September 2026

A Sovereign Future for Health

A Report by the Accra Reset High-Level Panel on Reform of the Global Health Architecture and Governance

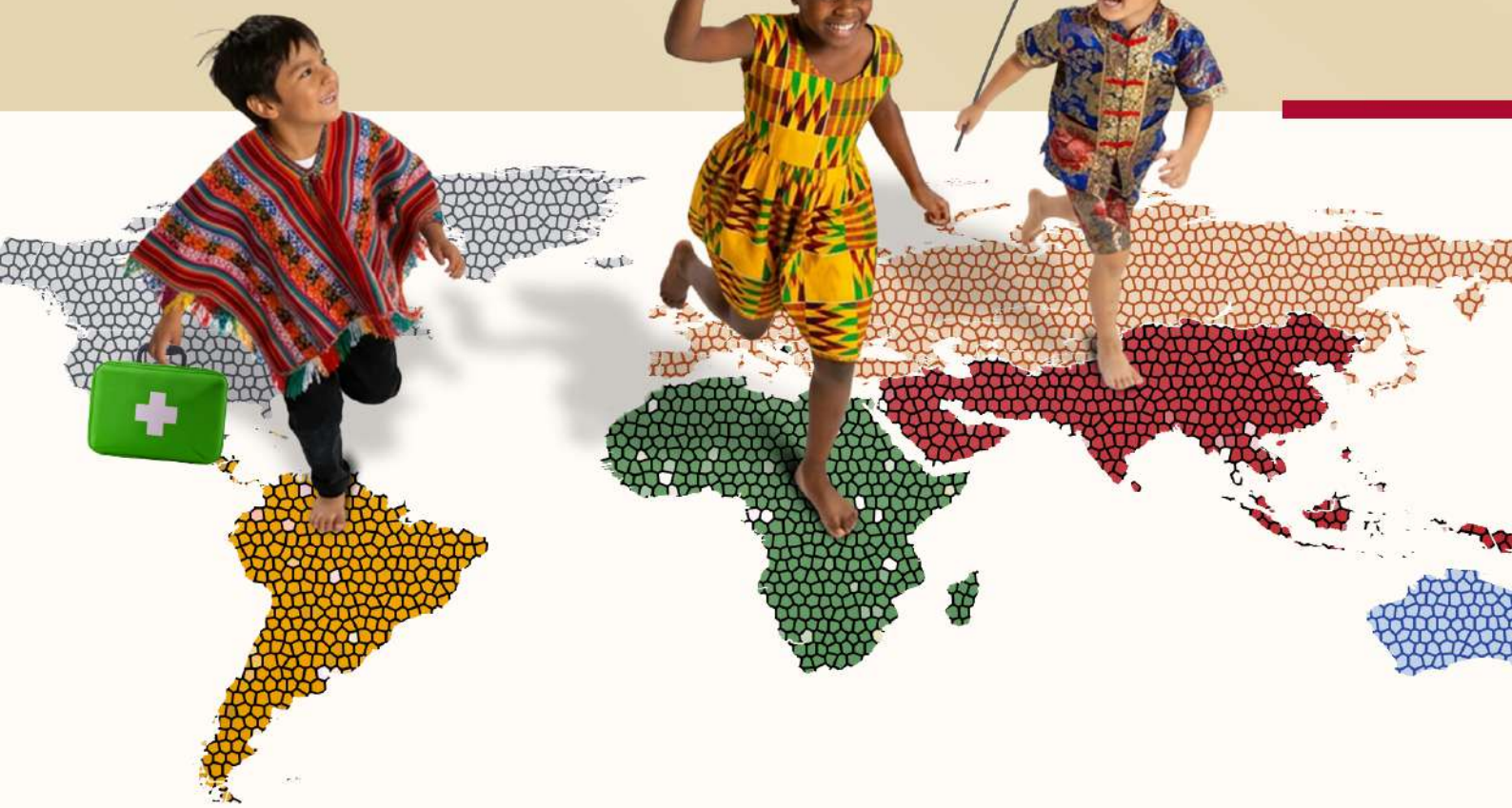

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Table of Contents

Foreword

On behalf of the Accra Reset Presidential Council

H.E. President John Dramani Mahama

The past few years have shaken global health cooperation to its foundations. The COVID-19 pandemic exposed the risks created by concentrated production and unequal access to essential health products; rising debt and fiscal pressures have constrained national health budgets; and declining development assistance is placing programmes and services under growing strain. These shocks have brought new urgency to reform debates that have continued for years with limited progress. It was in this context that we launched the Accra Reset and its Sovereign Health Agenda — to give renewed political force to the reform agenda and place the agency of countries of the Global South at its centre.

To translate this renewed political momentum into a credible reform agenda, the Presidential Council of the Accra Reset convened a time-bound High-Level Panel on the Reform of the Global Health Architecture and Governance, bringing together thought leaders and practitioners from across the world. We asked its members to examine what has worked, confront what has become unsustainable and propose credible alternatives. Their independence was the source of their authority. But we were equally clear about the kind of analysis the moment required.

We asked them to be specific. The world does not need another eloquent diagnosis of global health; what it lacks is clarity about alternative designs. We went further. We even asked them to choose their controversy – a report that does not push the boundaries changes nothing. And we asked them to write for the citizen – the mother in Tamale or Tambacounda may never read this report, but she can feel its impact.

The High-Level Panel has answered that mandate with recommendations that are ambitious, clear and grounded in the realities confronting countries. They are not a call to abandon international cooperation or dismantle institutions indiscriminately. Global health has achieved too much, and no country can protect health alone. The task is to build a more mature form of cooperation: one that strengthens national sovereignty and regional capability while it protects past gains, aligns authority with responsibility, and concentrates global action where it adds the greatest value.

A new global health order is already taking shape. Countries of the Global South should not merely adjust to emerging changes; they must lead its re-design in ways that strengthen the health sovereignty of nations while renewing solidarity. This report provides technical guidance for doing so.

This High-Level Panel has completed and delivered on its task. The political work to translate this into country, regional and global programmes now begins.

Preface

Co-Chairs, Accra Reset High-Level Panel on Reform of the Global Health Architecture and Governance

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The past twenty-five years have demonstrated what is possible when resources, political leadership, and innovation work together. Child mortality has been cut in half. New cases of the world's deadliest infectious diseases have fallen dramatically. Centres of excellence in health are now operational across the world, and manufacturing of medical commodities is now being developed in an increasing number of countries across the Global South. However, sustaining and extending those gains requires an honest reckoning with what is no longer working.

The global health architecture has grown in scale and complexity, but not in coherence. Fragmented institutions, overlapping mandates, and volatile financing place a heavy burden on the very countries they are meant to support — consuming scarce government capacity for planning, reporting and compliance rather than for delivering health services to people. Programmes have too often been designed around donor priorities rather than nationally defined needs. Meanwhile, the accelerating burden of non-communicable disease, compounded by climate-related pressure and demographic change, remains largely absent from international and often domestic health financing, and is outpacing the capacity of many health systems to respond.

The financing landscape is shifting sharply, and this is not a temporary fluctuation to be waited out. The model of development assistance for health that served the past quarter-century cannot simply continue as before. Our collective mission is now to strengthen more sustainable, more equitable, and more effective health systems, to improve the health of all citizens. The momentum for genuine reform, co-created with countries, regional bodies, and global institutions, and as much as possible funded domestically, has never been stronger.

It was to seize this moment that President John Dramani Mahama of Ghana launched the Accra Reset — a global initiative, initiated in Africa, to build a world order in which relationships between countries are defined by genuine partnership and mutual benefit rather than by dependency. Under its auspices, the Presidential Council of Heads of State, together with the Guardians' Circle, established this High-Level Panel of 23 eminent experts from across the world and representing government, civil society, business, and academia. Our primary mandate is to produce a report with a small number of ambitious, practical, and executable reform proposals that governments, investors, and institutions can act on — recommendations the Council can champion at the 81st United Nations General Assembly (UNGA) in September 2026 and beyond.

A reformed global health architecture must support the capacity of countries and regions to set their own health agendas. We would like to thank all Panel Members for their outstanding commitment over the past six months, and for their inspiring contributions to our report.

We hope that the work of the High-Level Panel will lead to much-needed reforms in line with the recommendations and that these will be translated into action at the country, regional, and global levels for the benefit of all our citizens.

1. Executive Summary

Global health cooperation has delivered gains of historic importance over the past three decades. But the architecture that helped to secure these gains now operates in a profoundly different world, marked by overlapping disease burdens, fiscal pressures and high debt, declining development assistance, concentrated supply chains and a more fragmented geopolitical order. The case for a reset rests on the recognition that an architecture built for an earlier era must evolve if it is to preserve its achievements and remain equal to the demands of the next. But even more important, it is time for countries of the Global South to define and pursue their own development paths and health priorities.

This report proposes five political shifts and ten recommendations for reforming the global health architecture and advancing health sovereignty.

The current global health architecture is organised largely around external financing streams, individual institutions and disease-specific mandates. The Reset proposes an architecture organised around country-defined priorities, sovereign national capabilities, delegated regional functions and a limited set of genuinely global public goods. Institutions and financing mechanisms must align with that architecture.

Under Accra Reset's broader Sovereign Health Agenda, true sovereignty goes beyond mere political independence and requires economic, resource, and systemic self-reliance. Health is a central driver of development, and better health and healthcare must rely on domestic financing, local and regional manufacturing of essential medicines, legal, economic and environmental support, and self-sustained health infrastructure. [1]

The Accra Reset and its Sovereign Health Agenda build on decades of global health reform thinking. Its diagnosis reflects a growing consensus, and many of its proposed instruments have identifiable precedents. Its unique contribution is the political architecture created by bringing these elements together. Collectively, the five shifts and the ten recommendations amount to a constitutional settlement for global health.

Five Political Shifts

From Nominal Country Ownership Towards Practical Sovereignty: First, the reset advances practical sovereignty. Countries should own the decisions, the financing framework and the data required to govern their health systems. They should not merely endorse externally financed programmes; health, financial and data sovereignty are mutually reinforcing. Productive sovereignty adds the scientific, technological, regulatory and manufacturing capability required to translate national decisions into actual products and services.

From Aid-Centred Cooperation to Sovereign Partnership: Second, the reset moves beyond the traditional debate on aid effectiveness. It asks what global health cooperation should become when aid can no longer remain its principal organising framework. Domestic resources become the foundation for core national responsibilities, while external financing is redirected towards managed transitions, capacity development, fragile settings, regional functions, emergencies and global public goods. This will redefine solidarity between more sovereign partners.

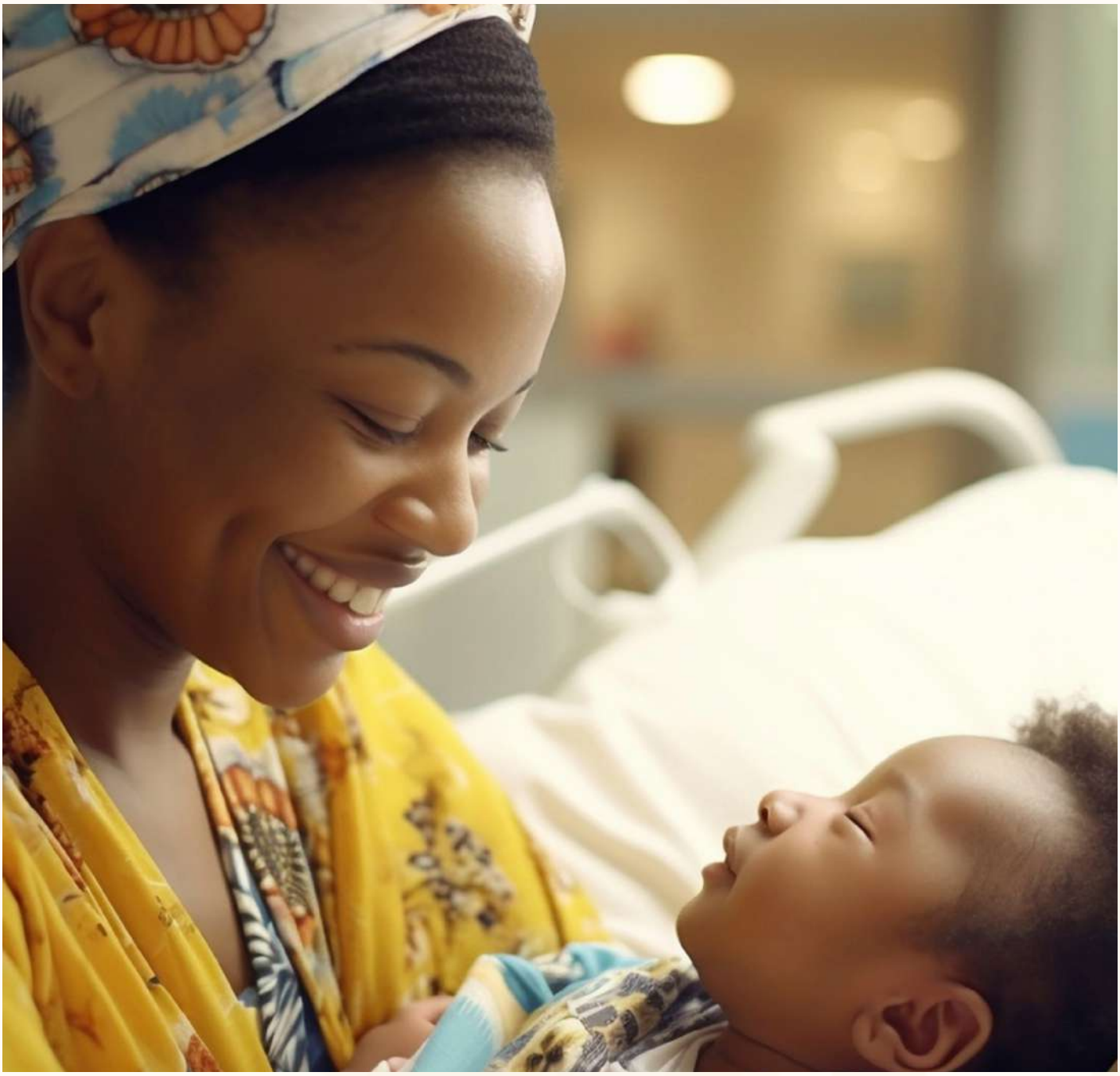
From Regional Coordination to Collective Power: Third, it transforms regional cooperation from a diplomatic aspiration into an exercise of collective power. Regional institutions are not treated simply as intermediaries between countries and global organisations. They become the level at which countries can jointly regulate, research, manufacture, procure, negotiate and respond to cross-border threats. The Reset connects innovation, technology transfer, production, regulation and predictable demand into one regional economic ecosystem, with subsidiarity as a guiding principle.

[1] Accra Reset. (n.d.). What we deliver: Health. https://accrareset.org/what-we-deliver#health

From Institutions First to Functions First: Fourth, the reset subjects global health institutions to a continuing functional test. It proposes 'The 4Cs' – Commit, Collaborate, Consolidate and Close – to move the discussion from "How can existing institutions coordinate better?" to the more fundamental question: "Which functions still justify a separate global institution?" Institutions would be judged by their continuing functions and comparative value, not merely by their history, constituencies or ability to mobilise resources.

From Self-Reporting to Independent Accountability: Fifth, the reset moves from institutional promises and self-reporting towards independent and public accountability. The combination of Head-of-State leadership, measurable benchmarks, public reporting and citizen-accessible information could bridge the gap that has undermined previous reform efforts: the gap between technical recommendations and political implementation.

These political shifts represent the logic and architecture of the Reset. The ten recommendations that follow are the operational pathways for translating them into action.



Ten Recommendations

Every person is born with the fundamental right to health, well-being, and the opportunity to achieve their full potential as a foundation for every community and country - a basis for global collective progress towards a mutually beneficial world.

Over the past decades, global health cooperation has delivered tremendous gains, saving millions of lives through programs, innovations, and partnerships with governments, donors, the private sector, civil society, and communities. The world has since evolved - with new health needs, disease epidemiology, country capacities, geopolitics, and funding challenges - but the global health architecture has been left behind.

A shift - the Reset - is needed now. One that elevates country leadership, advances sovereignty, realigns cooperation based on shared priorities, and ensures that a fairer and more equitable global health ecosystem can deliver for decades to come.

The Global South is home to over 80% of the world's population and two-thirds of the world's youth population in an ever more connected world. It holds vital reserves, trillions of dollars in collective economic power, and is driving global consumption. Innovations and strategic investments in health and other fields will either catalyse solutions and generate economic growth and regional stability or accelerate systemic failures, including increasing inequality, uncontrolled pandemics, socioeconomic crises and mass migration.

The choice is ours to make.

