf CDC, the Arab League and the Organisation of Islamic Cooperation (OIC) could serve as coordination and leadership hubs. Regionalisation will require critical consideration of existing arrangements (see section III), followed by a concerted effort to strengthen key capacities, recognising that this may require flexible, networked models with variable geometry and involvement across different functions rather than

one single, neatly bound regional hub. Advancing health effectively at the regional level will require collaboration not only with health-focused organisations but – as with at the global level – with actors whose mandates span other sectors, reflecting the inherently cross-cutting nature of health challenges.

### 1.2.2. Provide regional public goods and pooled functions

In line with the desire to increase regional level provision of public goods and pooled functions (see section III), the development or strengthening of mechanisms for joint procurement, regional manufacturing, regulatory harmonisation and emergency response capacity – in order to leverage economies of scale and reduce reliance on external systems – also emerged as a common priority across regions (see Box 2).

#### Box 2

### Example: Proposal for LAC Health Catalytic Platform (LAC-HCP)

The Latin America and the Caribbean dialogue proposed the creation of a LAC Health Catalytic Platform (LAC-HCP) to reshape and strengthen the region by fostering collaboration and enabling coordinated investment in two distinct but interconnected domains:

- 1) The development of regional public goods (RPGs), such as health data architectures, health technology assessment (HTA) methodologies, shared generation and analytical capacities for AI-powered data-driven solutions and regional knowledge repositories.
- 2) South-to-South cooperation for shared production and services (non-RPGs), such as joint/ coordinated procurement, regional manufacturing and shared regulatory strengthening. The platform would operate as a unifying, non-duplicative mechanism, fully complementary to the mandates of PAHO, sub-regional mechanisms and multilateral development banks.

## Proposed next steps:

- Building on the global review proposed in sub-section 1.1., governments and organisations in regions identify and agree which (combination of) regional organisation(s) will lead key functions at the regional level, and work together to ensure the relevant mandates and financing are in place. The specific pathways to achieve this will vary and should be determined and agreed on a regional basis.
- Global organisations and their regional offices respect the central role of regionally-led organisations, the principle of subsidiarity and foster equal partnerships with them.
- Donors align financing and technical assistance with regional priorities and strategies.

## Outstanding questions and trade-offs:

- How should regions be delineated – for example, by political geography, economic blocs or functional health networks – given overlapping memberships and varying integration levels?
- How can regional organisations work with their member states on agenda-setting, oversight and financing without duplicating global or national functions, given that operational boundaries may remain contested and global organisations may be reluctant to cede space?
- Through what practical steps can regions develop and agree an approach to the provision of regional public goods for health, including identifying mechanisms that would most effectively enhance provision?
- How can regional health organisations at very different levels of institutional development and integration connect to, and be accountable within, a coherent global health architecture?
- What would an effective devolution of functions from global health organisations, including their regional offices, entail? What would be the implications for the management and reporting lines of the WHO's regional offices?
- How can peer-learning across regional health organisations and networks be effectively fostered as they seek to strengthen capacities?



Africa's role in global initiatives such as the Global Fund and Gavi needs to shift from symbolic to actual influence and co-architecture in governance. This will ensure Africa's agency and true representation, turning symbolic presence into real parity



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### 1.3. Rebalance decision-making structures and practices

Across all regions, two priorities stood out for improving global health decision making. These were:

- Rebalancing board representation and governance practices to elevate the voice and authority of LMICs.
- Hardwiring civil society and other non state actors into governance at all levels.

#### 1.3.1. Rebalance the composition and practices of global health boards for greater effectiveness

There was general agreement across the dialogues that global health organisations should ensure that their governing boards are more representative of LMICs, so that decision-making authority better reflects the countries the organisations intend to serve.

The Africa and Asia Pacific dialogues called for substantive change that achieves parity in decision-making authority and practices for global health governance and financing, going beyond financial contribution and better reflecting burden, stake and responsibility in global health.

The dialogue in Europe and North America supported better representation of LMICs on global health boards. It highlights the need to make board practices more effective and coherent through clarifying board decision-making processes as well as strengthening board meeting preparation and follow through, alongside ensuring that organisations present consistent positions across different global health boards.

#### 1.3.2. Hardwire inclusive governance at all levels

All regions converged on the recommendation to institutionalise the systematic and meaningful participation of non-state actors, especially civil society and community actors, in health governance across organisations and levels, including in decision making and oversight. The Africa dialogue specifically called for gender parity in governance.

Two or more dialogues emphasised the need for:

- Formal participation mechanisms over informal arrangements to increase transparency and legitimate influence.
- Consistency and feedback loops over ad hoc consultations to prevent tokenism.
- Participation throughout the policy process over insular engagement to ensure decisions respond to lived experience.
- Institutionalising such mechanisms at national, regional and global health governance levels.

Civil society, youth, academia as well as community and patient groups were most mentioned across the dialogues. The Middle East and Central Asia and Europe and North America dialogues explicitly mentioned the private sector. The Middle East and Central Asia stakeholders further emphasised the need for participation from refugees.



**Participants stressed that stronger MECA representation in global forums is needed for regional priorities to influence global decision-making**



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## Proposed next steps:

- Independent think tanks and civil society analyse gaps in current board composition across key organisations and then consult governments and partners to propose new representation targets for LMICs, regional organisations and civil society. This analysis would create a shared evidence base to advance collective reform discussions.
- Governments authorise a global health board reform working group, comprised of cross-regional representatives from government, civil society, funders and other board seat holders. The working group would collectively consider change options, trade-offs, legal constraints in charters and interdependencies across key global health boards, proposing a path forward to enhance transparency, administrative feasibility and coherence.
- Governments and regional organisations identify and support global health champions from LMICs and small island states to articulate and advocate in global fora.
- Global and regional organisations incorporate or strengthen formal participation mechanisms for civil society at all governance levels.
- Global partners (including foundations and other funders) and governments resource civil society to enable meaningful participation in global and regional health governance.

