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

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.

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 (NHP) 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 (NHP). 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.

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