Overarching Principles

Health as a key driver of development | Universal access and equity | Sovereignty — health, financial, and data | Country agency and subsidiarity Efficiency gains | Accountability at every level

10 Recommendations for Reforming the Global Health Architecture

1. One-Stop Country Compact: One Plan. One Budget. One Platform

Establish a one-stop country compact within 12 months, jointly led by the Ministries of Health, Finance and Planning and together with locally relevant stakeholders, with full alignment of restructured international partners. Using credible National Health Plans (NHPs) aligned with broader development strategies as the single organising framework, embed a costed, multi-year Health Investment Plan (HIP) within the NHP as its financing and implementation component; integrate it into the national budget and public financial management cycle; map domestic and external resources, financing gaps, and a realistic financing pathway. Establish a single country-led National Coordination Platform (NCP) as the governance, coordination, implementation and mutual-accountability mechanism for health financing, building on existing national budgeting, public financial management, audit, procurement, coordination and health-information systems which may be supported by interoperable digital tools where appropriate. International partners will be expected to reorganise their structures and ways of working to fully comply with NHPs.

2. Accelerate a Sustainable Financing Transition: Build Health Sovereignty on Domestic Resources

Treat health as an investment in economic growth, productivity, employment, human capital development, stability, resilience and prosperity. Using National Health Plans (NHPs) as a foundation, governments should mobilise sustainable and equitable domestic financing through national budgets, progressive revenue measures, national health insurance and other pooling arrangements, while ensuring universal health coverage as defined by WHO through financial protection and reduction of out-of-pocket expenditure. NHPs should allocate domestic and external resources according to the country's needs, shifting progressively from disease-specific silos towards people-centred national health systems. Recognising country variation and the challenges of fragile and low-capacity states, external financing, including multilateral banks, should complement country priorities through managed, context-specific transitions that safeguard essential services and fiscal and debt sustainability, while strengthening national capacities.

3. Empower Regional Institutions as Expressions of Country Agency

Where countries determine that shared health priorities are more effectively pursued through regional cooperation, they should formally recognise and empower existing regional institutions (where possible) as actors with delegated mandates for specified regional and cross-border functions — surveillance and reference laboratories, pooled procurement, regulatory harmonisation, emergency response, and manufacturing ecosystems — backed by sustainable member-state financing and accountability to their Member States. Respecting the subsidiarity principle, global partners should recognise these mandates and redirect technical support and financing where appropriate to this level, reinforcing or establishing at least one pooled mechanism at the regional level within 12-18 months.

4. Build an Equitable Health Innovation Ecosystem

Reinforce or establish regionally led platforms that advance coordinated research and development (R&D) and innovation priorities based on national and regional health needs, using integrated, disease-agnostic clinical trial platforms that also build the capacity of discovery sciences to feed the product pipeline and are empowered with the required skilled workforce, driven by scientists and expert collaborations working cross-regionally. This should attach committed public financing with built-in access provisions whenever public or philanthropic funding is deployed to develop innovations, and an assured demand for the R&D priorities listed in National Health Plans (NHPs). Publicly supported R&D should also leverage cross-regional and global collaboration that translates innovations into accessible and affordable health products.

5. Increase Investment in Health Products Manufacturing based on Organised Regional Collaboration

Countries should increase direct investments in the manufacturing of health products, align national efforts with regional priorities, and commit to a coordinated regional division of labour centred around product availability, access, affordability, and sustainability, with a regionally led pilot initiated or reinforced within 12-24 months. Backed by country and regional financing mechanisms, and governed through existing (or new) regional governance arrangements, investments must prepare manufacturers to co-develop, absorb full-process technology transfer, and use other recipient-readiness facility models. Leaders should advocate for the adoption by IP holders of technology-transfer terms that secure regional supply rights and the right to improve, adapt, and sublicense technologies; facilitated through regional regulatory compacts whereby countries commit to making reliance the legal default.

6. Turn Fragmented Demand into Market Power through Regional and Global Procurement and Commodity-Security Coalitions

As a driver for regional health security within 18 months, establish or reinforce country-led procurement and commodity-security coalitions, while recognising and collaborating with existing and impactful procurement programmes, many of which may also evolve in support of the broader reform of the global health architecture. Coalitions will often be regional or sub-regional because regulation, trade, logistics, and political accountability are frequently organised at those levels but may also include strategic partnerships with countries across regions or at a global level. Countries should aggregate nationally and/or across borders to coordinate demand and supply, making predictable and reliably financed purchasing commitments, while strengthening local and regional productive, regulatory, technological, and manufacturing capacities. Countries may also operate across regions where product markets, disease priorities, or manufacturing capacity make that more effective. Regional sourcing preferences should be phased progressively over five to ten years, in step with the maturation of regional manufacturing capacities, and in partnership with existing global initiatives as they evolve to support country and regional priorities.

7. Refocus Global Cooperation on Global Public Goods

Refocus global cooperation on global public goods (GPGs) based on shared responsibility and mutual benefit, enabled by predictable collective financing beyond aid budgets and equitable, transparent governance. Through a coordinated process within 12 to 24 months, participating governments should define the functions covered, costs, contribution approach, governance, financing instruments, institutional home, and equitable-access safeguards, using or reforming existing mechanisms where possible.

8. A Stronger Humanitarian Continuity Mechanism for Health

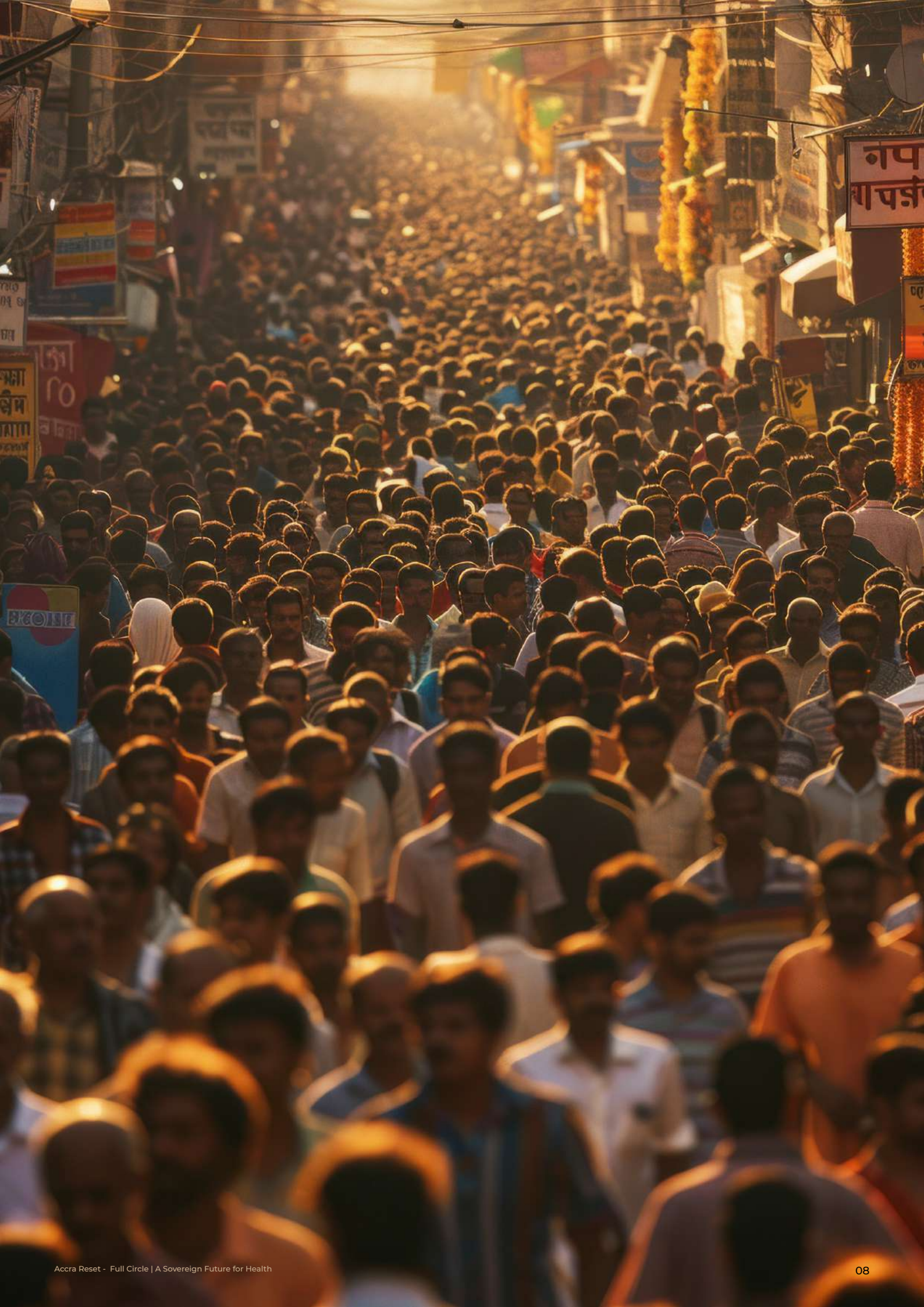
Countries should develop a coherent cross-institutional humanitarian response capability for humanitarian crises and other shocks, coordinated through national Health Emergency Operation Centres within 12 months. It should use existing activation triggers, access criteria, decision rights, disbursement channels, replenishment rules, and equitable-access safeguards; cover countries based on need, including fragile populations in middle-income countries; and avoid diverting routine country allocations or essential services. Collaborative, multi-sectoral country, regional and global action will be essential to its delivery.

9. Intentionally Reform Global Health Institutions through more effective collaboration, strategic consolidation and closure when appropriate

With immediate effect, strategically reform global health institutions whose main business is passing money, commodities and products to countries, through the 4Cs pathway – Commit, Collaborate, Consolidate, Close. Consolidation should occur in the medium-term as National Health Plans (NHPs) help discern how to most effectively combine functions of international organisations. Where appropriate, complete the transition within five to ten years while continuing and adapting functions and international funding to safeguard global public goods, humanitarian continuity, and the health gains of the past two decades. This will require international partner buy-in and reformed boards giving countries an equitable say over the pace and shape of the transition, with appropriate support for countries. This transition should be managed through a country-led process including relevant actors and taking into account the function and governance mechanisms for each institution considered.

10. An Independent Accountability Mechanism for the Reset and Continued Evolution of the Global Health Architecture

Within 6 months of the launch of this report, the Accra Reset Presidential Council should establish an independent follow-up and accountability mechanism to monitor and regularly report on the implementation of the Accra Reset Sovereign Health Agenda, including the HLP recommendations — tracking progress made by governments, international partners, global health institutions, development banks and regional bodies against agreed benchmarks, and publishing the results openly. The mechanism should be co-designed and led by governments, prioritising utility and building trust, with citizens and local organisations able to follow and verify whether commitments made to their health systems are being delivered.



2. ‘The Reset’ and Why it is Needed Now

A record of achievement, and a responsibility to adapt

The existing global health architecture has delivered gains of historic importance over the last three decades. Between 2000 and 2023, the global universal health coverage service coverage index increased from 54 to 71, while the share of people who became financially constrained as a result of out-of-pocket health payments fell from 34% to 26% between 2000 and 2022. [2] Over the same broad period, under-five mortality fell by more than half. [3] AIDS-related deaths have declined by 73 per cent from their 2004 peak. [4] Cooperation among governments, multilateral organisations, global health initiatives, development partners, research institutions, civil society, communities and businesses has expanded access to vaccines, diagnostics, medicines and essential health services; accelerated scientific innovation; strengthened disease surveillance and emergency response; and helped reduce suffering on a vast scale.

The aim of the proposed reform of the global health architecture is to ensure that the gains of the past can be sustained, and that the global health architecture responsible for them evolves to remain legitimate, effective and capable of responding to the world taking shape now. [5]

That world differs markedly from the one in which many of today’s institutions and operating arrangements were established. Countries face an increasingly complex combination of infectious diseases, non-communicable diseases, demographic change, climate-related risks, conflict, displacement and recurring emergencies. [6] Fiscal constraints have deepened, while development assistance has become more uncertain and contested. [7] Geopolitical power is becoming more dispersed, and governments across the Global South are seeking a role commensurate with their growing capabilities and responsibilities.

The case for a reset therefore rests on the recognition that an architecture built for an earlier era must evolve if it is to preserve its achievements and remain equal to the demands of the next.

From persistent pressures to structural questions

Successive reform processes have drawn international attention to inequity, fragmentation, financing gaps, weak coordination, insufficient country ownership and the need for stronger preparedness. Though global conversations have advanced and, in numerous settings, improved delivery and access, [8] several underlying questions remain unresolved when it comes to determining what the future of global health should look like. Who ultimately sets priorities? How should domestic and external resources be brought into one credible national framework? Which functions properly belong at country, regional or global levels, and who decides this? How can countries assume greater responsibility without exposing people to abrupt losses of support? How should institutions with overlapping mandates collaborate, consolidate or evolve? And how can governments, donors and global institutions be held to account through a common view of commitments, expenditures and results?

[2] World Health Organization & World Bank. (2025, December 6). Most countries make progress towards universal health coverage, but major challenges remain, WHO/World Bank report finds [Press release]. https://www.who.int/news/item/06-12-2025-most-countries-make-progress-towards-universal-health-coverage-but-major-challenges-remain-who-world-bank-report-finds
[3] World Health Organization. (2026, March 18). Progress in reducing child deaths slows as 4.9 million children die before age five [Press release]. https://www.who.int/news/item/18-03-2026-progress-in-reducing-child-deaths-slows-as-4.9-million-children-die-before-age-five
[4] Joint United Nations Programme on HIV/AIDS. (n.d.). UNAIDS fact sheet. https://www.unaids.org/en/resources/fact-sheet
[5] Accra Reset. (n.d.). What we deliver: Health. https://accrareset.org/what-we-deliver#health
[6] World Health Organization. (2026). World health statistics 2026: Monitoring health for the SDGs, Sustainable Development Goals. https://iris.who.int/server/api/core/bitstreams/45189137-2f10-48e1-ae43-91b0d8ddd120/content
[7] Organisation for Economic Co-operation and Development. (2026). ODA projections for 2026 and the near term. OECD Publishing. https://www.oecd.org/en/publications/oda-projections-for-2026-and-the-near-term_d7c74fa2-en/full-report.html
[8] Future of Global Health Initiatives. (2023). The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives process. https://futureofghis.org/final-outputs/lusaka-agenda/

Combined, these questions concern the distribution of authority, responsibility, capability and accountability. Too often, country ownership is affirmed as a principle while financing cycles, reporting requirements, programme designs and institutional incentives continue to be determined elsewhere. National authorities may be required to manage multiple plans, applications, missions, procurement channels and results frameworks, each individually defensible but collectively burdensome. Regional institutions are frequently expected to perform essential cross-border functions without sufficiently clear mandates or the predictable financing needed to effectively deliver them. At the global level, valuable institutions can find themselves operating through arrangements that duplicate effort, diffuse responsibility or increase avoidable costs, which may reduce what ultimately reaches the countries they exist to support.

The result is a system whose value is often delivered through arrangements that are more fragmented, administratively demanding and externally directed than present circumstances require. Incremental improvements remain necessary, but they are unlikely on their own to resolve these deeper structural questions. Adaptation of the global health architecture must now become structural: careful enough to preserve continuity, but ambitious enough to change how the system works for the better.

Dependency, vulnerability and marginalisation in global health

The Sovereign Health Agenda of Accra Reset situates these challenges within a wider triple burden that constrains the agency of many Global South countries: dependency, vulnerability and marginalisation. In health, these burdens are closely connected.

Dependency arises where essential programmes, commodities, technical functions or institutional capacities rely heavily on decisions, supply chains, and financing beyond the effective control of the countries concerned. External support has often been indispensable and will remain important, particularly for countries facing severe fiscal constraints and for humanitarian and epidemic response. The difficulty arises when support substitutes indefinitely for national systems, fragments national priorities, or can be withdrawn without an orderly transition capable of protecting essential services.

Vulnerability follows when countries remain exposed to abrupt changes in aid, supply disruptions, emergencies, price movements, or decisions taken in distant institutions. The COVID-19 pandemic made these risks unmistakable, but they extend beyond emergencies. Limited fiscal space, high debt burdens, concentrated manufacturing and supply chains, weak procurement leverage, incomplete data and uncertain access to innovation can each constrain a government's ability to protect its population. [9]

Marginalisation occurs when communities that carry a substantial share of disease burdens have insufficient influence over the rules, priorities and value chains that shape their health outcomes. It is reflected in governance arrangements, research agendas, financing terms, access to intellectual property and technological capabilities, and the distribution of value across pharmaceutical and supply chains. It can also be reproduced within countries when communities, civil society and frontline practitioners are excluded from decisions and cannot verify whether commitments translate into services for their communities.

Addressing this triple burden requires redesigning international relationships and partnerships so that cooperation expands agency, reduces vulnerability, and gives countries and communities a meaningful sovereign role in shaping the decisions that affect them and their health outlook.