## Outstanding questions and trade-offs:

- What metrics should define parity, fair representation and “meaningful” participation, and how can an appropriate balance be struck?
- How can wider participation be balanced against the need for efficient decision making?
- How can continued donor expectations of control and oversight be better understood and navigated within more inclusive and effective governance models?
- How can global health organisations navigate vested interests and possible legal constraints (for example, in founding charters) to reallocate board seats or voting power to achieve fairer representation?
- What practical steps and processes – in, for example, decision making and other aspects of institutional governance – can be taken forward by board chairs, secretariat and seat holders to make boards more effective individually, as well as collectively?

## 1.4. Make accountability reciprocal and consequential

While regional proposals to reform accountability mechanisms varied in emphasis and depth, consensus emerged on making accountability mechanisms more reciprocal and increasing their credibility.

### 1.4.1. Make accountability mechanisms more reciprocal

The Africa and Asia Pacific dialogues stressed the need to move beyond the one-way monitoring of “recipient” countries and ensure donor performance against agreed priorities is also tracked. This asymmetry should be actively counterbalanced by introducing or strengthening mechanisms that ensure that all actors – donors, funding organisations, governments, implementers and others – are held mutually accountable against agreed commitments. Other regions agreed on the principle, but did not discuss this as specifically.

### 1.4.2. Increase the credibility and consequences of accountability mechanisms

To replace existing insufficient mechanisms, dialogues agreed that clearer rules, greater transparency, more robust incentive systems, as well as meaningful consequences for non-compliance, are needed to strengthen accountability. While dialogues agreed that in the absence of a global government formal enforcement is often politically unrealistic, these measures are critical to make global health commitments more credible and binding. The Middle East and Central Asia specifically highlighted the need to tie clearly articulated mutual commitments between global, regional and country actors to practical mechanisms that can function in politically complex contexts – expanding tools such as public scorecards or dashboards, independent audits and performance-linked financing.

## Proposed next steps:

- Governments, regional organisations, civil society, academic and others take regionally-specific steps to strengthen mutual accountability, for example:
  - Africa: i) expand country-to-country review, leveraging the African Peer Review Mechanism (APRM); ii) develop and operationalise “external” review mechanisms to monitor global stakeholders’ commitments and implementation against agreed priorities (the Lusaka Agenda Monitoring and Accountability Framework, for example).
  - Asia Pacific: i) establish robust resource mapping and expenditure-tracking mechanisms at national and regional levels to accurately and dynamically track allocation and disbursement of financial resources across all sources (for example, from governments, philanthropies and aid); ii) develop and lead parallel monitoring and evaluation mechanisms, for example, a combination of self-assessment, peer review, independent external evaluation and community participation, with clearly defined indicators that are rooted in achieving health equity.
- Governments, global and regional organisations explore developing more binding rules and structured incentives as a prerequisite for future regional and global cooperation partnerships, such as preferential access to pooled financing, technical cooperation or governance roles for actors that demonstrate alignment with agreed priorities and transparent reporting.

## Outstanding questions and trade-offs:

- What external commitments should be tracked – for example, financing, representation and reform progress – and how can indicators balance comparability with local relevance?
- Will major actors – particularly sovereign donors – accept more binding constraints? If not, what incentive structures can substitute effectively?
- What accountability mechanisms (binding rules, incentives and transparency) will actually change behaviour within the current geopolitical climate, and where can they be anchored effectively?
- How can lessons from existing use of tools, such as public scorecards, dashboards or independent audits, inform more effective use moving forwards?

In addition to key governance reforms, a number of financing reforms were also identified as critical to the effective evolution of the global health ecosystem.

## 2. Financing

### 2.1. Advance domestic financing

Regional dialogues agreed that countries must lead in increasing both the quantity and quality of domestic health financing, and manage sustainable transitions. Alongside this, macro financial constraints must also be addressed.

#### 2.1.1 Increase the quantity and quality of domestic health finance, reorienting health systems to Primary Health Care

To increase the quantity of health financing, two or more dialogues recommend that governments expand budgetary allocations, broaden the public revenue base and leverage private finance (with public interest safeguards).

To increase the quality of health financing, all dialogues underscored the need to anchor financing reforms in PHC, in order to reduce fragmentation in health systems delivery, strengthen institutional capabilities for effective and equitable resource allocation and, within this, increase spending on prevention and health promotion.

### Proposed next steps:

- Governments institutionalise monitoring of financial flows to allow timely and transparent reporting on domestic resource mobilisation and allocation, and strengthen national accountability mechanisms.
- Regional organisations track the implementation of domestic financing commitments and encourage peer-accountability among member states (for example, tracking Abuja Declaration commitments through per-capita indicators and regional peer review mechanisms).
- Governments refocus national financing reforms on PHC, integrating vertical programs into a unified platform, and directing domestic investment towards PHC building blocks including infrastructure, workforce, services and medicines.
- Governments, with support from partners where appropriate, strengthen public financial management, strategic purchasing and health technology assessment capabilities to improve efficiency and equity.

### Outstanding questions and trade-offs:

- How can countries protect or expand fiscal space for health when overall fiscal margins are limited and reallocations risk crowding out other sectors?
- What capacities and political incentives are necessary to ensure mechanisms for tracking domestic financing commitments – such as scorecards and peer review mechanisms – are effectively implemented, and how can the risk of gaming or superficial compliance be minimised?

## 2.1.2. Manage sustainable transitions, with partners playing a complementary, aligned role

All dialogues stressed the importance of responsible transition towards domestically financed and integrated health systems, with the following proposals highlighted in particular:

- Expand domestic co-financing requirements in health cooperation (from several dialogues).
- Utilise national coordination platforms – embedded within existing health sector coordination committees – to develop national health investment plans. These should be aligned with ‘one national plan’ (see next sub-section 2.2), mapping current resources and drawing on explicit transition plans for external financing in order to chart pathways toward domestic financing. Expanded committee mandates may be required to ensure inclusion of all relevant actors, including finance ministries, climate sectors and marginalised groups (from the Asia Pacific dialogue).