What 'the Reset' means for Global Health

This reset is a deliberate effort to achieve health sovereignty. In this framework, countries begin from different fiscal, institutional and epidemiological circumstances, and the path towards greater health and financial responsibility will vary accordingly. Technical support and external financing should complement rather than direct national priorities, and any agreed transitions should be paced, jointly managed and supported. Data sovereignty similarly requires more than formal ownership. Countries need reliable systems, quality assurance and the capability to turn data into timely decisions. Across all three dimensions – health, financial and data sovereignty – the objective is practical agency exercised within a system of continuing interdependence.

[9] Independent Panel for Pandemic Preparedness and Response. (2021). COVID-19: Make it the last pandemic. https://theindependentpanel.org/main-report/

Why the Global South must take Initiative

The countries of the Global South are not a single bloc, nor are they defined by geography; they are a collective of countries from Africa, Latin America, the Caribbean, parts of Asia, and Oceania. Their interests, capabilities, and economies are diverse. They nevertheless share a compelling stake in the reform of global health. They are home to most of the world's young people, carry a substantial share of its health challenges, and experience most directly the consequences of fragmented financing, constrained policy space, and unequal access to innovation. They also possess expanding scientific, policy, manufacturing, digital, and institutional capabilities that can contribute far more to global solutions than existing arrangements often permit. [10]

Leadership by the Global South does not exclude or displace established partners. A durable global health system will continue to depend upon shared responsibility among countries at all income levels, international institutions, philanthropy, business, science and civil society. But legitimate cooperation requires those most affected to participate meaningfully in the redesigned global health architecture. It also requires countries seeking greater authority to accept greater responsibility: to invest in their own systems, strengthen public institutions, improve transparency and confront domestic inequalities.

What makes the Accra Reset different for Global Health

The Accra Reset is a Head-of-State-driven initiative, convened under the stewardship of serving and former leaders, to address the interconnected burdens of dependency, vulnerability and marginalisation that constrain the policy agency of Global South countries across sectors including health, trade, finance, agriculture, manufacturing and governance. Health stands at the leading edge of this broader agenda. It is the sector most exposed to the consequences of aid dependency, but also one of the clearest testing grounds for demonstrating that sovereignty-led models can deliver.

The Accra Reset and its Sovereign Health Agenda build on a substantial body of global health reform thinking developed through earlier initiatives. These include the Paris Declaration [11], IHP+, UHC2030 [12], the Lusaka Agenda [13], Africa's New Public Health Order [14], and the Wellcome dialogues. [15]

Its claim to distinctiveness lies in the way the initiative brings together political sponsorship, a sovereignty-centred framework and a practical pathway from recommendation to implementation.

First, **the Reset connects reform across country, regional and global levels.** It treats global institutional reform as an integral part of the organisation of national plans, budgets, data and accountability. By applying subsidiarity, it asks where each function can be discharged most effectively and with the clearest accountability.

Second, **the Reset treats health, financial and data sovereignty as mutually reinforcing.** Countries cannot meaningfully determine their priorities without a financing pathway, and they cannot plan, allocate or account without trustworthy data. Conversely, domestic responsibility cannot be strengthened through abrupt withdrawal or by transferring obligations without the corresponding capability and resources. The recommendations therefore combine greater country agency with managed transition and continuing international solidarity to build delivery capacity at levels where it is most required.

Third, **the Reset addresses institutional incentives and relationships.** It calls for clearer mandates, reduced procedural burdens, stronger regional functions, collaboration and consolidation where fragmentation no longer serves countries, and the preservation of essential global and humanitarian functions. In doing so, it recognises that institutional reform must be negotiated with those whose mandates, resources and responsibilities will change.

Fourth, **the Reset is designed to travel beyond publication.** The Presidential Council provides high-level political sponsorship; the Circle of

[10] Håheim, S., & Mushtaq, U. (2025, November 26). A turning point: Lusaka Agenda is anchored in the G20 declaration. Health Policy Watch. https://healthpolicy-watch.news/a-turning-point-lusaka-agenda-is-anchored-in-the-g20-declaration/
[11] Organisation for Economic Co-operation and Development. (2005). Paris Declaration on Aid Effectiveness. OECD Publishing. https://www.oecd.org/en/publications/2005/03/paris-declaration-on-aid-effectiveness_g1g12949.html
[12] UHC2030. (n.d.). About us: History. https://www.uhc2030.org/about-us/history/
[13] Future of Global Health Initiatives. (2023). The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives process. https://futureofghis.org/final-outputs/lusaka-agenda/
[14] Africa Centres for Disease Control and Prevention. (2023, April 4). The new public health order: Africa's health security agenda. https://africacdc.org/news-item/the-new-public-health-order-africas-health-security-agenda/
[15] Wellcome Trust. (2026). Rethinking the future of global health: A global dialogue. https://wellcome.org/insights/reports/rethinking-future-global-health-global-dialogue

Guardians contributes experience and moral authority; the High-Level Panel provides independent analysis and advice; and a coalition of willing countries and institutions can translate proposals into early demonstrations. Engagement through African, Global South and universal forums can then build broader support, while independent accountability can show whether commitments are being honoured.
These elements create an opportunity to bridge a divide that has weakened many previous global health reform efforts: the divide between technical recommendation and political implementation. The Accra Reset Sovereign Health Agenda is intended as a politically empowered platform through which global health reform, informed in part by the work of this High-Level Panel, can be debated, demonstrated, measured and progressively institutionalised.

The country and community test

The ultimate test of any architecture is the difference it makes in people's lives. For communities, the Reset should mean stronger and more resilient services; continuity during financial or institutional transitions; greater influence over decisions; and accessible information about the resources committed in their name and the results achieved. For countries, it should mean one coherent framework for priorities and financing, stronger national and regional capability, better value for money, and partnerships that support rather than circumvent public systems. For the global community, it should mean more reliable provision of public goods, better preparation for shared threats, better value for money and a fairer basis for collective action.

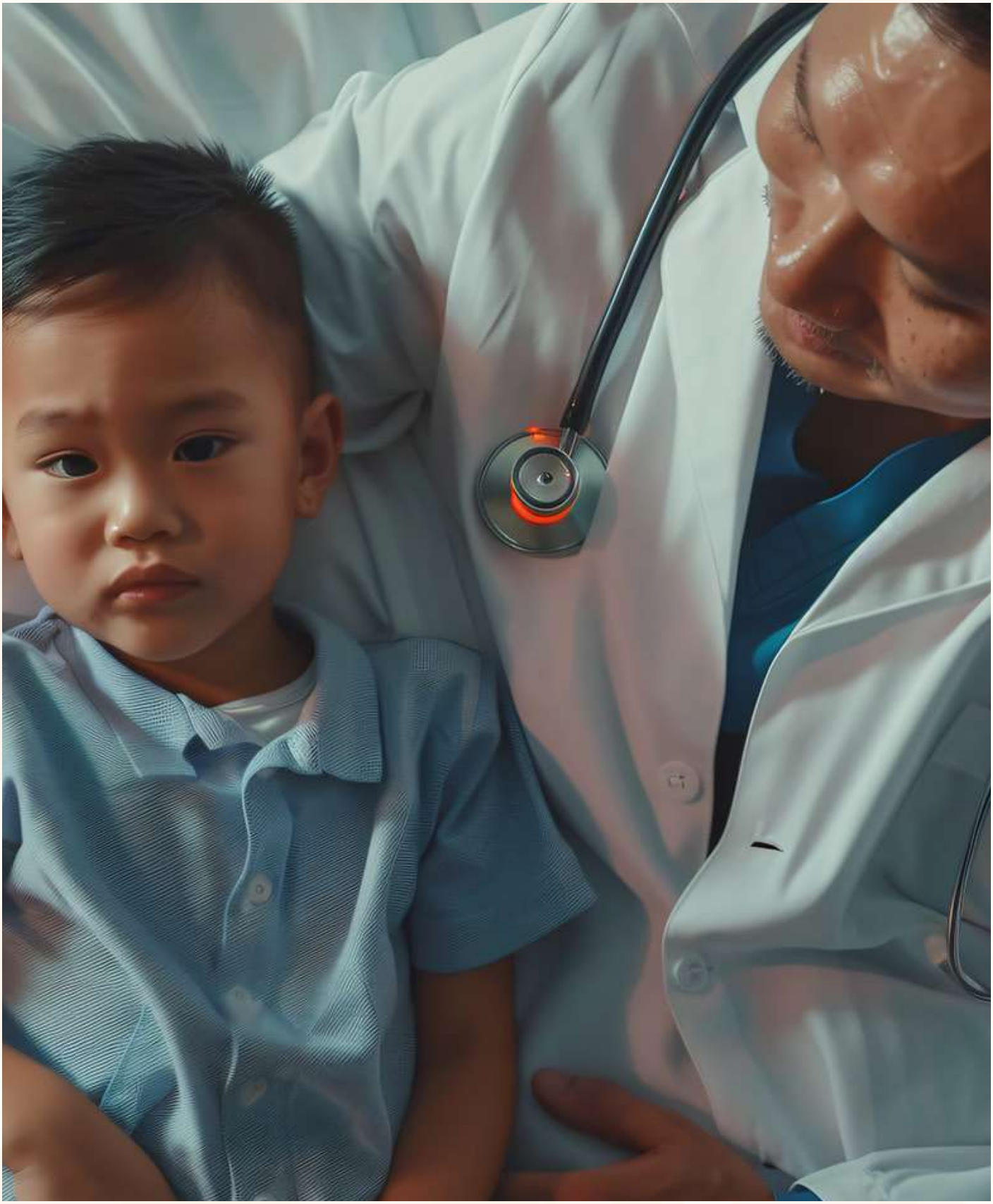
This is the standard against which the recommendations that follow should be judged. They do not offer a single institutional blueprint for every country or prescribe change without regard to context. Together, they set out a direction: from fragmentation towards coherence; from externally driven arrangements towards shared responsibility and country agency; from episodic commitments towards predictable capability; and from self-reported promises towards transparent accountability.

From Analyses to Recommendations: The HLP's Approach

The HLP's 23 members, drawn from government, civil society, business, and academia across the world, were announced in April 2026, alongside the HLP's concept note. To ensure each area of inquiry had a senior champion, the Co-Chairs divided leadership of the HLP's three workstreams among themselves: Priscila Ferraz led the work on health sovereignty, spanning the full value chain from innovation and regulation through production, procurement, and access; Minister Budi Gunadi Sadikin led the workstream on the financing of health in a post-aid world; and Peter Piot and Elhadj As Sy co-led the workstream on governance and institutional reform. This division assigned clear responsibility without limiting any Co-Chair's engagement across the full scope of the HLP's work.

Building on previously published analyses, the Panel applied a shared success framework and a five-part decision test: each recommendation had to name a concrete action, relevant actors, a proposed timeline, a credible mandate, and a clear account of why this Panel — by virtue of its political access, Global South anchoring, and cross-cutting scope — was uniquely placed to advocate for its advancement.

Recommendations were then tested through successive rounds of engagement: consultations at the World Health Assembly in May 2026, including the Accra Reset High-Level Dialogue hosted by President Mahama, where the HLP also set out its complementarity with parallel reform processes; and written comment and virtual deliberation by the full panel on draft working papers in June. The process converged at the full panel plenary in Dakar in July 2026, where members — with input from stakeholders working on health systems transformation on the ground — debated, stress-tested, and validated the headline recommendations. A final HLP comment period and Co-Chair review preceded endorsement by the Presidential Council, ahead of the report's presentation at the United Nations General Assembly in September 2026.



3. Recommendations for Reforming the Global Health Architecture

Leveraging previous analyses on Global Health Reforms

The case for reform has been argued by experts across academia, public policy and public health advocacy across five broad themes. These themes formed the basis of the HLP's recommendations.

Sovereignty and Country Ownership
The most consistent and widely voiced area for reform is country ownership. Over the years, GHIs have operated parallel programmes that have not only run counter to national health needs but have also, in some cases, created institutional substitution, in which domestic capacity stagnates and is displaced while external organizations influence and shape national priorities. [16] [17] Various reforms by GHIs are underway, with efforts to better align with and empower countries, as well as support national priorities. [18] The proposition here is to push for a national plan led by Ministries of Health and Finance and any other relevant ministries, with external actors aligning behind it. [19]

Financing Transition
The pace of transitioning to domestic financing will vary. For many countries in the Global South, the abrupt changes in the global health financing system require rapid response and adjustments that their fiscal structures are not able to accommodate in the short-term. External financing for health in Africa has contracted by close to 70 per cent between 2021 and 2025 [20], and historically aid-dependent countries, particularly in Africa, must adapt quickly. We have seen some bold responses over the past year. Ghana, for instance, removed its National Health Insurance Levy cap, thus generating a GHS 3.4 billion health budget increase [21], while Nigeria increased its health budget by USD 200 million [22] with plans to absorb the 28,000 health workers previously on USAID payroll. [23] While the capacities of individual countries will differ, domestic financing must be the foundation on which external financing and aid provide support during the transition phase.

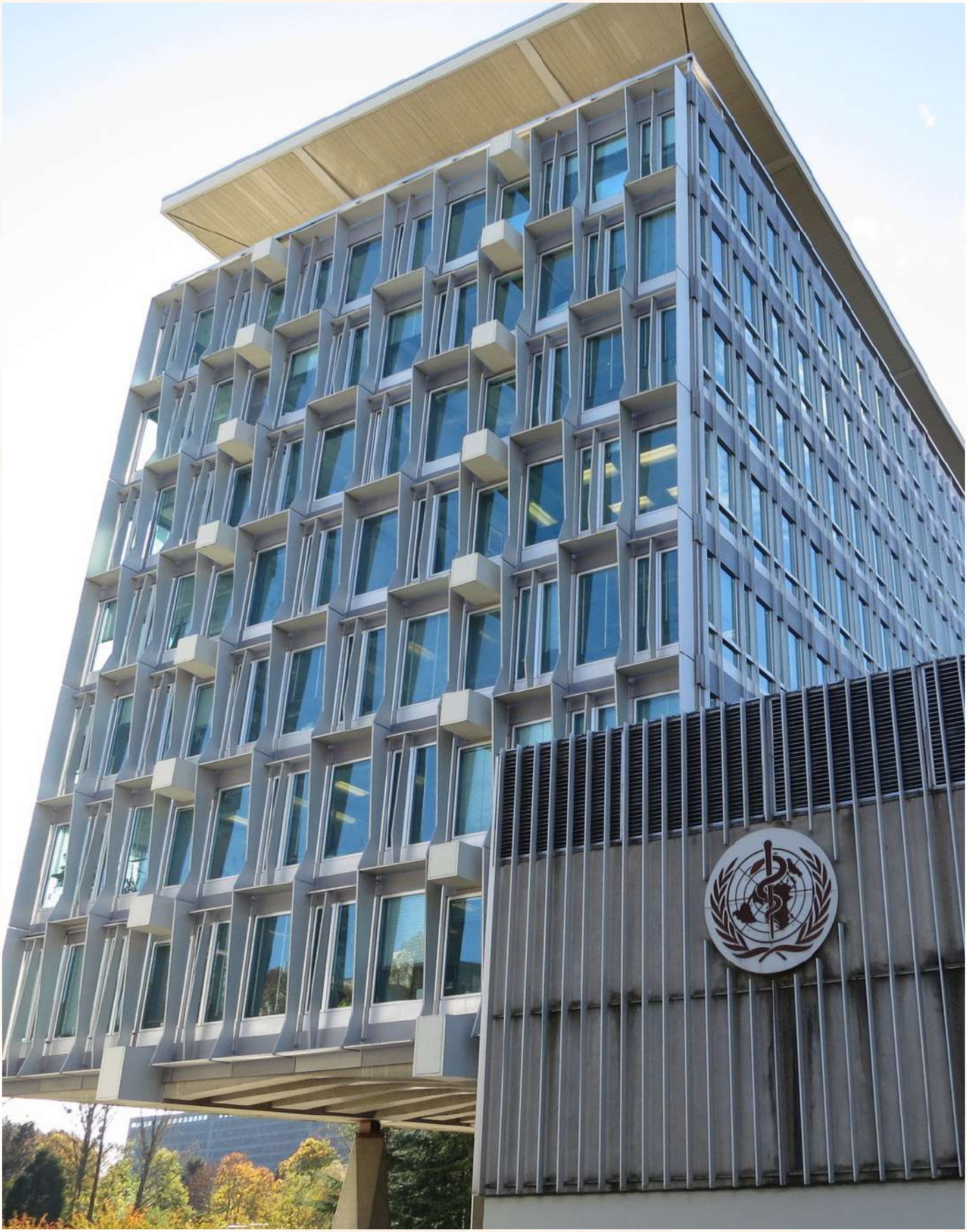
Decentralized Decision-Making
The case for empowering regional institutions more and transferring certain best-fit responsibilities from global to regional and national bodies is one widely advocated for by various health actors. The Wellcome dialogues, which drew on contributions from over 114 countries, provided critical insights into the gains of subsidiarity and the need for differentiated and tailored interventions rather than a one-size-fits-all approach, which produces sub-optimal results. A key starting point to implementing this is empowering regional bodies, within-country delivery structures and enabling cross-national coordination and collaboration so that the connection between countries and their regional bodies becomes substantive rather than merely ceremonial.

Value Chain Alignment: Innovation, Production and Market Access or Control
The path to sovereignty is incomplete without some control and level of in-country or regional R&D and production value chains. For health in particular, the constraints include intellectual property restrictions, supply chain disruptions, and limited access to pooled procurement.13 Underdeveloped national and regional R&D and manufacturing capabilities are a structural issue which extends beyond health and as such requires deeper engagement across critical industries and with a range of actors, particularly in the private sector.

Global Public Goods and Emergency Preparedness
There are some elements of global health that experts agree must be owned jointly as they, by their nature, require coordination: rapid response;

[16] Kyobutungi, C. (2025). Rethinking the global health architecture in service of Africa's needs: A perspective from the Africa region. Wellcome Trust.
[17] Wellcome Trust. (2026). From rethinking to reform: The way forward for the global health system. A global synthesis across five regional dialogues.
[18] Nishtar, S. (2025). The Gavi Leap: Radical transformation for a new global health architecture. The Lancet, 405(10495), 2112–2113. https://doi.org/10.1016/S0140-6736(25)01177-8
[19] Pate, M. A., Kaberuka, D., & Piot, P. (2026). Transforming the global health ecosystem: Lessons learned and a vision for the future. Accra Reset. https://accrareset.org/publications/Transforming-the-Global-Health-Ecosystem/
[20] Kaseya, J. (2025). Africa's health security and sovereignty agenda: A new way forward. The Lancet, 406(10518), 2394–2396.
[21] Lagba, C. Y. (2025, October 29). GH¢3.4bn injection strengthens NHIS — Chief of Staff. Ghanaian Times. https://ghanaiantimes.com.gh/gh%C2%A23-4bn-injection-strengthens-nhis-chief-of-staff/
[22] Africanews. (2025, February 14). Nigerian lawmakers approve $200 million to offset shortfall from US health aid cuts. https://www.africanews.com/2025/02/14/nigerian-lawmakers-approve-200-million-to-offset-shortfall-from-us-health-aid-cuts/
[23] Ileyemi, M. (2025, February 16). Nigerian govt to absorb 28,000 health workers formerly paid by USAID. Premium Times. https://www.premiumtimesng.com/news/top-news/774709-nigerian-govt-to-absorb-28000-health-workers-formerly-paid-by-usaid.html

essential R&D that is jointly owned with equal access; and pooled procurement where economies of scale can be realised. Critical issues include how GPGs are financed to ensure fairness and predictability, and how data security is ensured with regions or countries retaining some degree of ownership or control of their data.



10 Recommendations for Reforming the Global Health Architecture

Overarching Principles

Health as a key driver of development.	Health should not be viewed as a sector to be funded in isolation, but as a form of sovereign wealth to be cultivated, protected, and leveraged. A healthy population is a fundamental driver of economic growth, productivity, resilience, and national stability. Investments in health yield benefits across government and society, returning dividends that are transversal, whole-of-government, and central to national development strategies.
Universal access and equity	Universal access must become a reality for all, where geographical, economic, sociocultural, organisational, or gender barriers are progressively eliminated, ensuring equitable access and use of comprehensive and holistic quality health services across the life continuum as determined at a national level.
Sovereignty — health, financial, and data	The significant gains made through global cooperation over the last 25 years must be sustained and advanced: essential services and disease prevention should without question continue, particularly in humanitarian and epidemic situations. [24] While recognising that global cooperation is still essential, the Reset is pushing for a broad shift in systems that deliver health outcomes. Countries must own the three foundations of their health systems: the decisions, the money, and the data. Health sovereignty: national priorities set nationally, through one plan and one platform. Financial sovereignty: domestic resources as the foundation, with external financing complementing and not substituting or directing. Data sovereignty: country ownership and use of data to guide national development decisions; reliable, quality-assured, nationally owned data as the basis of health intelligence, evidence-based decision-making, sound prioritisation, planning, and timely execution, monitoring and evaluation.
Country agency and subsidiarity	Decisions and implementation should occur as close as possible to citizens, moving to regional or global levels only where collective action produces better outcomes and greater efficiency. Through realignment of the global health architecture, the Reset should arrive at a global health ecosystem with fewer institutions, yet with a critical mass of human and financial resources, working with the countries they serve equitably and effectively [25]. Emergency response, innovation, and biosecurity will continue to require cooperation and support beyond national borders, even where consolidation and domestic capacity have advanced [26] - which should be managed through fair, simplified and transparent procedures.
Efficiency gains	Any reform must be results-driven, striving to maximise impact while promptly delivering greater efficiency and value for money, and reducing the procedural and administrative burden on countries. [27]
Accountability at every level	Accountability must focus on the results of the global health system and the principles that will shape a reformed GHA. Accountability must be built into national, regional, and global governance structures, not treated as an afterthought during implementation, ensuring transparency and fostering public trust. Independent mechanisms should hold every level to its commitments, driven from the country level up.

[24] Pate, M. A., Kaberuka, D., & Piot, P. (2026). Transforming the global health ecosystem: Lessons learned and a vision for the future (p. 2). Accra Reset.
[25] Pate et al. (2026, p. 11).
[26] Pate et al. (2026, p. 2).
[27] Pate et al. (2026, p. 9).

Recommendation 1 | One-Stop Country Compact: One Plan. One Budget. One Platform

Establish a one-stop country compact within 12 months, jointly led by the Ministries of Health, Finance and Planning together with locally relevant stakeholders, with full alignment of restructured international partners. Using credible National Health Plans (NHPs) aligned with broader development strategies as the single organising framework, embed a costed, multi-year Health Investment Plan (HIP) within the NHP as its financing and implementation component; integrate it into the national budget and public financial management cycle; map domestic and external resources, financing gaps, and a realistic financing pathway. Establish a single country-led National Coordination Platform (NCP) as the governance, coordination, implementation and mutual-accountability mechanism for health financing, building on existing national budgeting, public financial management, audit, procurement, coordination and health-information systems which may be supported by interoperable digital tools where appropriate. International partners will be expected to reorganise their structures and ways of working to fully comply with NHPs.

Global-level reform is continuous with country-level and regional reform and should reflect evolving country needs so that the architecture contributes to equitable health outcomes with reduced reliance on external support and maximally leverages countries' capacities and national systems. The Government (Ministries of Health and Finance) should lead the political and economic case for health, within a whole-of-government and all-of-society approach with the engagement of all relevant ministries and planning authorities as directed by the Heads of State or Government as appropriate for each country's context.

The NHP should be aligned with broader national development strategies and integrated across multiple sectors of government to ensure effective implementation of both the NHP and the broader strategies. The NHP should include planning, environment, and other relevant authorities, with support provided at country request by WHO, development banks, academia, and technical partners, under clear rules on legal authority, data sovereignty, verification, and public access. The Ministries of Health and Finance and other strategic national authorities should then jointly convene development banks, donors, global health institutions, civil society, the private sector, foundations, and philanthropies to align their strategies, financing, implementation cycles, and reporting with the NHPs and national budget and public financial management cycle.

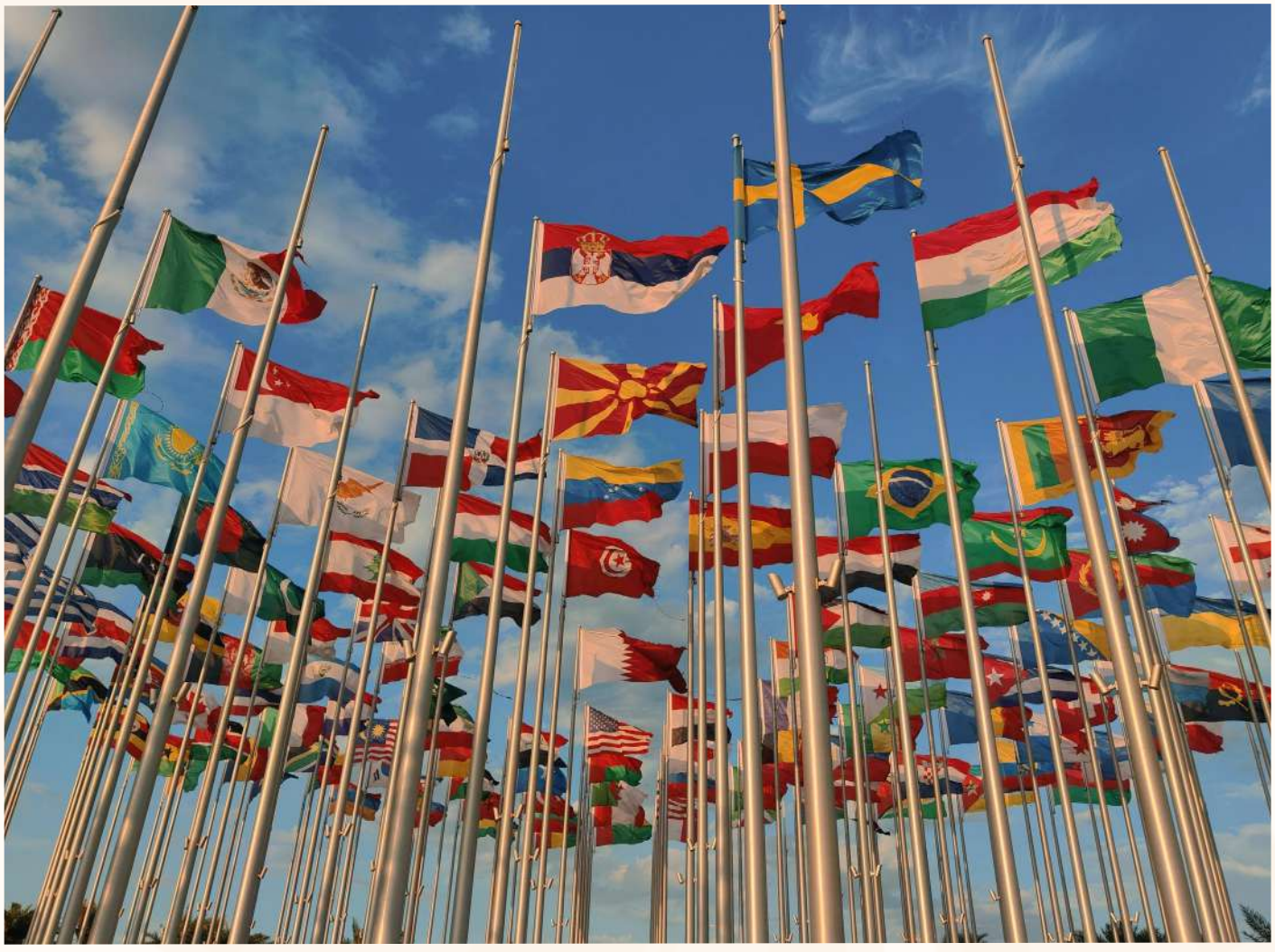
All global health institutions and multilateral funders and banks should reform within 12 months their operating models and country engagement, including a single country team and grant and reporting mechanisms. International partners should support the institutional capacity, interoperability, and existing national systems required to implement the NHP and the NCP, rather than create separate reporting arrangements, as well as providing support to the transition. Alignment should improve predictability, mutual accountability, and continuity rather than permit abrupt withdrawal of external support or substitution of domestic financing.

Indonesia: a national plan the money follows

Indonesia's National Health Master Plan (Rencana Induk Bidang Kesehatan, RIBK), mandated by the 2023 Health Law, is a nationally owned and costed plan that links priorities and measurable results to a five-year financing framework — and central and local budgets are legally required to align with it. [28]

Financing gap analysis distinguishes between what domestic budgets will cover and what requires complementary external support, enabling the government to approach partners with a single investment case rather than a collection of fragmented requests. This approach has been tested at scale: following a nationwide assessment across all 514 district and city health offices that identified a funding gap in infrastructure and equipment for health facilities, Indonesia mobilised approximately US$4 billion in aligned financing from the World Bank, AIIB, ADB and IsDB — with the four institutions harmonising their requirements around the government's plan. [29]

External financing achieves scale and alignment when a country defines its priorities, costs them, commits its own resources and presents the remaining gap — the One-Stop Compact's operating manual, already written.



[28] Ministry of Health of the Republic of Indonesia. (n.d.). Indonesia Health Systems Strengthening Project. https://ihss.kemkes.go.id/
[29] World Bank. (2023). Indonesia Health Systems Strengthening Project: Project appraisal document (Report No. PAD00155). https://documents1.worldbank.org/curated/en/099111723114093413/pdf/BOSIB0fdfe176800908ac8043df4bf6fcfb.pdf

Recommendation 2 | Accelerate a Sustainable Financing Transition: Build Health Sovereignty on Domestic Resources

Treat health as an investment in economic growth, productivity, employment, human capital development, stability, resilience and prosperity. Using National Health Plans (NHPs) as a foundation, governments should mobilise sustainable and equitable domestic financing through national budgets, progressive revenue measures, national health insurance and other pooling arrangements, while ensuring universal health coverage as defined by WHO through financial protection and reduction of out-of-pocket expenditure. NHPs should allocate domestic and external resources according to the country's needs, shifting progressively from disease-specific silos towards people-centred national health systems. Recognising country variation and the challenges of fragile and low-capacity states, external financing, including multilateral banks, should complement country priorities through managed, context-specific transitions that safeguard essential services and fiscal and debt sustainability, while strengthening national capacities.

Global health financing is entering a period of profound transition. Declining official development assistance, rising debt burdens, fiscal constraints, and increasing competition for public expenditure are reshaping the environment in which countries finance health. While development assistance has delivered substantial gains over the past two decades, the sustainability of those gains increasingly depends on countries' ability to mobilise, allocate, and govern their own resources.

The pace of this transition will vary by country due to multiple factors, including debt burden, fiscal space, and humanitarian crises. Countries should establish measurable, time-bound fiscal targets to progressively increase sustainable domestic public financing for core health services, while reducing excessive dependence on fragmented external financing where appropriate. External financing remains important for managed transition support, people-centred health-system strengthening, emergency preparedness, research and development, and other global public goods. With the NHP as the foundation, countries should define allocation priorities, while national and multilateral development banks, donors, global health institutions, private capital, philanthropy, and innovative instruments align behind the NHP.

The objective is a financing architecture in which countries lead, partners align, and resources translate into equitable services and sustainable, sovereign health systems that deliver quality, equitable health outcomes. The international financial architecture should also address disparities in the cost and availability of capital. Countries facing higher borrowing costs should not be expected to finance long-term investments in health and resilience under fundamentally unequal financial conditions.

Ghana: financing the transition domestically

Ghana has responded to the collapse of external health financing with budget lines, not appeals. The 2026 national budget allocates 34.2 billion cedis to health, including 11.4 billion to the National Health Insurance Scheme; [30] the insurance levy has been uncapped; and coverage has been expanded to 20 million people [31] — reforms the government presents to the world as a model for the region. The convening country of the Accra Reset is doing at home what this report asks of others.