More broadly, several dialogues<sup>10</sup> emphasised the need for plans to reflect that countries are at varying stages of transition; in particular, many fragile and conflict-affected states remain far from full domestic financing and require sustained external support. In addition, partners, including donors, must ensure they play a complementary role that reinforces self-sufficiency, and work to overcome incentives to maintain dependence.

## Proposed next steps:

- Governments strengthen national health investment and transition plans, and integrate into the existing health sector strategic planning and coordination mechanisms to structure a coherent shift from donor-driven systems to domestically financed systems.
- Partners align external financing with country-defined transition pathways, ensuring that support phases out in a gradual and coordinated way, with partners’ roles adapting over time to reinforce a coherent shift toward domestic financing.
- Normative organisations, such as the WHO, the World Bank, the IMF, think tanks, academia and others, work closely with governments and financing partners to provide guidance on the appropriate use of different types and instruments of funding from domestic and partner sources, to support transition plans.

## Outstanding questions and trade-offs:

- What can be learned from existing transition policies? Specifically, how can countries ensure that transition plans are designed and implemented in ways that avoid increased out-of-pocket spending, service gaps or fiscal shocks as external funding declines?
- How can partners with different mandates and exit pressures be held accountable for following country-defined transition pathways, so their withdrawal is gradual, predictable and does not disrupt services or create funding shocks?

### 2.1.3. Address macro-financial constraints to unblock fiscal space

Nearly all dialogues explicitly highlighted the need to address unsustainable debt burdens and inequitable borrowing costs in order to catalyse increased domestic investment in health. Africa focused on debt swaps, while Latin America and the Caribbean emphasised credit-enhancing tools (to reduce loan costs) and graduation criteria changes, highlighting that current criteria classify some countries – such as small island developing states (SIDS) – as high-income while overlooking their specific vulnerabilities. Asia Pacific acknowledged climate-related fiscal pressures that also shape the feasibility of domestic health financing. Overall, the dialogues called for a more nuanced approach to eligibility criteria, guided by factors such as humanitarian and environmental vulnerability, disease burden and sector performance.

“  
A reformed global health architecture should embed financial justice – through debt relief, fair lending, and equitable fiscal governance – as a foundation for health equity.  
”

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### Proposed next steps:

- Ministries of finance and health work together, and with relevant intergovernmental organisations (such as the UN Economic Commission for Africa) and the World Bank, to jointly assess, adapt, and, where useful, implement debt swap arrangements aligned with national and regional health priorities. Lesson learned and good practices are documented, exchanged and elevated in upcoming Spring Meetings.
- Global and regional partners (such as the World Bank and others) reassess the use of income level as the primary criterion for concessional financing or grants-based health assistance.
- Global and regional partners (for example, the Inter-American Development Bank, philanthropies and others) collaborate to scale up credit enhancing tools – such as loan guarantees<sup>11</sup> – to reduce country borrowing costs and mobilise additional health investment.

### Outstanding questions and trade-offs:

- What governance arrangements are needed to ensure that debt swap commitments for health translate into real, sustained budget increases rather than symbolic or short-term allocations?
- Can credit-enhancing tools be designed to support long-term domestic investment without reinforcing dependence on external financing or increasing fiscal risk?

## 2.2. Improve the quality of international financing

In line with the Lusaka Agenda, all regions call for better aligned, simplified and more predictable external financing, alongside evolving the role of MDBs.

### 2.2.1. Align support with country priorities, realising “one plan, one budget, one M&E” and reinforcing integrated PHC systems

Operationalising country ownership was seen by all as the central organising principle of global health support – ensuring all external assistance aligns with nationally defined priorities, strategies and plans. Following the Lusaka Agenda, this means transitioning support from supply-driven vertical disease specific programs into country-led primary health care and systems<sup>12</sup>. Countries should lead the design, coordination and oversight of one plan, one budget and one monitoring and evaluation (M&E) framework, ensuring these are credible and jointly owned by ministries of health and finance. In turn, donors must align support behind one national plan, one budget and one M&E framework, instead of fragmenting national health programming and administration.

Stakeholders in Europe and North America note that alignment efforts often stall when national plans lack detail or evidence. They also recognise that bilateral donors’ political cycles, accountability pressures and administrative constraints often limit how they can align in practice, while global health initiatives are constrained by their own planning and replenishment cycles.



**Global support only works when it follows national priorities – otherwise it fragments our systems and diverts energy away from what people actually need.**



**Middle East and Central Asia Dialogue Participant**

## Proposed next steps:

- Governments establish and execute a robust “one plan, one budget, one M&E” framework for health, co-owned between ministry of health and finance, with a clear set of national health priorities.
- Governments strengthen and consolidate health coordination platforms to align support, learning from successful mechanisms (as, for example, in Rwanda)
- Partners (including multilateral and bilateral donors) abide by the “one plan, one budget, one M&E” principle, shifting away from parallel plans or compacts.
- Partners (including multilateral and bilateral donors) adopt greater flexibility in funding cycles and arrangements to reduce the administrative burden on countries and projects.

## Outstanding questions and trade-offs:

- What is the best pathway for shifting from vertical to PHC-centred approaches, in order to ensure integration and system strengthening without undermining disease outcomes, particularly among marginalised groups?
- How can countries reinforce their health sovereignty and create strong political, operational and reputational incentives for donors to align, so that adherence to country-led priorities becomes the default rather than an optional good practice?
- How can countries and partners avoid a proliferation of donor specific compacts and conditionalities that risk undermining alignment and coherence efforts?
- Recognising the limited success of previous alignment efforts, how can obstacles to realising “one plan, one budget, one M&E” be overcome?

## 2.2.2. Pool, integrate and simplify international financing

Across dialogues, stakeholders agreed on the need to expand pooled and integrated financing mechanisms to reduce fragmentation and better coordinate multi-donor investments for health systems – as well as regional and global public goods.