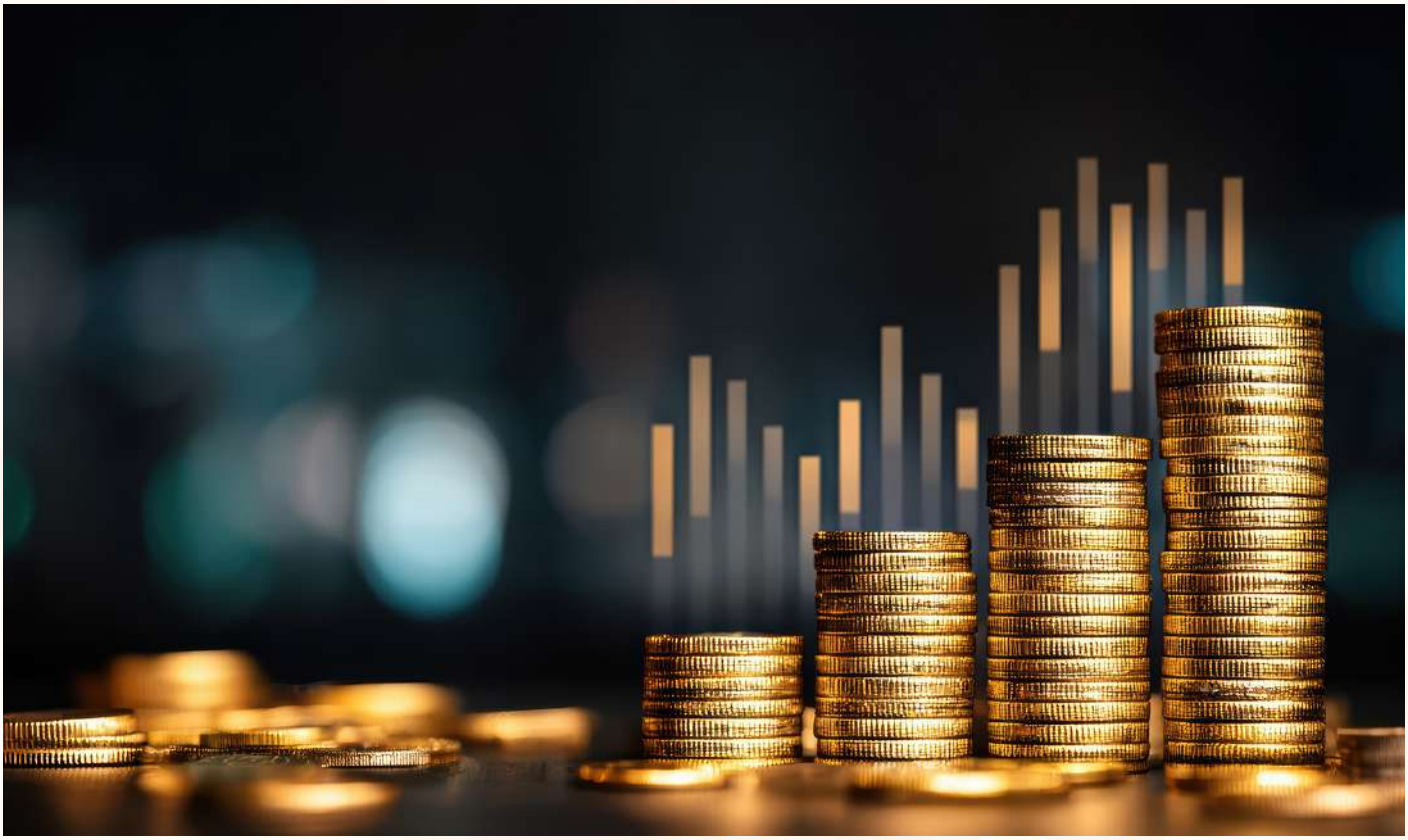
The post-aid transition can be led rather than suffered — political leadership at head-of-state level is what converts fiscal shock into reform.

[30] Ghana News Agency. (2026, February 27). Government boosts domestic health financing to 72 per cent. https://gna.org.gh/2026/02/government-boosts-domestic-health-financing-to-72-per-cent/
[31] Mahama, J. D. (2026, May 18). Full text: Mahama's address to the 79th World Health Assembly [Speech transcript]. Ghana Broadcasting Corporation. https://www.gbcghanaonline.com/speeches-and-lectures/mahama-general-assembly/2026/

Many countries already have national health strategies, but these are not always translated into financing plans that Ministries of Finance, heads of government, development banks and external partners can understand and support. Without a clear investment case, health financing remains fragmented and often dependent on donor priorities. Fragmentation is often created by multiple donor systems: when each donor, fund or institution operates its own plan, budget, reporting system, disbursement process and procurement rules, countries are left with parallel or duplicate systems, which creates administrative burden, poor coherence and, eventually, erosion of country ownership. Consolidation should reduce reporting and coordination burdens for ministries, with one NHP turning national health priorities into an investment case.

The proposed health financing model emphasises country-led planning with diversified funding sources (primarily domestic) and a well-thought-through allocation plan. The sustainable financing transition should be guided by six considerations:

1. The institutional form is left to countries, avoiding over-engineering and a one-size-fits-all model given country diversity in wealth, capacity and size.
2. External financing partners will commit funding behind country-owned National Health Plans, rather than create parallel priorities.
3. The approach is differentiated across faster transition countries, medium to longer-term transition countries, and fragile or humanitarian situations.
4. In fragile and humanitarian situations, country-led recovery is undertaken through gradual integration of humanitarian programmes into nationally led health systems in a way that preserves agency and country ownership.
5. Data sovereignty and financial sovereignty are crucial, while noting that some data may be a global commons (e.g. infection counts).
6. Accountability is a mechanism rather than a framework, with clear actions, a responsible actor and monitoring and reporting, and with civil society involvement.



Recommendation 3 | Empower Regional Institutions as Expressions of Country Agency

Where countries determine that shared health priorities are more effectively pursued through regional cooperation, they should formally recognise and empower existing regional institutions (where possible) as actors with delegated mandates for specified regional and cross-border functions — surveillance and reference laboratories, pooled procurement, regulatory harmonisation, emergency response, and manufacturing ecosystems — backed by sustainable member-state financing and accountability to their Member States. Respecting the subsidiarity principle, global partners should recognise these mandates and redirect technical support and financing where appropriate to this level, reinforcing or establishing at least one pooled mechanism at the regional level within 12-18 months.

Countries should determine which functions can be performed more effectively through regional cooperation and identify existing institutions capable of facilitating them. Any formal mandate, member-state financing model, direct accountability arrangement, or designation as a preferred delivery pathway should be decided by the relevant member states and explicitly validated through their governance processes. This approach preserves country sovereignty while avoiding new regional fragmentation.

Regional mechanisms complement — and coordinate closely with — efficient global mechanisms for market shaping, procurement and global public goods rather than replacing them; where capable regional institutions do not yet exist, countries should choose the arrangements that serve them best through their regional governance mechanisms.

African Medicines Agency: one approval, one continent

The treaty-based **African Medicines Agency (AMA)** [32], which builds on harmonisation platforms such as African Medicines Regulatory Harmonisation (AMRH) [33] programmes and the African Vaccines Regulatory Forum (AVAREF) [34], is building mutual-recognition and reliance pathways so that a quality-assured product approved once can move across borders. As WHO refocuses prequalification on norms and standards, regional regulators — with empowered national authorities — can progressively take on product approval directly.

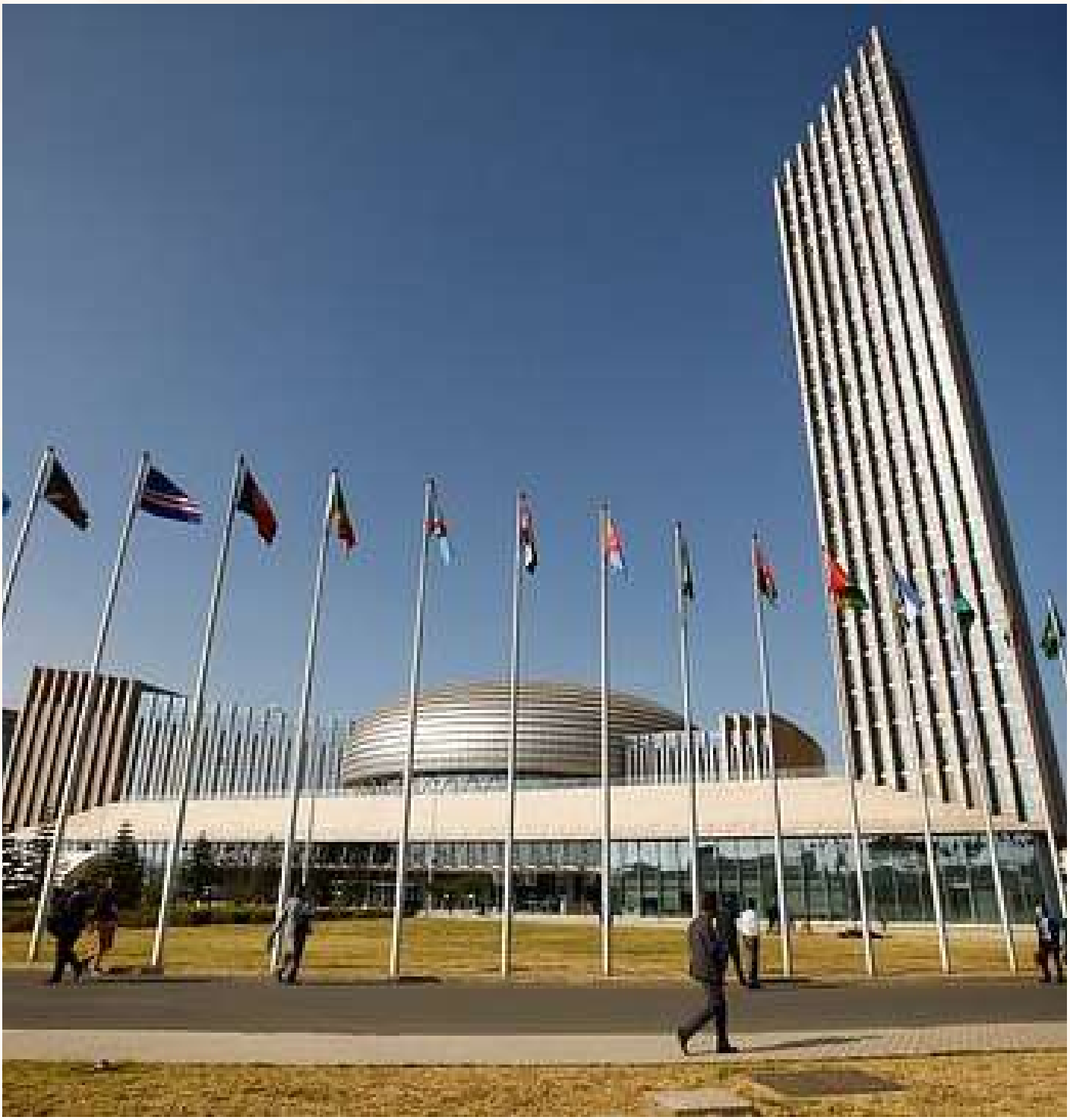
Regulatory harmonisation, the binding constraint on sovereign health value chains, advances when authority is delegated upward by countries — not downward by global bodies.

The principles of sovereignty and subsidiarity should guide the distribution of responsibilities across the global health architecture. Genuine sovereignty depends on financial independence, allowing governments to retain full authority over defining national priorities and determining how partnerships contribute to achieving them. Financially sovereign countries can determine which priorities are best pursued nationally and which would benefit from regional or global cooperation.

Many national health priorities cannot be achieved optimally by countries acting alone, yet do not require global solutions. Examples include joint procurement, regulatory harmonisation,

[32] African Medicines Agency. (n.d.). Ratifications. African Union. https://au-ama.africa/ratifications/
[33] African Union Development Agency–NEPAD. (n.d.). Who we are. African Medicines Regulatory Harmonisation Programme. https://amrh.nepad.org/amrh-microsite/who-we-are
[34] World Health Organization Regional Office for Africa. (n.d.). African Vaccine Regulatory Forum (AVAREF): Overview. https://www.afro.who.int/health-topics/immunization/avaref/overview

workforce mobility, regional manufacturing ecosystems, surveillance, and health diplomacy and negotiations. Regional cooperation in these areas offers economies of scale, greater political legitimacy, contextual adaptation, and reduced duplication, stronger markets and greater collective negotiating power. However, the current architecture is characterised by institutional overlap, unclear divisions of responsibility, and an overreliance on global institutions, leaving the potential of regional cooperation underutilised. Existing regional institutions should therefore be mandated and resourced to become the primary governance actors for regional functions.



Recommendation 4 | Build an Equitable Health Innovation Ecosystem

Reinforce or establish regionally led platforms that advance coordinated research and development (R&D) and innovation priorities based on national and regional health needs, using integrated, disease-agnostic clinical trial platforms that also build the capacity of discovery sciences to feed the product pipeline and are empowered with the required skilled workforce, driven by scientists and expert collaborations working cross-regionally. This should attach committed public financing with built-in access provisions whenever public or philanthropic funding is deployed to develop innovations, and an assured demand for the R&D priorities listed in National Health Plans (NHP). Publicly supported R&D should also leverage cross-regional and global collaboration that translates innovations into accessible and affordable health products.

Regions set research priorities but rarely build the shared capacity, financing, and demand to pursue them, so "regional diseases" depend on outsiders' interest in finding a solution. An ecosystem-wide transformation is needed across innovation, technology, manufacturing, regulation, and purchasing, which together turn scattered ecosystem efforts into a shared industry that helps the Global South achieve health sovereignty and health security.

Regions should revive existing platforms such as those developed during the COVID-19 pandemic, establish shared research and development (R&D) agendas and integrated clinical-trial platforms across diagnostics, therapeutics, and vaccines (DTVs), building an adequately skilled workforce, based on equitable access conditions to public- and philanthropic-funded R&D, including access and benefit sharing, with set-asides for pathogens of regional concern, anchored in global convening authority, as well as pursue research in both directions, from products with existing markets to upstream discoveries for underserved pathogens. Reviving and expanding these platforms should support sustainable domestic science ecosystems through strategic government investment, education, infrastructure, and private-sector partnerships, while also translating scientific advances into equitable health policies and technologies to ensure inclusive development.

African-led innovation: from drug discovery to clinical trials

African institutions are developing world-class innovation and R&D partnerships.
The **Holistic Drug Discovery and Development (H3D)** [35] Centre at the University of Cape Town — Africa's first integrated drug discovery centre — developed the first antimalarial medicine to enter Phase 1 human studies on the continent and is building African-specific pharmacogenetic tools so that medicines are optimised for the populations who will use them. [36]
The **Africa Clinical Research Network (ACRN)** [37], founded in 2024, is building an African clinical research organisation: in 2025 its site served as clinical lead for a Phase 1 HIV vaccine trial run by African principal investigators [38], and its call for trial sites drew close to 600 applications [39] from sites and investigators — on a continent that today hosts fewer than 3 per cent of the world's clinical trials. [40]
The **Institut Pasteur de Dakar** [41] is completing the value chain from research to manufacturing of a yellow fever vaccine.

Innovation can be discovered and tested in Africa, for Africa — when knowledge systems and research workforces are financed as institutions, not projects, and research leaders are empowered and supported by local leadership as well as regional and international partners alike.

[35] H3D Centre. (n.d.). Home. University of Cape Town. https://h3d.uct.ac.za/
[36] Gates Foundation. (n.d.). Africa drug discovery [Case study]. Global Grand Challenges. https://gcgh.grandchallenges.org/case-study/africa-drug-discovery
[37] Africa Clinical Research Network. (n.d.). Company overview. https://acrnhealth.com/company-overview/
[38] Africa Clinical Research Network. (2025, August 9). African research institutions launch Phase 1 HIV vaccine clinical trial in Southern Africa. https://acrnhealth.com/2025/08/09/african-research-institutions-launch-phase-1-hiv-vaccine-clinical-trial-in-southern-africa/
[39] Clinical Leader. (2026, March 6). Why Africa could be the next frontier for clinical trials. https://www.clinicalleader.com/doc/why-africa-could-be-the-next-frontier-for-clinical-trials-0001
[40] Yilma, D. (2024). Breaking the barriers for conducting clinical trials in Africa: A need for higher commitment and collaborations. Ethiopian Journal of Health Sciences, 34(3), 171–172, at 171. https://pmc.ncbi.nlm.nih.gov/articles/PMC12110202/
[41] Institut Pasteur de Dakar. (n.d.). Home. https://institutpasteurdakar.sn/

The recommendations on technology transfer and on productive capacity both presuppose a flow of regionally relevant products. Where that flow does not materialise, the result is equipped plants running below viable utilisation, which is a worse outcome than not having built them. Demand remains the anchor of the value chain and the pull that makes the other links viable; the function of this recommendation is to fill the chain that demand pulls.

It may not be necessary to add new initiatives to the existing landscape; rather, what is required is stronger political convergence around existing efforts, better coordination across them, and a more deliberate focus on connecting the layers of the system.

- The Global Coalition for Local and Regional Production, Innovation and Equitable Access[42] is an example of a candidate platform for coordination, coherence and collective action across the regional and global health-production ecosystem, on the grounds of its convergence mandate and the breadth of expertise in its membership and governance structure.

Similarly, the technical functions are held by institutions already operating in several regions. Some examples, which are not non-exhaustive, are given below:

- In **Africa,** these include the Pasteur Network, Institut Pasteur de Dakar [43] and the clinical trials partnership model established by the European and Developing Countries Clinical Trials Partnership (EDCTP). [44]

- In **Asia-Pacific,** they include the International Vaccine Institute (IVI). [45]

- In **Latin America and the Caribbean,** they include Fiocruz [46], the Health Economic-Industrial Complex [47] approach, and the PAHO Regional Production Platform. [48]

  At the **global level,** they include the Coalition for Epidemic Preparedness Innovations (CEPI)[49] and the International Pandemic Preparedness Secretariat (IPPS) [50], the product development partnerships, and the WHO R&D Blueprint. [51]

[42] Global Coalition for Local and Regional Production, Innovation and Equitable Access. (n.d.). Home. https://globalcoalitionforlocalproduction.org/
[43] Pasteur Network. (n.d.). Home. https://pasteur-network.org/
[44] European and Developing Countries Clinical Trials Partnership. (n.d.). Home. https://www.edctp.org/
[45] International Vaccine Institute. (n.d.). Home. https://www.ivi.int/
[46] Oswaldo Cruz Foundation. (n.d.). Home. https://fiocruz.br/en
[47] Ministério da Saúde do Brasil. (n.d.). Departamento do Complexo Econômico-Industrial da Saúde (DECEIIS). https://www.gov.br/saude/pt-br/composicao/sectics/deceiis
[48] Pan American Health Organization. (n.d.). Special Program, Innovation and Regional Production Platform. https://www.paho.org/en/special-program-innovation-and-regional-production-platform-rp
[49] Coalition for Epidemic Preparedness Innovations. (n.d.). Home. https://cepi.net/
[50] International Pandemic Preparedness Secretariat. (n.d.). Home. https://ippsecretariat.org/
[51] World Health Organization. (n.d.). WHO R&D Blueprint for epidemics. https://www.who.int/teams/blueprint/who-r-and-d-blueprint-for-epidemics

Recommendation 5 | Increase Investment in Health Products Manufacturing based on Organised Regional Collaboration

Countries should increase direct investments in manufacturing of health products, align national efforts with regional priorities, and commit to a coordinated regional division of labour centred around product availability, access, affordability, and sustainability, with a regionally led pilot initiated or reinforced within 12-24 months. Backed by country and regional financing mechanisms, and governed through existing (or new) regional governance arrangements, and including partnerships with the private sector, investments must prepare manufacturers to co-develop, absorb full-process technology transfer, and use other recipient-readiness facility models. Leaders should advocate for the adoption by IP holders of technology-transfer terms that secure regional supply rights and the right to improve, adapt, and sublicense technologies; facilitated through regional regulatory compacts whereby countries commit to making reliance the legal default.