Preferences varied by focus and ambition. Stakeholders in Asia Pacific stressed harmonised financing with clear coordination structures and mandate reforms – across MDBs, bilateral donors, philanthropies and private actors – to align investments in regional and global public goods. The Latin America and the Caribbean dialogue advanced a pooled regional mechanism hosted by MDBs, designed to leverage existing regional health funds to support public goods and emergency response (see also next section). Stakeholders across Europe and North America supported expanded pooling in principle, yet put emphasis more on operational harmonisation, and with divergence on the extent: agreement on “pragmatic” steps – such as harmonising funding cycles and country-level engagement, aligning allocation models, joint transition roadmaps and clarifying the division of labour across Gavi, the Global Fund, the Global Financing Facility and the World Bank – yet none on structural reforms like shared boards, consolidation or sunset clauses. This also applies to pandemic preparedness financing, where preferences varied between a single mechanism and better coordination across multiple instruments.



Stakeholders in Asia Pacific stressed harmonised financing with clear coordination structures and mandate reforms – across MDBs, bilateral donors, philanthropies and private actors – to align investments in regional and global public goods.



## Proposed next steps:

- Governments authorise an independent review of the roles and funding modalities of major regional and global financing mechanisms, in terms of both country support and regional/global public goods. This review would pinpoint where financing functions overlap and identify harmonisation, integration and/or pooling opportunities and steps.
- Governments assess the outcomes of this review and implement necessary reforms in line with findings.

These steps should be closely linked to the analysis of organisational mandates set out in the governance section (see subsection 1.1.).

## Outstanding questions and trade-offs:

- How far should pooled and integrated financing mechanisms go to advance efficiency and coherence? Is incremental harmonisation of funding cycles and division of labour sufficient, or is deeper structural consolidation (such as shared boards or merged functions) needed?
- Is there any conflict between consolidation of mechanisms at the global level and the need to prioritise country-ownership and alignment behind country priorities at the national level? If so, how can this be mitigated?

### 2.2.3. Structure financing to be stable and predictable

Stakeholders across all regions agree on the need to move from short-term funding cycles towards predictable, multi-year international financing that allows countries to plan effectively and strengthen their systems, and to reliably finance global and regional public goods such as pandemic preparedness.

For example, the Africa dialogue saw longer and better aligned donor budget cycles as essential for effective national programming and sustaining integrated, PHC centred approaches. Europe and North America echoed this need and recognised that donors must work to overcome their own political and administrative constraints that often limit predictability; they also stressed the importance of reliable and collective “peacetime” pandemic preparedness financing rather than siloed emergency funds. Latin America and the Caribbean stakeholders highlighted the need for finance to become more long-term to support structural reforms instead of short-term, isolated projects. Similarly, the Asia Pacific dialogue called for long-term oriented global health financing, while the stakeholders in the Middle East and Central Asia emphasised multi year commitments and transparency.

### Proposed next steps:

- Secretariats of major multilateral and regional health funders (overseen and supported by their boards) and bilateral funders work with country governments and other actors to redesign health financing instruments to allow for multi-year and system focused commitments, aligning cycles and extending disbursement windows.

### Outstanding questions and trade-offs:

- How can legal, administrative and political constraints be addressed, so that global health funders reshape their instruments to offer more stable, multi year predictability?
- As countries transition away from external support, how can financing models balance the need for predictable multi year external commitments with the expectation of steadily increasing domestic financing?

#### 2.2.4. Evolve and elevate multilateral development bank finance for health

As global health financing moves away from grant-based, vertical programmes and toward long-term system strengthening, stakeholders across regions highlighted the need for a greater, more strategic role for both regional and global MDBs. While there are acknowledged risks, such as increased debt servicing and financialisation, MDBs are increasingly seen as well-suited to support multi year national strategies at a scale that traditional donors cannot.

Regions highlighted distinct dimensions. African stakeholders emphasised the importance of negotiating better MDB investment terms, including enhanced social service investments via IDA/IBRD, and using MDBs to support graduation and sunset clause discussions. The Asia Pacific dialogue highlighted a role for MDBs in coordinating funding strategies and investments in global and regional public goods, and in conducting routine resource mapping for health – particularly at regional levels. European and North American stakeholders saw MDBs as critical to sustainability, highlighting PFM strengthening and concessional financing for PHC and systems.

#### Proposed next steps:

- MDBs work with governments and other actors to refine their mechanisms for sustainable, country-led concessional financing to support equitable and effective primary health care and public goods.
- Governments, MDBs, GHIs and other actors explore country-led MDB financing packages that blend concessional loans with GHI grants and domestic financing to support effective transitions.
- Governments, MDBs and other actors consider whether and how regional, MDB anchored pooled financing mechanisms for cross border public goods and preparedness could improve financing predictability, efficiency and alignment with regional priorities.

#### Outstanding questions and trade-offs:

- How can countries invest in stronger health systems without over-extending debt servicing obligations, and where should the line between concessional borrowing and grant-based funding be drawn, especially considering differentiated fiscal capacity across countries?
- How can MDBs expand financing while mitigating the risks of financialisation, such as the reshaping of national health programs towards bankable projects at the cost of essential and equitable public health systems?
- How can countries use blended finance – for example, GHI grants combined with MDB loans and domestic finance – in ways that reinforce country ownership and support long term, integrated health system reforms?

## 2.3. Build regional financing mechanisms

Dialogue participants proposed bolstering regional financing mechanisms for regional public goods and country support. In line with the principle of subsidiarity<sup>13</sup>, situating financing functions at the regional level is expected to improve self-sufficiency and sovereign ownership, ensure proximity to contextual needs and facilitate timely action. Meanwhile, this could also maintain enough scale to generate efficiencies, foster solidarity and support regional public goods investments beyond the capacity of individual states.

### 2.3.1. Pool and coordinate diverse regional financing sources

The common approach is to aggregate multiple funding sources and streams – domestic public budgets, regional multilateral development banks, philanthropy, diaspora, bilateral donors and (where appropriate) private capital – into pooled funding mechanisms that can coordinate regional health investments. This serves to create a shared resource base, harmonise funding flows and promote efficiency, enabling coherent investment in regional public goods and solidarity-based country support.

Within this, regions provided different emphases: the Africa dialogue highlighted mobilising resources from domestic treasuries, philanthropy and diaspora into funds linked to Regional Economic Communities (REC) or the African Union (AU) to reduce fragmentation and strengthen preparedness and response. Participants in the Asia Pacific dialogue stressed the importance of coordinating MDB, bilateral and philanthropic flows to support regional public goods, while ensuring this coordination does not take over priority setting or implementation functions. European and North American stakeholders supported regional financing mechanisms for pooled procurement and advance market commitments aligned with global standards. The Latin America and Caribbean dialogue proposed establishing a Regional Health Solidarity Fund; a pooled, catalytic financing mechanism – hosted by a multilateral development bank and governed by countries – to coordinate and leverage regional health funds.

Capitalised through health related taxes and redirected multilateral surpluses, the fund would increase efficiency by pooling resources from multiple donors, reducing administrative costs and spreading financial risk, as well as supporting regional solidarity by allocating funds where they are most needed – particularly as many countries no longer qualify for traditional aid. Meanwhile, participants in the Middle East and Central Asia advocated for the building of predictable, regionally anchored co investment streams backed by shared monitoring to coordinate funding for PHC and regional public goods.

### 2.3.2. Embed shared principles for effective regional financing

Common characteristics for effective regional health financing mechanisms highlighted in two or more dialogues include:

- **Government led and regionally owned:** Mechanisms are accountable to governments and place decision-making authority firmly in the hands of countries from the region, ensuring sovereign control and political legitimacy.
- **Transparency:** Shared monitoring frameworks and routine resource mapping ensure clear, predictable tracking of contributions, allocations and performance, strengthening trust and accountability across the region.
- **Efficiency through coordinated pooling** (see above) .
- **Solidarity as a guiding principle:** With traditional aid diminishing or absent for many countries, allocation should ensure resources flow to where regional needs are greatest.
- **Co-investment for shared goals:** Mechanisms must incentivise collective country investment, using arrangements that galvanise contributions and build commitment to regional priorities.
- **Build on and integrate existing organisations:** Leverage existing regional or multilateral structures to avoid duplication and maximise institutional capacity. This could mean being hosted by an MDB, strengthening a continental fund (for example, the Africa Epidemic Fund), or working through sub regional organisations.

### Proposed next steps:

- Across Africa, governments and regional organisations align to increase pooled funding for emergency response via the Africa Epidemic Fund.
- Across Latin America and the Caribbean governments, think tanks, academia and other sub-regional and regional actors work with a selected MDB to explore the design of a Regional Health Solidarity Fund, including its governance board, capitalisation model and potential funding instruments.
- Across Asia Pacific, think tanks and academia work with governments, partners and regional organisations to establish a routine, multisectoral resource mapping function, aligned with regional health strategies, to inform the evolution of regional pooled financing mechanisms.
- Regional organisations and partners work together to establish structured, cross-regional knowledge exchange on regional health financing mechanisms – including governance models and revenue mixes – hosted by a neutral platform or MDB.

### Outstanding questions and trade-offs:

- What incentives will persuade governments to join a regional health financing mechanism, and how can regions manage the risk that countries hold back if near-term benefits appear uncertain?
- How can regional ownership and strong sovereign control be balanced with the need for interoperability with global funds and MDBs, and engagement with external partners?

In addition to common priorities for the evolution of health governance and financing, dialogues touched on key reforms to data, knowledge and product development and supply.

## 3. Data, knowledge and products

### 3.1. Augment regional data and knowledge systems

Regions agreed on the urgent need to reinforce interoperable, regionally governed health data and knowledge systems – underpinned by strong digital infrastructure clear data governance, and structured knowledge exchange – to enable trusted evidence and stronger cooperation.

#### 3.1.2. Set up or strengthen regional digital data systems and hubs, with wide interoperability

Common priorities include establishing regionally governed data systems that guarantee national data sovereignty, ensuring countries remain primary authorities over collection, storage and sharing. In particular, the Africa dialogue highlighted the need to secure benefit sharing conditionalities and benefits (of various kinds, such as technology transfer) via the Pathogen Access and Benefits Sharing (PABS) system.

Dialogues also highlighted the need to build unified, interoperable digital infrastructure for data on human health outcomes, health financing and program performance, as well as disease surveillance. These should be anchored in trusted regional organisations that allow for the aggregation of data from various systems, and create regional data hubs that enforce harmonised standards and enable real time analytics across countries. The latter should be supported by digital dashboards for transparency and efficient decision making. Participants in the Africa dialogues considered the role that AI could play, seeing it as a “backbone” for new digital health infrastructure to boost operational efficiency, cut costs and increase productivity.

#### Specific examples include:

- An African Health Data and Governance Framework to strengthen data sharing and systems. This framework would ensure that African health data is stored, managed and used within the continent to protect national sovereignty and enable monetisation through value addition (for example, clinical trials).
- An ASEAN Health Data Repository to enable Southeast Asian countries to benchmark health system investments and identify best practices in sustainable financing models. Repositories would be country-owned, with sub-regional hosting facilitated by national multi-stakeholder forums, thereby distributing the administrative burden and reinforcing the role of sub-regional coordination in serving national priorities.

### 3.1.3. Institutionalise structured knowledge exchange mechanisms

To further unlock peer-to-peer knowledge exchange and technical cooperation within regions, dialogues proposed more systematic exchange mechanisms anchored in regional governance and supported by digital tools.

For example, the LAC Innovation Hub proposed through the Latin America and Caribbean dialogue would build on the considerable capacities that already exist within countries across the region; capacities that are often underutilised or insufficiently recognised by others. Through annual calls for proposals, establishment of regional priorities and leveraging and expanding existing capacities through structured country-to-country exchanges, the Hub would address barriers that currently undermine South–South technical cooperation. In the Asia Pacific, this can be enabled through regional and sub-regional knowledge hubs that gather evidence on best practices for cross-sectoral and cross-country learning, leveraging existing organisations such as the WHO, the Global Fund, the World Bank, ADB, ASEAN and academic organisations.