Strengthening local and regional production requires moving beyond isolated national investments toward integrated and sustainable production ecosystems in which countries specialise in complementary segments of the value chain according to their capacities and comparative advantages, through coordinated regional division of labour and partnership with the private sector. Strengthening domestic and regional manufacturing capacity is therefore both a public health and an economic imperative. Increased investment in health products manufacturing can improve supply security.

Nigeria: industrial policy for health sovereignty

Founded by President Tinubu in 2023, the Presidential Initiative for Unlocking the Healthcare Value Chain (PVAC) [52] treats local production as an end-to-end ecosystem — policy and regulation, R&D and workforce, manufacturing, and demand aggregation [53] — confronting Nigeria's dependence on imports for around 70 per cent of its healthcare products. [54] Progress is tangible: under the initiative's 2024 agreement with Vestergaard/Health Textiles Nigeria (HTN) [55] , a dedicated facility has been established in the Lagos Free Zone to produce dual-active-ingredient bed nets [56], that are estimated to have already prevented some 13 million malaria cases and 24,600 related deaths in sub-Saharan Africa [57]

Treating the health value chain as economic development, and including business, delivers products — provided the wider architecture supplies the predictable, coordinated demand on which such investments depend.

Production capacity should be developed aiming to provide health products that are accessible; rather than each country seeking to establish end-to-end manufacturing capabilities, regional production networks can maximise efficiency, avoid duplication, and ensure that investments are complementary. Regional strategies should therefore combine existing strengths with deliberate investment in emerging and strategically important capabilities, encouraging countries to develop new areas of specialisation over time. This approach will also depend on innovative financing mechanisms (including blended finance and public-private partnerships) that prepare manufacturers to co-develop, absorb full technology transfers, and engage in other

[52] Presidential Initiative for Unlocking the Healthcare Value Chain. (n.d.). About us. https://pvac.gov.ng/about-us/
[53] Presidential Initiative for Unlocking the Healthcare Value Chain. (n.d.). Our mandate. https://pvac.gov.ng/our-mandate/
[54] International Finance Corporation. (2025, July 25). Building Nigeria's healthcare ecosystem [Interview with A. Mukhtar]. https://www.ifc.org/en/interviews/2025/building-nigeria-s-healthcare-ecosystem
[55] Health Textiles Nigeria. (n.d.). PermaNet Dual mosquito net manufacturing. https://healthtextilesng.com/
[56] Vestergaard Sàrl. (2026, September 10). Nigeria achieves historic milestone as Health Textiles Nigeria begins manufacture of Vestergaard's PermaNet® Dual mosquito nets [Press release]. Distributed by APO Group. https://www.africannewspage.net/2026/09/nigeria-achieves-historic-milestone-as-health-textiles-nigeria-begins-manufacture-of-vestergaards-permanet-dual-mosquito-nets/
[57] Unitaid. (2024, April 17). New nets prevent 13 million malaria cases in sub-Saharan Africa. https://unitaid.org/news-blog/new-nets-prevent-13-million-malaria-cases-in-sub-saharan-africa/

forms of technological cooperation based on mutual learning and co-development by strengthening infrastructure, workforce skills, quality management systems, and regulatory capacity.

An enabling environment for technology transfer and regulatory cooperation is equally essential. Transparent technology transfer agreements that enable equitable access and allow regional manufacturers to produce, improve, adapt, and, where appropriate, sublicense technologies can help build long-term technological autonomy and reduce dependence on external suppliers. At the same time, regional regulatory compacts that make reliance on decisions by trusted reference authorities in the region or WHO-listed authorities the default can streamline approvals, reduce duplication, and facilitate market access. Together, coordinated investment, financing, production, procurement, technology transfer, and regulatory cooperation can result in greater regional resilience and strategic autonomy within interconnected global markets, build more resilient supply chains, improve equitable access to health products, and enhance preparedness for future health emergencies and emerging health needs.

Brazil: the Health Economic-Industrial Complex (HEIC) — an ecosystem, not a factory

Brazil's Health Economic-Industrial Complex (HEIC) National Strategy treats health production as a coordinated ecosystem: [58] a network of public and private laboratories, industrial and innovation policy instruments, technology-transfer partnerships, and the public health system as anchor purchaser. Its two main policies use the State's purchasing power as a strategic instrument for industrial and technological development — the Productive Development Partnerships Program (PDP) [59], focused on the transfer and internalisation of existing technologies, and the Local Development and Innovation Programme (PDIL) [60] and the National Programme for Radical Health Innovation (PNIRS), which stimulate local development of innovative solutions — both incentivised by guaranteed public procurement. Public institutions such as Butantan and Bio-Manguinhos/Fiocruz, supplying the national immunisation programme and exporting to over 70 countries [61] , are instruments of the strategy rather than isolated champions. Brazil is strengthening domestic health production and innovation capacities through the HEIC strategy, and the HEIC model is being recognised as an inspiration [62] for Mexico's new health industrialisation programme.

Manufacturing sovereignty comes from an ecosystem designed together — laboratories, industrial policy, technology transfer and an anchor purchaser — not from standalone plants.

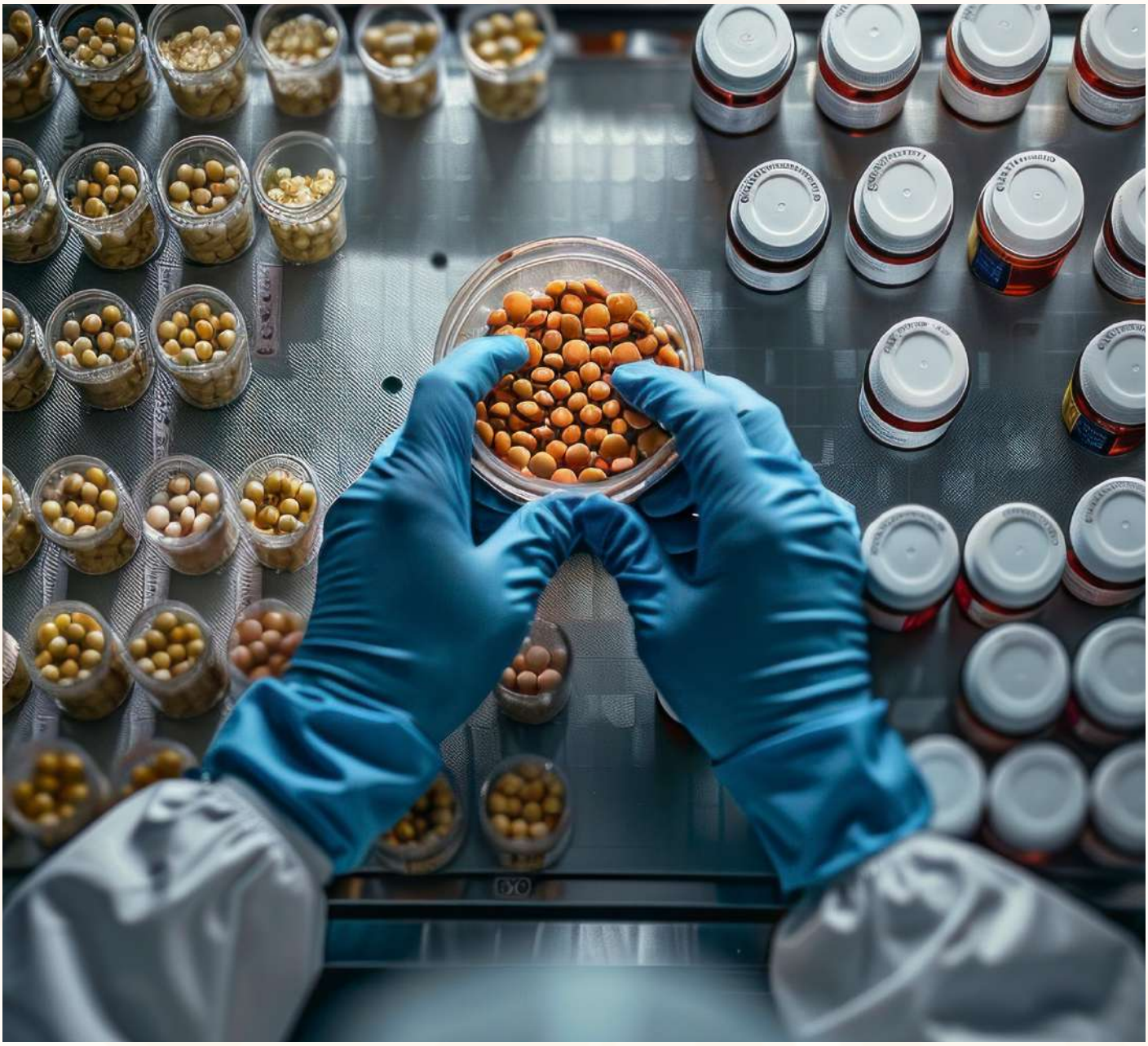
The proposed action will result in a coordinated regional strategy for health products manufacturing that links industrial policy, access policy, financing, technology transfer and regulatory cooperation. Its starting point is simple: not every country needs to manufacture every medicine, vaccine, diagnostic, active ingredient or device. What regions need is a deliberate division of labour in which countries identify complementary strengths and organise them into a functioning regional value chain. One country may be better placed to host drug-substance, antigen or active ingredient production; another may specialise in formulation, fill-finish or packaging; another may provide quality-control and reference laboratory

[58] Presidency of the Federative Republic of Brazil. (2023). Decreto nº 11.715, de 26 de setembro de 2023 [Decree No. 11,715 of 26 September 2023, establishing the National Strategy for the Development of the Health Economic-Industrial Complex]. https://www.lexml.gov.br/urn/urn:lex:br:federal:decreto:2023-09-26;11715
[59] Ministry of Health of Brazil. (n.d.). Parcerias para o Desenvolvimento Produtivo (PDP) [Productive Development Partnerships]. Secretariat of Science, Technology, Innovation and the Health Economic-Industrial Complex. https://www.gov.br/saude/pt-br/composicao/sectics/pdp
[60] Ministry of Health of Brazil. (n.d.). Programa de Desenvolvimento e Inovação Local [Local Development and Innovation Programme]. Secretariat of Science, Technology, Innovation and the Health Economic-Industrial Complex. https://www.gov.br/saude/pt-br/composicao/sectics/pdil
[61] Pan American Health Organization. (2022, July). For vaccine equity: Producers work together to advance mRNA technology in Latin America. https://www.paho.org/en/stories/vaccine-equity-producers-work-together-advance-mrna-technology-latin-america
[62] Arruda, G. (2025, July 21). Mexico raises the flag for health sovereignty (Outra Saúde & Peoples Dispatch, Trans.). ScheerPost. https://scheerpost.com/2025/07/21/mexico-raises-the-flag-for-health-sovereignty/

capacity; and others may lead clinical research, regulatory assessment, procurement, logistics, digital systems, workforce development or regional stockpiling. [63]

This approach shifts the policy discussion from "local production" understood as a stand-alone factory to "regional productive capability" understood as a shared system. A facility matters only when it is embedded in a delivery loop: demand must be predictable, payment reliable, quality trusted, data shared, regulation usable across borders and procurement capable of anchoring sustainable markets. In that sense, the action is not simply to add more manufacturing sites, but to connect the functions that make regional supply possible. Production, procurement, regulation and financing must become mutually reinforcing rather than separately managed policy silos. [64]

The approach outlined above treats health products as strategic public goods whose availability depends on the alignment of demand, financing, technology, regulation, and production. It also reframes regional interdependence as a practical expression of sovereignty. Countries of the Global South do not lose ownership by coordinating production functions across borders; they gain collective power to innovate, regulate, procure and supply in ways that no single country can achieve alone.



[63] World Economic Forum. (2024). Regionalized Vaccine Manufacturing Collaborative: A framework for enhancing vaccine access through regionalized manufacturing ecosystems (p. 6). https://www3.weforum.org/docs/WEF_Regionalized_Vaccine_Manufacturing_Collaborative_2024.pdf.
[64] Pippo, T. (2025). Regional production and innovation of health technologies [Conference presentation]. Special Program, Innovation and Regional Production Platform, Department of Innovation, Access to Medicines and Health Technologies, Pan American Health Organization.

Recommendation 6 | Turn Fragmented Demand into Market Power through Regional and Global Procurement and Commodity-Security Coalitions

As a driver for regional health security within 18 months, establish or reinforce country-led procurement and commodity-security coalitions, while recognising and collaborating with existing and impactful procurement programmes, many of which may also evolve in support of the broader reform of the global health architecture. Coalitions will often be regional or sub-regional because regulation, trade, logistics, and political accountability are frequently organised at those levels but may also include strategic partnerships with countries across regions or at a global level. Countries should aggregate nationally and/or across borders to coordinate demand and supply, making predictable and reliably financed purchasing commitments, while strengthening local and regional productive, regulatory, technological, and manufacturing capacities. Countries may also operate across regions where product markets, disease priorities, or manufacturing capacity make that more effective. Regional sourcing preferences should be phased progressively over five to ten years, in step with the maturation of regional manufacturing capacities, and in partnership with existing global initiatives as they evolve to support country and regional priorities.

Global collaboration has delivered several procurement programmes that have allowed countries and global programmes to get best value for money for many health products. However, these have been largely centralised, leaving Global South countries with limited flexibility, manufacturing capacity or ownership. Building manufacturing capacity by itself will not guarantee access or commercial viability. Viability will depend on a connected system of credible demand, timely payment, quality regulation, market data, technical capability, and dependable supply arrangements. Demand aggregation alone will not correct structural dependence. Conversely, reserving purchases for preferred regional producers before adequate quality, capacity, and competition are in place can increase costs, create shortages, or weaken public confidence. Countries should retain authority over their priorities and participation while using or expanding existing regional and global pooled-procurement mechanisms. Prioritisation of pandemic-related health products and essential medicines can be a consideration for aggregating demand through regional and international procurement alliances, to achieve more favourable contractual terms.

Strategic use of purchasing power by governments with aligned support from international organisations should be utilised to shape markets, create predictable demand, support sustainable production capacity, and strengthen local and regional innovation and manufacturing capabilities. This should leverage existing regional initiatives and regional procurement platforms that enable participating countries to negotiate as a bloc. Effective policy must therefore phase regional sourcing preferences progressively over five to ten years, in step with the maturation of regional manufacturing capacity and quality, maintain quality standards, permit cross-regional supply, protect competition, and finance emergency access separately. International institutions must redirect efforts to support country-led processes, including global public goods where required by countries or regions as these mechanisms are established on a sustainable basis, aligned with and complementary to global initiatives.

PAHO Pan American Health Organization World Health Organization Americas

PAHO Regional Revolving Funds: procurement that shapes markets

The Pan American Health Organization's Regional Revolving Funds [65] have pooled member states' procurement demand — for vaccines since 1979, and for essential medicines and supplies since 2000. [66] In 2025 alone they delivered more than US$900 million in vaccines, medicines, and health technologies, including over 234 million vaccine doses, reaching 85 million people across the Americas — financed and governed by the countries themselves, including the smallest island states. [67] The Funds are now being extended from pooling purchasing power to shaping the region's productive environment: a 2024 Directing Council resolution allocates part of their capital to incentivise [68] local and regional production, innovation and access to cutting-edge medical technologies. The share of RRF procurement that came from the region has risen from 1.5 per cent in 2020 to 23 per cent in 2025[69] — exemplified by the 2025 agreement between Argentina, Sinergium Biotech, Pfizer and PAHO to produce pneumococcal vaccine regionally at the most affordable price for all member states. [70]

Purchasing power, deployed deliberately, becomes an instrument for innovation, local production and regional resilience — not only lower prices.