### Proposed next steps:

- Across Latin America and the Caribbean, interested governments launch preliminary discussions with PAHO and other partners to co-design the LAC Innovation Hub, and set up a Regional Committee and ad hoc working group to define priorities.
- Across Africa, governments and regional partners develop an Africa data information system anchored within the Africa CDC as a Digital Public Infrastructure (DPI) for African countries.
- Across the Middle East and Central Asia, governments and regional partners establish a regional health data hub to enable cross-border data sharing and advanced analytics; strengthen existing regional bodies to coordinate surveillance, laboratory networks and cross-border preparedness; and establish regional knowledge sharing platforms that support joint research, monitoring and capacity-building.

### Outstanding questions and trade-offs:

- How can strict national control over health data be reconciled with the need for rapid, cross-border data exchange during emergencies?
- How can coherence be ensured within and across regions to ensure strong regional systems are also globally aligned?
- How can digital tools and open-access policies enhance knowledge use without undermining data protection and intellectual property?

## 3.2. Shape markets, pool procurement and distribute manufacturing

Across regions, there was consensus that health markets must be proactively shaped to ensure equitable access, greater resilience and increased regional sovereignty. This should include pooled procurement as well as better regulated and distributed manufacturing and harmonised regulatory processes. This was also viewed as an opportunity to create economic benefits – spurring innovation, growth, industrial development and productivity – and thereby aligning health and economic objectives within a shared framework.

### 3.2.2. Shape markets through pooled procurement and progressive conditionalities

The dialogues consistently pointed to pooled procurement, price negotiations and standardised product requirements as essential tools for lowering prices, ensuring supply reliability and expanding access – especially for countries with limited bargaining power.

Regions had different starting points and views for taking this forward at regional and global levels. Stakeholders in Latin America and the Caribbean highlighted the positive impact of PAHO's Revolving Fund across the region, but call for its modernisation and expansion. The African dialogue recommended operationalising continent-wide pooled procurement by mapping existing capacities and piloting AU wide pooled procurement by mapping existing capacities and piloting AU mandated approaches for predictable demand.

The Asia Pacific dialogue recommended aligning pooled procurement (first at a sub-regional level, such as the Pacific or ASEAN) with financing reforms and transition plans. Stakeholders across the Middle East and Central Asia proposed coordinating procurement, stockpiling and logistics regionally to standardise purchasing and ensure rapid access to key supplies across countries, including in fragile settings. The Europe and North America dialogue highlighted maintaining global interoperability and shared standards to avoid fragmented markets and access; participants suggested harmonising growing regional mechanisms while strengthening global mechanisms, including pooled procurement, advance market commitments and early fair access clauses in R&D partnerships.

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### 3.2.3. Strengthen distributed manufacturing capacities, leveraging regional frameworks

Regions converged on the need to increase local and regional manufacturing capacity, strengthen supply chains and harmonise regulatory processes. Many saw expanding production as essential to ensuring timely access during crises and to reducing reliance on external markets.

Within this, different motivations and directions emerge. Stakeholders across the Middle East and Central Asia focused on building regional manufacturing and logistics hubs, supported by public–private partnerships (PPPs) and digital supply chain modernisation. Participants across Africa highlighted the most comprehensive agenda: investment in local manufacturing and R&D; regulatory harmonisation under the African Medicines Agency (AMA); supply chain strengthening under the African Continental Free Trade Area (AfCFTA); building capacity for compulsory licensing; and fostering a self-reliant industry capable of serving both regional and global markets.

The Latin America and the Caribbean dialogue proposed the deepening of joint production models, regional supply chain integration and the use of venture mechanisms to fund health innovations. The Europe and North America dialogue emphasised aligning manufacturing initiatives with global frameworks, refining global R&D processes to better reflect country priorities.



**Africa is saying: we don't just want vaccines delivered to us, we want the capacity to produce them ourselves... The world must adjust to this new reality.**



**Africa Dialogue participant**

### Proposed next steps:

- Governments and regional organisations take forward regionally specific plans for expanding pooled procurement.
- Regional organisations share pooled procurement lessons and best practices across regions, for example drawing on PAHO's Revolving Fund as well as other successful models, and explore joint opportunities.
- Governments and regional organisations advance regulatory harmonisation to support scalable regional production. This may include fast-tracking respective organisations (for example, AMA implementation), establishing mutual recognition arrangements, and aligning product standards and licensing pathways so that regionally manufactured products can move efficiently across borders.

### Outstanding questions and trade-offs:

- How should global and regional procurement roles be balanced so regions can act faster without fragmenting standards or losing the scale advantages of global mechanisms?
- Which market shaping instruments could be applied more systematically, including in PPP design, to maximise public health returns?
- How can regional manufacturing frameworks unlock shared health and economic value – through aligned regulation and supply chain integration – while ensuring all countries, including smaller or fragile states, benefit equitably?
- How can national and regional organisations partner with manufacturers and other (private sector) actors to overcome obstacles within the current industrial landscape and build effective production systems?

# Way forward

## 1. Enablers

Advancing these reforms will not be easy.

While regional dialogues strived for consensus and the identification of specific next steps, setting out the “how” of reforms, particularly at the global level, remains a challenge.

There was also wide recognition that many of the reforms identified – which include the implementation of new ways of working, reallocations of power and changing fundamental narratives about what global health is and who gets to make decisions – will meet resistance, and it is possible that reform efforts may be blocked or co-opted by established structures. Indeed, the turn toward regionalisation itself reflects the difficulty of delivering reform at the global level.