Demand is the pull that can connect priority-setting, technology transfer, productive capacity, and regulatory reform. A credible buyer and a sufficiently predictable market can reduce investment risk, improve production planning, and create a pathway from regulatory approval to actual use. Demand aggregation can also improve bargaining power and make small markets more attractive to qualified suppliers.

The objective is not import substitution at any cost or self-sufficiency in every country. It is resilient commodity security: timely access to quality-assured products, diversified supply, competitive productive capability across LMIC regions and fair emergency allocation. Any preference or price premium for local or regional production should be designed to strengthen innovation, manufacturing capacity, resilience and industrial development, while remaining transparent, product-specific and subject to periodic review based on measurable benefits.

[65] Pan American Health Organization. (n.d.). PAHO Revolving Fund. https://www.paho.org/en/revolving-fund
[66] Pan American Health Organization. (2024). Overview of PAHO Regional Revolving Funds [Conference presentation]. 2024 Joint UNICEF, UNFPA and WHO meeting with manufacturers and suppliers, UN City, Copenhagen. https://extranet.who.int/prequal/key-resources/documents/2024-joint-unicef-unfpa-who-meeting-overview-paho-regional-revolving-funds
[67] Pan American Health Organization. (2026, February 19). PAHO's Revolving Funds deliver 234 million vaccines and critical health supplies in 2025, reaching 85 million people across the Americas. https://www.paho.org/en/news/19-2-2026-pahos-revolving-funds-deliver-234-million-vaccines-and-critical-health-supplies-2025
[68] Pan American Health Organization. (2024, October 3). Countries of the Americas agree on measures to encourage innovation and regional production of health technologies. https://www.paho.org/en/news/3-10-2024-countries-americas-agree-measures-encourage-innovation-and-regional-production
[69] Pan American Health Organization. (2026, February 19). PAHO's Revolving Funds deliver 234 million vaccines and critical health supplies in 2025, reaching 85 million people across the Americas. https://www.paho.org/en/news/19-2-2026-pahos-revolving-funds-deliver-234-million-vaccines-and-critical-health-supplies-2025
[70] Pan American Health Organization. (2025, January 15). PAHO, Argentina, Pfizer, and Sinergium drive local production of 20-valent pneumococcal vaccine for Latin America and the Caribbean. https://www.paho.org/en/news/15-1-2025-paho-argentina-pfizer-and-sinergium-drive-local-production-20-valent-pneumococcal

Recommendation 7 | Refocus Global Cooperation on Global Public Goods

Refocus global cooperation on global public goods (GPGs) based on shared responsibility and mutual benefit, enabled by predictable collective financing beyond aid budgets and equitable, transparent governance. Through a coordinated process within 12 to 24 months, participating governments should define the functions covered, costs, contribution approach, governance, financing instruments, institutional home, and equitable-access safeguards, using or reforming existing mechanisms where possible.

As countries progressively take full ownership of health nationally and strengthen regional cooperation around shared priorities, global cooperation should focus on what no country or region can effectively provide alone but from which all countries benefit.

Global cooperation for health should refocus on the provision of GPGs: cross-border health intelligence, interoperable surveillance functions, and appropriately governed data-sharing arrangements; normative and standard-setting guidance; research pipelines from discovery through to affordable supply; use of consolidated and predictable demand and joint purchasing to shape markets; and standing capacity to detect and respond to cross-border threats. [71] *Data sovereignty should be accompanied by data solidarity where countries retain appropriate control over their health data while enabling trusted, interoperable sharing where this is necessary for regional and global public goods, including surveillance, health security and collective learning. These functions should be collectively defined and governed through arrangements that reflect shared responsibility and ensure equitable decision-making and access.*

The GPGs should be funded through collective financing mechanisms beyond aid that distinguish predictable 'peacetime' financing for global public goods from pre-arranged surge financing for emergencies. These arrangements should be operational ahead of the next replenishment cycles, starting with the next replenishment cycle for each of the relevant GHIs for agreed GPGs within 12 to 24 months. The GPG architecture must be in place before transfer functions begin to wind down so that no essential function falls into a gap. These functions, and the global knowledge and R&D agenda, should be rebalanced to take greater account of priorities beyond high-income countries, with a greater role for regional bodies than has been the case until now. [72]

[71] Pate et al. (2026, p. 9).
[72] Pate et al. (2026, p. 9).

The mRNA Technology Transfer Programme: distributed innovation, concrete results

The WHO-backed mRNA Technology Transfer Programme has demonstrated a new model for building distributed innovation and manufacturing capacity. From its technology hub at Afrigen in Cape Town, South Africa — where the base mRNA technology was developed and from which it is transferred outward — the Programme connects 15 institutions which includes the hub and 14 manufacturers —around a shared objective: advancing platform technologies simultaneously in multiple regions, building sustainable regional capacities and enabling their adaptation to local health priorities. [73] Global agreements with the Medicines Patent Pool further support technology transfer and the development of legal frameworks towards scaling a new generation of mRNA vaccines for endemic diseases. [74] Fiocruz's Bio-Manguinhos illustrates the potential of this approach in practice. Recognised by WHO as one of two reference centres for mRNA development and production in Latin America, it has built Brazil's first national mRNA platform for vaccines and therapies using domestic resources and technologies [75], established Latin America's first pilot GMP mRNA facility, and is advancing candidate products for endemic diseases through its pipeline — registered [76] to initiate clinical studies of its first mRNA vaccine, a COVID-19 booster, demonstrating the transition from capacity-building to product development. [77] [78] In parallel, Indonesia is among the Programme's manufacturing partners, carrying the platform into Southeast Asia [79].

Platform technology developed as a shared global public good, advanced simultaneously across regions, and strengthened through South–South collaboration.

Activities performed by global health institutions are commonly referred to as global functions. For decades, global functions for health have centred on transferring financial and in-kind resources directly to countries to address the priorities of the health-related Millennium Development Goals (MDGs) and subsequently the Sustainable Development Goals (SDGs). In today's epidemiological, economic and geopolitical environment, this has become increasingly ill-suited and difficult to justify as the primary role of global institutions.

Countries are demonstrating both the capability and the readiness to assume many of the responsibilities that have historically been outsourced to global institutions. This would enable governments to become more accountable to their citizens and more responsive to national health needs, rather than being constrained by cumbersome institutional processes and focused on externally defined priorities. However, greater national ownership does not render international cooperation obsolete. Rather, it changes its purpose and terms.

The international system for health was designed around direct country assistance in a different epidemiological and economic era. As countries increasingly finance and govern their own health systems, the comparative advantage of international institutions lies in providing functions that neither countries nor regions can effectively perform alone.

Provision of GPGs should therefore become the defining global function. It should not be framed as foreign assistance or financed through traditional aid budgets. Instead, it requires predictable, non-aid financing arrangements supported by all governments according to agreed principles. Guardrails should be put into place to ensure that larger financial contributions do not translate into disproportionate influence over joint decision-making.

[73] World Health Organization. (n.d.). The mRNA vaccine technology transfer programme. https://www.who.int/initiatives/mrna-technology-transfer-(mrna-tt)-programme
[74] Medicines Patent Pool. (n.d.). The mRNA Technology Programme agreements. https://medicinespatentpool.org/what-we-do/mrna-technology-transfer-programme/agreements
[75] Bio-Manguinhos/Fiocruz. (n.d.). Bio-Manguinhos is selected as a WHO hub for mRNA vaccine. https://www.bio.fiocruz.br/index.php/en-us/mrna-vaccine
[76] The Immunobiological Technology Institute (Bio-Manguinhos)/Oswaldo Cruz Foundation (Fiocruz). (2026). Study to evaluate the safety, reactogenicity, and immunogenicity of the Bio-Manguinhos/Fiocruz COVID-19 (mRNA) vaccine booster in healthy adults (Identifier No. NCT07640308). https://clinicaltrials.gov/study/NCT07640308
[77] Quantoom Biosciences. (2024, May 29). Quantoom Biosciences' Ntensify midi system adopted by Bio-Manguinhos/Fiocruz laboratory for future groundbreaking mRNA vaccine production in Latin America. https://quantoom.com/quantoom-biosciences-ntensify-midi-system-adopted-by-bio-manguinhos-fiocruz-laboratory-for-future-groundbreaking-mrna-vaccine-production-in-latin-america/
[78] Bio-Manguinhos/Fiocruz. (2026). Study to evaluate the safety, reactogenicity, and immunogenicity of the Bio-Manguinhos/Fiocruz COVID-19 (mRNA) vaccine booster in healthy adults (ClinicalTrials.gov Identifier No. NCT07640308). U.S. National Library of Medicine. https://clinicaltrials.gov/study/NCT07640308
[79] World Health Organization. (n.d.). mRNA Technology Transfer (mRNA TT) Programme. https://www.who.int/initiatives/mrna-technology-transfer-(mrna-tt)-programme

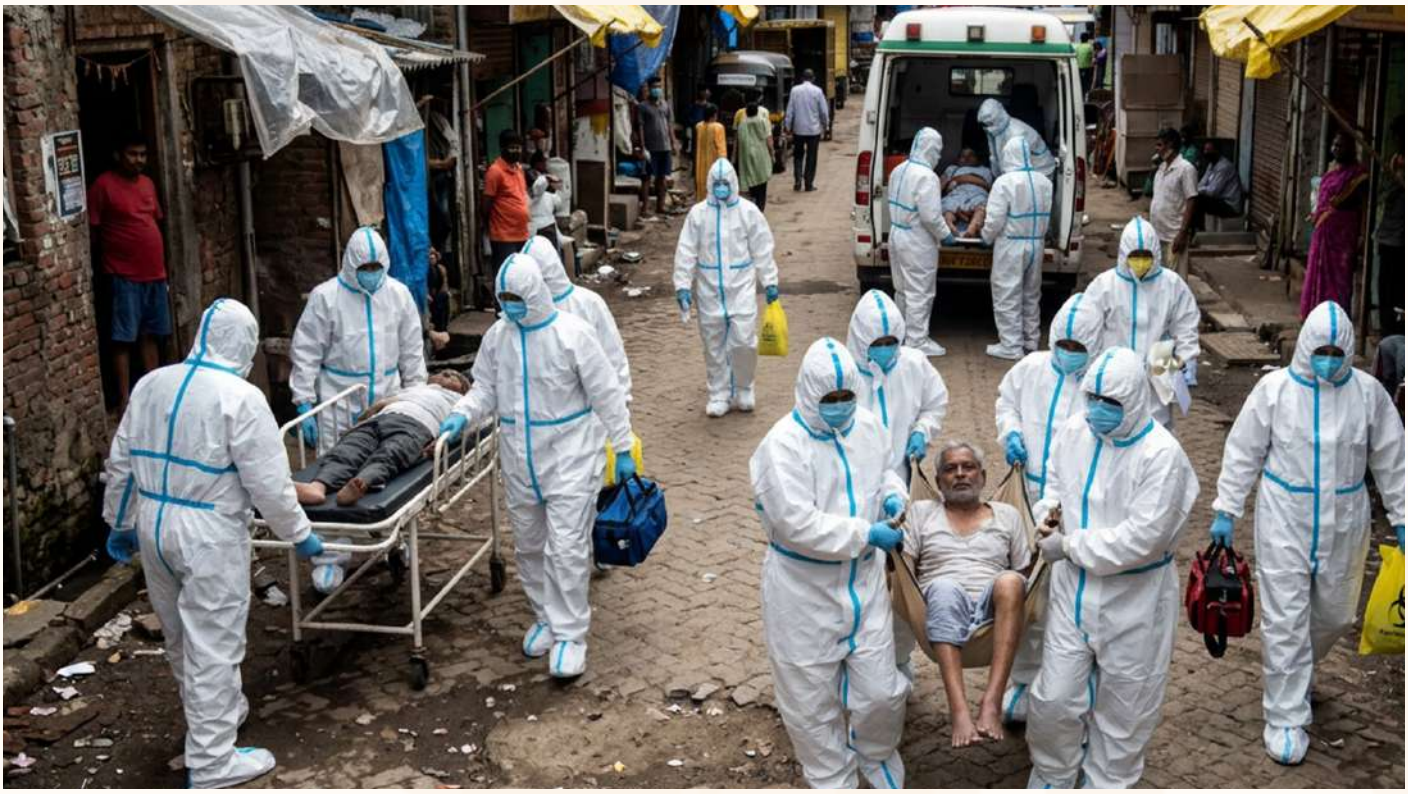
Recommendation 8 | A Stronger Humanitarian Continuity Mechanism for Health

Countries should develop a coherent cross-institutional humanitarian response capability for humanitarian crises and other shocks, coordinated through national Health Emergency Operation Centres designed within 12 months. It should use existing activation triggers, access criteria, decision rights, disbursement channels, replenishment rules, and equitable-access safeguards; cover countries based on need, including fragile populations in middle-income countries; and avoid diverting routine country allocations or essential services. Collaborative, multi-sectoral country, regional and global action will be essential to its delivery.

Health emergencies increasingly converge with climate shocks, conflict and violence: health is an essential intervention in every humanitarian setting and – as when epidemics strike amid conflict – can itself become the emergency, demanding the same anticipatory logic now applied to climate response: act on alerts, not on appeals. Through a Consolidated Humanitarian Health Plan framework aligned with existing humanitarian coordination structures and steadily funded health emergency operations centres, every response should simultaneously strengthen local capacity and build community resilience against future shocks, breaking the cycle of panic and neglect.

Delivery requires partnerships beyond the formal architecture — spanning UN agencies, NGOs, philanthropic and humanitarian organisations, and the informal structures communities already rely on. The collective surge mechanism should be designed and tested across acute crisis, protracted crisis, recovery, and cross-border emergency scenarios, with a first activation test exercise within six months of establishment and repeat testing annually, with operational links to national emergency systems, regional bodies, humanitarian agencies, development banks, and global health institutions. It should be tested on a bi-annual basis with clear operational links to national and regional emergency systems and existing humanitarian and global health mechanisms.

The objective is not to create parallel humanitarian systems but rather to ensure the humanitarian system supports country ownership when countries are under the greatest pressure. This function should form part of the common surge-financing window and follow agreed activation triggers, access criteria, decision rights, disbursement and replenishment rules and equitable-access safeguards. It should not rely on separate emergency reserves within individual global health institution country allocations or divert resources from routine services.



Recommendation 9 | Intentionally Reform Global Health Institutions through more effective collaboration, strategic consolidation and closure when appropriate

With immediate effect, strategically reform global health institutions whose main business is passing money, commodities and products to countries, through the 4Cs pathway – Commit, Collaborate, Consolidate, Close. Consolidation should occur in the medium-term as National Health Plans (NHPs) help discern how to most effectively combine functions of international organisations. Where appropriate, complete the transition within five to ten years while continuing and adapting functions and international funding to safeguard global public goods, humanitarian continuity, and the health gains of the past two decades. This will require international partner buy-in and reformed boards giving countries an equitable say over the pace and shape of the transition, with appropriate support for countries. This transition should be managed through a country-led process including relevant actors and taking into account the function and governance mechanisms for each institution considered.

Built to bridge a capacity gap and provide much-needed goods and services to many populations, these institutions leave a legacy of supporting a generation of health improvements, nationally and globally, bringing innovations to people in need and saving millions of lives. Yet, the same institutions are no longer as effective in their current form and mode of action for an increasing number of countries.

The 4Cs provide a pathway for transformation towards health sovereignty and reduced aid dependency that require a collective and intentional approach, which should be managed through a taskforce nominated and led by Member State that includes the Heads of GHIs:

***Commit:** Political commitment from key stakeholders, declared within 12 months, with countries committing to increasingly take responsibility for financing their own health systems through published country financing-transition plans, and donors committing to this pathway by redirecting their financing to country and regional systems as required, and fully aligning with the one-stop country compact.*

***Collaborate:** The five major multilateral global health institutions (Gavi, the Global Fund, Global Financing Facility, the Pandemic Fund, and Unitaid), the health functions of UNICEF, UNFPA, and the multilateral and regional development banks financing health (including the World Bank Group, the African Development Bank, Afreximbank, the Asian Development Bank, the Inter-American Development Bank, and the Islamic Development Bank) begin to align and operate as one system: co-located Board meetings that adopt joint decision points (not just shared venues), beginning by end-2027, consolidated back-office functions, and a single country interface — one joint country team, one application process, aligned funding cycles, joint missions, and one reporting system aligned to national processes. This includes unified access points for both financing and products through which countries can apply once for financial resources and commodities, ending the current fragmentation between funding and procurement channels. Within the same period, GHI boards should co-locate and hold simultaneous Board and Committee meetings with at least one day dedicated to joint planning and implementation including common decision points, as appropriate.*

***Consolidate:** Functions with a continuing global purpose – spanning disease control, financing, procurement, product development and access – are brought under consolidated governance (a 'holding company' with one board, one replenishment, one results framework, and one country interface, with the former institutions continuing only as operating arms organised by function – no separate boards or processes), in place within 12 to 36 months given the complexity of GHIs' legal arrangements.*

***Closure:** In selected cases, an orderly, time-bound wind-down with clear dates, sequencing, and the destination of all functions is agreed on up front within a foreseeable horizon of five to ten years while ensuring the continuity of global entities in charge of normative guidance (such as WHO) and the provision of global public goods and humanitarian support.*

This will require full support from international partners and reformed boards giving countries an equitable say over the pace and shape of the transition.