In addition, several trends in the rapidly shifting global economic and political context may also constrain the implementation of reforms. As the Latin America and Caribbean dialogue noted, the “global health crisis reflects a wider breakdown in geopolitics and international cooperation.” Reform efforts now face a fragmented landscape in which power is diffusing across more actors, ideological polarisation is deepening and competing models of order and rising nationalist populism weaken consensus and joint action. International health financing cuts are unlikely to be reversed in the short term, and multilateral arrangements are frequently giving way to transactional bilateral approaches.

Such an appraisal should be read as realistic, rather than pessimistic. To succeed in this context, reforms must be proactively navigated through the fast-changing geopolitical environment. Genuine transformation will require external pressures and new, more effective approaches that make fundamental, long-term change unavoidable.

Dialogues identified the following enablers as likely to play a critical role:

### 1. Leadership from LMICs and regions

Countries and regions closest to implementation must be at the centre of reform, with high-income countries and global organisations acting as enablers, backing country-led and regionally-owned reform agendas. Reform of the global health ecosystem will need to go hand in hand with joint action to drive cooperation at regional and national levels, which will only be possible if countries and stakeholder groups from all regions of the world are actively engaged in – and lead on – reform conversations.

### 2. Political and technical alignment

Enacting reforms will require an effective interface between ambitious, expert-informed technical reform proposals and mechanisms for political decision making. Such mechanisms should involve influential ministers from within and beyond the health and development sectors, ensuring high-level political authority from finance ministers and heads of state/government, alongside other regional and global leaders. Coalitions should mobilise political champions and utilise regional and global political moments and processes – such as AU Summits, Summits of the Americas, ASEAN meetings, Arab League, G20, United Nations General Assembly (UNGA) and World Health Assembly WHA – to advance decision making and high-level accountability around technically sound proposals. Chairs and board members of global and regional health organisations will also need to lean in to ensure coherence between high-level statements and strategic and operational decision making.

### 3. Dynamic coalitions for reform

Impactful and agile coalitions will be critical to progress. Regional coalitions, such as the Asia Pacific Global Health Reform Coalition proposed by the Asia Pacific Regional dialogue, have the potential to provide vital multi-stakeholder convening platforms for joint priority-setting and the piloting of reforms at the regional level. In addition, alliances across regional blocs – for example, to exercise joint influence in global fora such as the G20 – will be key to advancing the reform agenda. Political opportunities to bring heads of state from LMICs together with those of traditional donor countries should also be explored. Throughout, all actors must work together to ensure an alignment of ongoing and emerging reform initiatives – such as the Lusaka Agenda, Accra Reset, Sevilla Platform for Action, HEAR CSO and the emerging WHO-convened process, as well as the wider UN80 process – to ensure technical and political momentum for reform is not fragmented.

### 4. Quick and pragmatic progress

Reform is an iterative process, not a single leap. Quick wins will be critical to building momentum and trust. Despite outstanding questions, reforms should be initiated in a stepwise manner, rather than waiting for full clarity and consensus. Priority reforms in governance, financing and other key areas should be put into practice through pragmatic agreements among diverse actors, grounded in clear and shared benefits for cooperation. Regional and global health meetings should be used to share early reform results, build coalitions and sustain commitment.

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## 2. Call to action

Section IV highlights the key next steps needed to ensure reform of the global health ecosystem in critical thematic areas. Operationalising these will require collective effort, and this section therefore summarises the key actions required across stakeholder groups as highlighted through the regional dialogues. These are not intended to be comprehensive and other actors, such as philanthropy and the private sector, will also have a critical role to play.

### 1. Governments: Establish and execute shared direction for reform, strengthen and align financing behind one plan and enable devolution where it adds value.

- Continue to drive forward progress on the Lusaka Agenda commitments, including:
  - [LMIC governments] Mobilise new finance for transition towards the domestic financing of health systems and re orient delivery toward PHC.
  - [LMIC governments] Institutionalise “one plan, one budget, one M&E,” co owned by health and finance ministries; strengthen donor coordination platforms.
  - [Donor governments] Operationalise “one plan, one budget, one M&E”. Redesign bilateral funding instruments and adopt more flexible cycles and arrangements to reduce administrative burdens on countries and allow multi year, system focused commitments with aligned cycles and longer disbursement windows.
- [All governments] Recognise the vital role of different actors, including civil society and communities, in health governance, and provide effective participation mechanisms at national, regional and global levels.
  - [All governments] Authorise independent review(s) and establish time-bound, evidence-based decision-making mechanism(s) in order to:
  - Agree steps to streamline functions, mandates and funding modalities of global organisations and between global and regional organisations (including regional and global financing institutions).

- Agree a roadmap for predictable, phased devolution of appropriate mandates, decision rights and resources to regional organisations.
- Consider change options, legal constraints and trade offs to improve board representation and practices across key global health boards and propose a way forward.

### 2. Regional organisations: take on clarified functions, build shared systems and harmonise markets.

- Work together, and with governments, to:
  - Identify and agree which regional institution(s) lead which key health functions and secure the decision-making authority and stable financing needed for delivery (including from regional financing mechanisms, such as MDBs and others).
  - Build up regional data and evidence platforms to enable cross border sharing and analytics that serve regional strategies.
  - Expand pooled procurement, drawing on proven models (the PAHO Revolving Fund, for example) and sharing lessons across regions to improve predictability and value for money.
  - Increase joint production of health supplies through advancing regulatory harmonisation, and other measures.

### 3. Global organisations: streamline, back regional actors, align to country plans and fix financing instruments.

- [All] Respect regional organisations and proactively enable subsidiarity: partner equitably, align technical assistance and financing to regional strategies and cede space for devolving functions; tighten accountability and coordination with regional organisations.
- [Global health organisations] In line with the Lusaka Agenda, adopt more flexible, long-term financing cycles and pooled arrangements to reduce administrative burdens on countries, and operationalise “one plan, one budget, one M&E”.