CARPHA: the Caribbean consolidated five institutions into one

In establishing the Caribbean Public Health Agency (CARPHA), CARICOM member states merged five separate regional health institutions — spanning epidemiology, nutrition, drug testing, environmental health and health research — into a single agency serving more than two dozen member states. [80] [81] Small states with limited individual capacity chose consolidation as the route to a stronger collective institution, and CARPHA now anchors regional surveillance, laboratory services and emergency response for the Caribbean.

Consolidation is politically possible — a whole region has already walked the pathway from commitment to consolidation, and it was the smaller states that led.

Countries' capacities to govern and finance health have grown substantially, and citizens are actively demanding that governments fully leverage local capacity to advance economic development and national sovereignty, not least in health. Keeping the transfer machinery in place now duplicates what countries and regions increasingly do for themselves and delays the shift to sovereignty around which this HLP's recommendations are built. For the first time in decades, sunsetting — closure of an organisation — is genuinely on the table for global health institutions due to various financial and geopolitical shifts that have taken place.

GLOBAL HEALTH INSTITUTIONS IN SCOPE

Primary focus: the five major GHIs, which account for the largest flows of funds and commodities and most of the burdensome processes experienced at country level:

- **Gavi, the Vaccine Alliance**
- **the Global Fund to Fight AIDS, Tuberculosis and Malaria**
- **the Global Financing Facility (World Bank)**
- **the Pandemic Fund**
- **Unitaid**

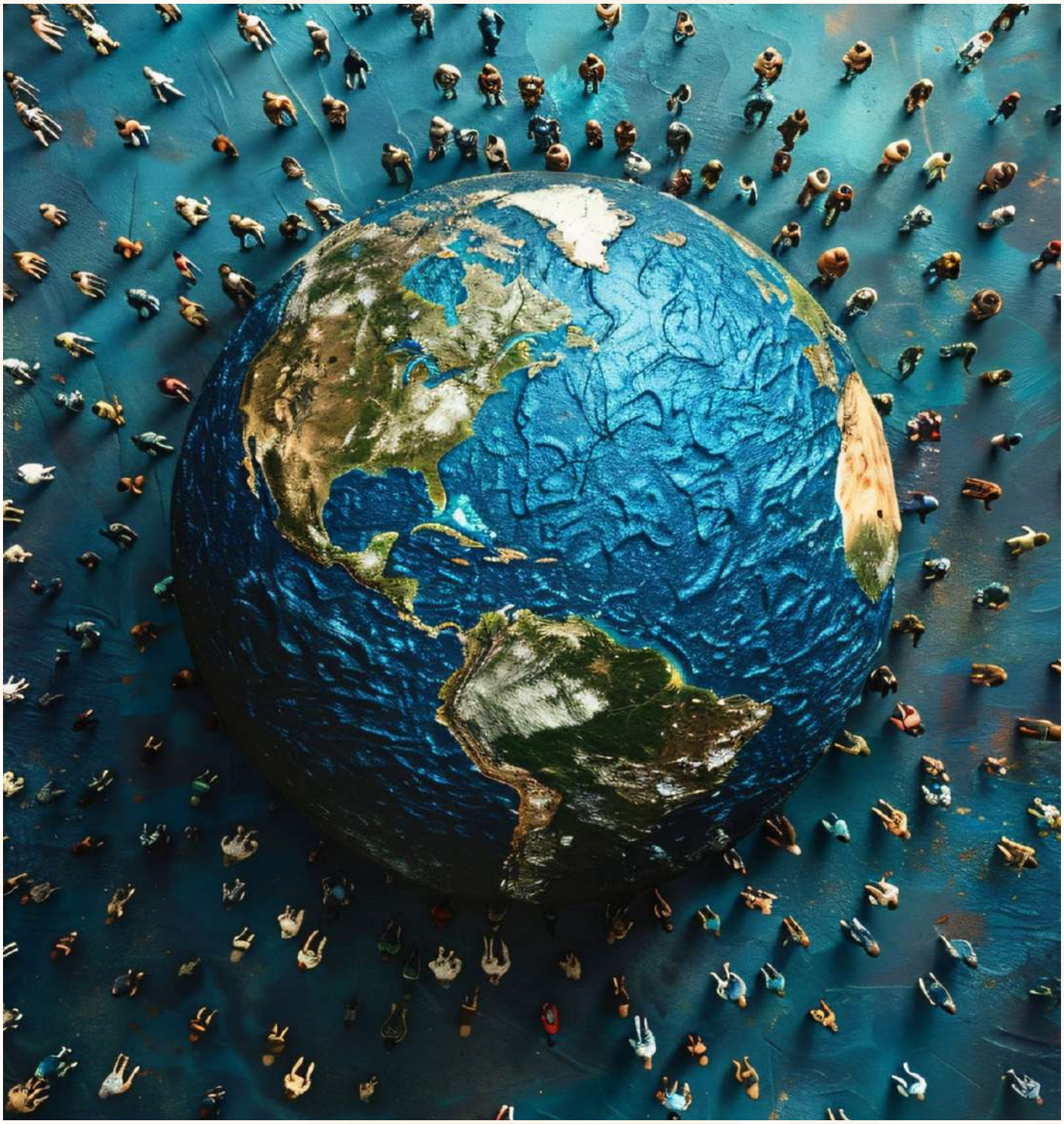
Also applicable to:

- disease-specific partnerships **(UNAIDS, Roll Back Malaria, Stop TB, GPEI),** whose separate maintenance is increasingly difficult to justify
- product development partnerships (e.g. the **Medicines for Malaria Venture, DNDi, the TB Alliance,** and the **International Vaccine Institute,** alongside **CEPI** as the principal multilateral funder of epidemic-related vaccine R&D), where rationalisation, merger and sunsetting should be considered
- and UN funds and programmes, whose reform is proceeding under UN80 **(UNICEF, UNFPA, UNDP, and WFP).** Multilateral and regional development banks should align their processes with the reformed landscape and with national one-stop shops.
- **WHO** reform is critical but constitutes a distinct internal governance agenda not covered here.

[80] Caribbean Community. (n.d.). Caribbean Public Health Agency (CARPHA). https://caricom.org/institutions/caribbean-public-health-agency-carpha/
[81] Pan American Health Organization. (2012, December 19). New Caribbean health agency, CARPHA, to begin operations on January 1. https://www.paho.org/en/news/19-12-2012-new-caribbean-health-agency-carpha-begin-operations-january-1

The 4Cs should be a sequenced pathway with hard, public benchmarks. Delivery should begin immediately, with actions that require no changes to institutional mandates or bylaws and build towards the structural steps.

The five to ten-year horizon is a deadline for global institutions, but responsible and realistic timelines will differ in different country contexts. Faster Transition Countries – capable of fully exercising leadership and reducing most dependence on external financing, technical support and global procurement for core health services – will complete the transition within five to seven years. Medium to Longer-Term Transition Countries will complete the transition within seven to ten years, with prior investment in planning, procurement, human-resource and financial-management capacity. In fragile and humanitarian settings, a coherent cross-institutional humanitarian response capability for pre-arranged, rapidly accessible surge financing during outbreaks, pandemics, humanitarian crises, and other shocks should be developed.

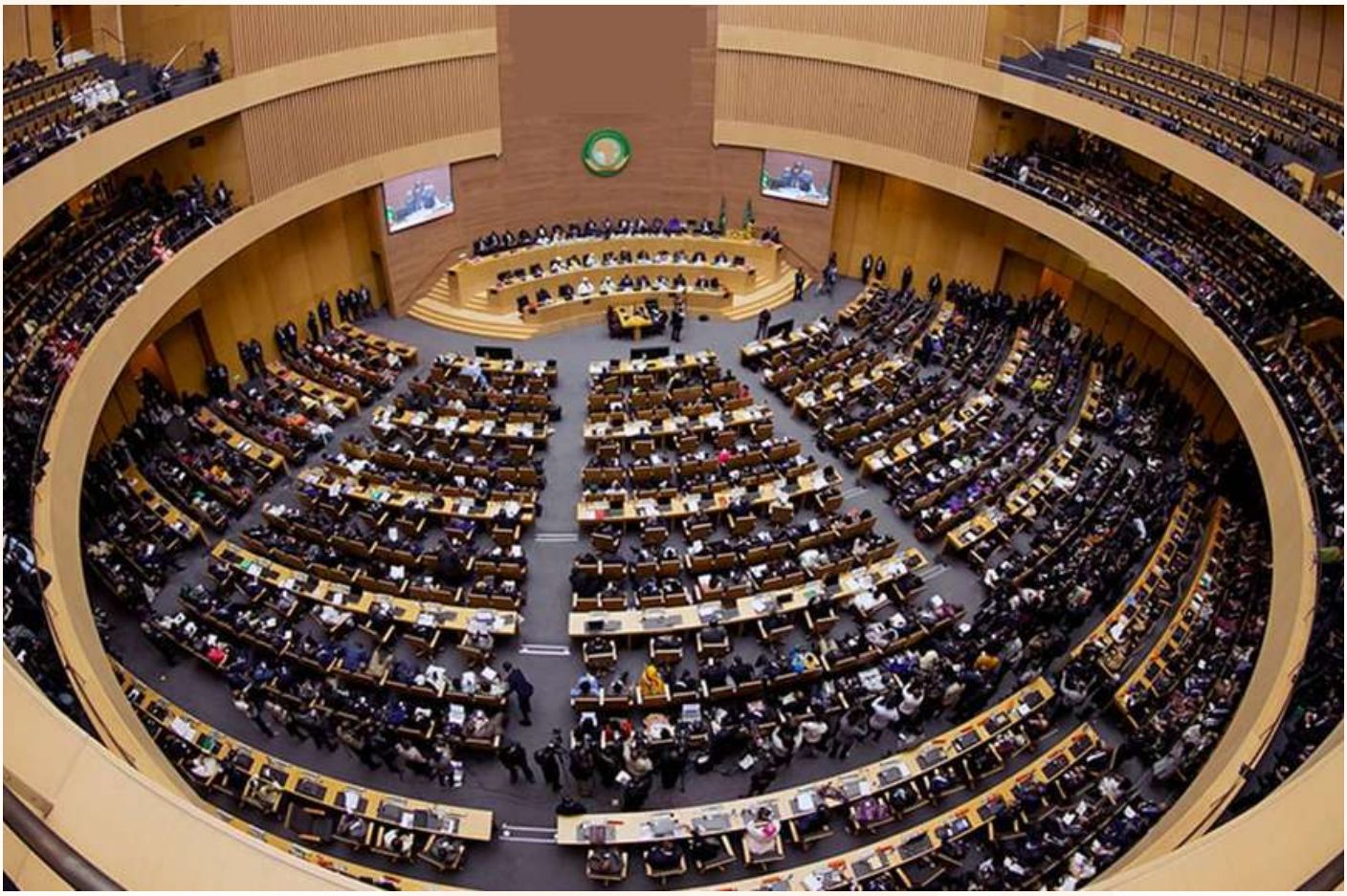


Recommendation 10 | An Independent Accountability Mechanism for the Reset and Continued Evolution of the Global Health Architecture

Within 6 months of the launch of this report, the Accra Reset Presidential Council should establish an independent follow-up and accountability mechanism to monitor and regularly report on the implementation of the Accra Reset Sovereign Health Agenda, including the HLP recommendations — tracking progress made by governments, international partners, global health institutions, development banks and regional bodies against agreed benchmarks, and publishing the results openly. The mechanism should be co-designed and led by governments, prioritising utility and building trust, with citizens and local organisations able to follow and verify whether commitments made to their health systems are being delivered.

Both health financing accountability and the quality of health services delivered have historically been self-reported. Governments report on their own budgets and health outcomes, donors report on their own disbursements, and GHIs report on their own results frameworks and measured impact. Each of these reports can be accurate individually and still leave a citizen with no way to check whether money promised for their local clinic actually got there, or whether a service they are owed is actually delivered. This requires investment in nationally owned health-financing data systems that are interoperable with national public financial management systems and enable transparent tracking from budgets and commitments through expenditure, procurement, and results.

Trust should come from clear rules and honouring the overarching principles outlined in this report, public disclosure, independent audit and verification, and meaningful participation by civil society and communities within country-led systems. Quarterly public tracking of Accra Reset commitments should begin within six months and a first full annual review within 24 months, aligned with existing governance calendars. This mechanism should, with time, extend beyond the Accra Reset Sovereign Health Agenda commitments and serve as a benchmark for transparent accountability.



4. Moving from Rhetoric to Action

The work of reforming the global health architecture has already begun, with some GHIs adapting to the current context and Member State needs. While these efforts are exemplary and should be commended, they are unlikely, if left to proceed institution by institution, to solve the broader system problems identified in the current global health architecture.

What is required now is pragmatic structural adaptation of the global health architecture to preserve continuity while improving the system. The HLP proposes a stepwise approach that respects sovereignty but also ensures that the structural problems identified can be addressed collectively through the political pathway provided by the Presidential Council of Accra Reset and taking advantage of relevant regional and global forums. Progress will depend on the leadership of self-selecting willing countries, the active participation of regional institutions and sustained engagement through global forums.

Across the set of recommendations provided, accountability will be critical as the reform of the global health architecture takes shape. Over the next decade, and through a transparent accountability mechanism, the progress of implementation must be publicly tracked and used to measure our collective progress towards the future state of the global health architecture that best serves countries and communities around the world.

Afterword

On behalf of the Circle of Guardians of the Accra Reset

H.E. Olusegun Obasanjo, Former President of the Republic of Nigeria

We congratulate the High-Level Panel on its work and on helping leaders to map a path towards a better future for all. Its members accepted a challenging mandate. They have discharged that responsibility with distinction. We have confidence in the promise of the recommendations presented here. They offer practical pathways towards stronger sovereign health systems, more capable regional institutions and a global health architecture better focused on the functions that require collective action. We are especially pleased that these objectives reinforce one another, for a global system is only as resilient as the national and regional systems on which it ultimately depends.

The HLP has provided clarity on possible pathways forward. It remains for sovereign nations to determine whether particular recommendations respond to their circumstances and, where they choose to adopt them, to decide the specific design, sequencing and modification required for implementation.

The success of these recommendations matters far beyond health. This report is about global health, but the condition it confronts is not confined to health. Dependency in health is connected to wider patterns of dependence across agriculture and food security, finance, trade, energy, technology, manufacturing, and data and digital infrastructure. The reform of global health is therefore the first test of a wider proposition: that countries of the Global South can exercise greater sovereignty in these other spheres while building stronger, fairer and more effective forms of international cooperation. This is the founding creed of the Accra Reset. Success in health can provide a template for advancing the Reset's wider agenda. And success in other sectors will in turn strengthen health sovereignty.

For that reason, we cannot allow these recommendations to remain on the shelves. As Guardians, we are committed to doing our part to sustain their political momentum and support their successful adoption and implementation.

We look forward to working with the Presidential Council in the days and months ahead. We invite national, regional, and international partners to engage seriously with the recommendations and support their country-led implementation. We urge the wider global health reform movement to work with the Accra Reset – to bring together our respective strengths, enlarge the coalition for change and convert this moment of disruption into an opportunity for renewal.

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Glossary

Abbreviation	Term in full and/or definition
4Cs	Commit, Collaborate, Consolidate, Close: a framework proposed as a pathway for reforming global health institutions
COVID-19	Coronavirus Disease outbreak of 2019
DTVs	Diagnostics, Therapeutics and Vaccines
GHIs	Global Health Institutions
Global South	The Global South is a term for developing, poorer, or formerly colonized countries. It includes about 130 nations in Africa, Latin America, parts of Asia, and Oceania. It is a political and economic group, not a strict geographic label.
GPGs	Global Public Goods for health are resources, services, or systems that include data, knowledge, strategies, and other shared resources that contribute to global health outcomes that benefit all people worldwide and whose use by one person or country does not reduce their availability to others.
HIP	Health Investment Plan: The costed, multi-year financing and implementation component embedded within the National Health Plan
HLP	High-Level Panel: The Accra Reset High-Level Panel on Reform of the Global Health Architecture and Governance
IP	Intellectual Property
NCP	National Coordination Platform: The country-led governance, coordination, implementation and mutual-accountability mechanism
NGOs	Non-Governmental Organisations
NHP	National Health Plan(s): The single organising framework for country health planning and financing
R&D	Research and Development
UN	United Nations
UNGA	The United Nations General Assembly
WHO	World Health Organization

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