- [Global health organisations] Work together and with governments to streamline organisational mandates and arrangements (see above).
- [MDBs] Work with governments and partners to review and streamline funding modalities, and refine and expand long-term, system-focused concessional financing instruments that complement domestic and other resources (including GHI grants), under clear country leadership, without exacerbating financialisation or unsustainable debt burdens.
- [International Financial Institutions] Address inequitable fiscal space constraints, including reconsidering eligibility criteria based on income level that miss critical vulnerabilities (as seen with SIDS, for example), and working with governments, philanthropies and regional MDBs to scale catalytic credit-enhancing tools (for example, loan guarantees) to lower borrowing costs.

#### **4. Civil society, think tanks and academia: strengthen voice, evidence and accountability.**

- [Civil society] Advocate for, and exercise meaningful participation in, health governance at all levels, fostering transparency and accountability towards equitable outcomes and processes.
- [All] Work with governments and others to propose evidence-informed LMIC/ regional representation targets and equitable participation mechanisms on global health boards.
- [Think Tanks and Academia] Provide analysis and thinking that can inform governments and global health organisations to co develop clear guidance on financing instruments for transitions, to match domestic/partner sources (including MDBs and philanthropies) to financing needs.
- [All] Use mapping of health financing flows to hold actors to account and shape the evolution of effective and equitable financing arrangements at country, regional and global levels.

### 3. Key questions for moving forward

As set out above, joint work to drive forward global health reform must start now. But while we should not let outstanding questions dissuade us from taking action, we must also be clear on where further analyses and deliberations are needed to ensure a clear and unified path forward.

Specific outstanding questions have been highlighted for each reform area in section IV. Taken together, these also point to a broader set of underpinning questions that require urgent further consideration:

1. Is there consensus on a vision of the global health ecosystem that encompasses international coordination, external assistance and provision of regional and global public goods, in order to improve health outcomes and deliver collective value for all?
2. Do the functions set out in Section III adequately capture the key functions of a reimagined global health ecosystem? Is there agreement on the proposed balance of functions across regional and global levels?
3. Within each level, where should responsibility for each of these different functions lie? How can organisational mandates be clarified and, where needed, institutional capacities strengthened, to ensure a streamlined, coherent and effective ecosystem?
4. What further information – for example, on opportunity costs or trade-offs for different reform scenarios – is needed to inform prioritisation and sequencing of reforms?
5. What decisions need to be taken where – and by whom – to realise key reforms? How can different processes and fora at different levels be utilised to drive change?
6. What actions are needed from different stakeholder groups to drive progress? How can the above call to action be refined, strengthened and put into practice?

It will be critical that upcoming regional and global health reform discussions focus on progressively addressing these questions.

### 4. Conclusion

Substantive change in global health is inevitable. It is not a question of if the system will change. It is a question of when, in which direction and who shapes this future system. This demands collective thinking and action. Complementing other initiatives at the regional and global level, this paper offers one contribution to answer these questions.

Governments and non-governmental organisations from over 114 countries made their voice heard in thorough and systematic deliberation. They debated what the future system should look like and how to get there. To benefit from collective intelligence around the world, and ensure all countries and regions – particularly LMICs – have a strong voice in shaping the path forward, these discussions happened concurrently in Latin America and the Caribbean, Africa, Europe and North America, the Middle East and Central Asia, and Asia Pacific. Diverse and expert participants from, and based in, these regions carefully assessed and coalesced around reform priorities.

Collectively, these dialogues set out clear next steps, centred on shifting power and decision making from the global level towards countries and regions to build a more responsive and equitable global health ecosystem that is decentralised yet interconnected. They also highlight a number of critical outstanding questions. The resolution of these, and the success of wider ongoing global health reform initiatives, now depends on working together and drawing on shared knowledge, with all regions meaningfully engaged as co architects. Reform of the global health ecosystem requires a coherent and aligned effort across regions and stakeholder groups to seize the current window of opportunity and deliver a global health ecosystem that can match the health needs of today – and tomorrow.

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It is not a question of if the system will change. It is a question of when, in which direction and who shapes this future system.  
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# Endnotes

1. [Tracking universal health coverage: 2025 global monitoring report](#).
2. Often understood to entail the systems, structures, institutions, rules, and processes that collectively guide, coordinate, finance and implement efforts to improve health outcomes on a globally, including multi- and poly-lateral global and regional institutions and mechanisms, and bilateral partnerships, and others.
3. These dialogues were preceded by [five provocative proposals for a reimagined global health architecture](#) from individual thought leaders, used alongside many other inputs, to kickstart discussions.
4. [Latin America and the Caribbean Dialogue on Reforming the Global Health Architecture: Dialogues Outcomes Document](#)
5. [Reimagining Global Health Reform in the Asia Pacific: Nationally Designed, Regionally Coordinated, and Globally Aligned. Final Report](#).
6. [Global Health Architecture Reform Africa Regional Dialogue. Output Paper](#)
7. [Reforming the Global Health Architecture. Priorities and Perspectives from the Europe and North America Regional Dialogue](#)
8. [Middle East & Central Asia Regional Dialogue on Global Health Reform](#)
9. <https://futureofghis.org/final-outputs/lusaka-agenda/>
10. This was particularly raised in the Middle East and Central Asia, as well as Europe and North America dialogues.
11. Loan guarantees are catalytic or concessional capital to share the risk of a debt investment and to crowd-in additional capital. (<https://thedocs.worldbank.org/en/doc/164f0203d738919baef24f0a1a2fb788-0140022024/original/Development-Bank-Working-Group-Joint-Roadmap-JUNE-12-2024-FINAL.pdf>)
12. This is emphasised in particular in the Africa, Europe and North America as well as Middle East and Central Asia dialogues.
13. The Europe and North America dialogue expressed general support for subsidiarity, openness to greater regionalisation, and leveraging regional development banks and other financing mechanisms. However, the region did not discuss specific regional financing mechanisms in detail.
14. Further information about the Health Architecture Reimagined Civil Society Organizations project can be found here: <https://hearcso.org/>

# Partners

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## Africa:



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## Asia Pacific:



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## Europe and North America:



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## Latin America and the Caribbean:



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## Middle East and Central Asia:



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