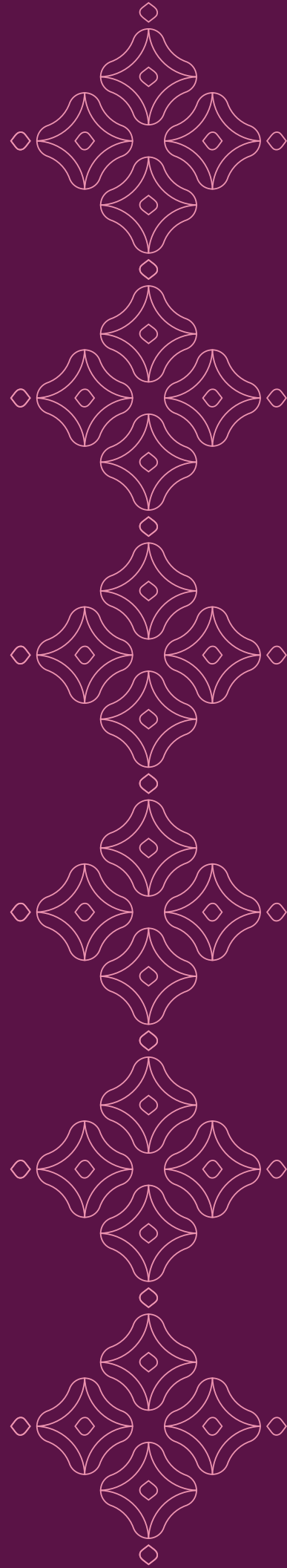




The Present and Future of the Global Health Architecture

Navigating a System in Transition

A note on this edition (August 2026): This updated edition reflects feedback shared during and after Kinaura's July 2026 webinar on the paper, together with review comments from colleagues across the field. Revisions include factual and terminology corrections, added context on the 2025 U.S. aid retrenchment, and updated references to the ongoing Ebola outbreak in Ituri Province, DRC. The paper's core argument is unchanged.



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Introduction



The global health architecture is being reshaped. COVID-19 exposed many of the strengths and limits health systems around the world, while recent shifts in the funding landscape have made questions about how global health priorities are financed, governed, and delivered more urgent. Yet the pressures facing the global health architecture are not only external, nor are they entirely new. Many reflect legitimate critiques of how the architecture has shaped and supported national health systems: underinvestment in primary health care relative to vertical disease programs; persistent failures of equitable access that have disadvantaged high-burden countries; and financing models that, in some cases, deepened external dependency rather than strengthening domestic capacity. This moment can therefore be understood as a collision between longstanding weaknesses within the global health architecture – and in the health systems it has helped shape – and a rapidly changing external environment that is exposing and amplifying them.

Some of the foundational conditions that underpinned decades of progress – predictable commitments, concentrated philanthropic capital, and the convening authority of multilateral institutions – are shifting rapidly, possibly more rapidly than the system can manage. For the first time in a generation, many of the major actors that have historically underwritten global health efforts are recalibrating. Donor governments are placing multilateral institutions under heightened scrutiny and are increasingly prioritizing domestic needs over international engagement; and global health is competing more directly with other policy priorities, including defense and domestic spending. At the same time, key philanthropic actors are moving toward more time-bound and catalytic models of support, while the regional and national institutions expected to assume greater responsibility are inconsistently resourced and unable to absorb the functions now at risk.

In this paper, we explore whether this transition can be managed deliberately enough to safeguard hard-won gains while addressing the weaknesses that have long limited the architecture's effectiveness. This is both a moment of pressure and of possibility: an opportunity to assess the system as it is today and the forces reshaping it and consider how it might evolve to overcome challenges. The discussion begins by defining the system itself before turning to the pressures reshaping it and the implications of those shifts on the future of global health.

Our discussion focuses on the institutions, financing arrangements, and coordinating mechanisms that shape the governance and implementation of global health priorities across borders. Broader political, macroeconomic, security, and development dynamics are considered as far as they influence the structure, performance, and trajectory of the architecture itself. These perspectives draw on Kinaura Partners' research, experience, and engagement across the global health ecosystem. We recognize that views on the architecture and its future are evolving and often shaped by different institutional positions and regional contexts. The observations and considerations offered here are therefore intended to inform discussion and reflection, not to prescribe a single path forward.



An Overview of the Global Health Architecture



The World Health Organization (WHO) defines the global health architecture as the “combination of actors, frameworks and processes that guide, coordinate, finance, and implement efforts to improve and protect health globally.”¹ Although “global health architecture” and “global health ecosystem” are sometimes used interchangeably, the terms have different emphases. Architecture refers more directly to the formal institutions, governance arrangements, financing structures, and processes that organize global health action. Ecosystem refers to the broader and more organic set of relationships, incentives, and interactions within which those arrangements operate. We generally use “global health architecture,” while recognizing that these wider relationships and dynamics shape how the architecture functions in practice.

Since the early 2000s, that architecture has expanded significantly, creating a more complex and crowded landscape of institutions and initiatives. For the purposes of this paper, we regard it as including member state and treaty-based organizations, donor governments and bilateral aid agencies, multilateral financing institutions and pooled funds, country governments and public sector institutions, and a range of non-state actors, including academia and research institutions, international and local nongovernmental organizations (NGOs) and implementing partners, philanthropic organizations, civil society and community-based organizations, and private sector and commercial entities.



A Five-Actor Framework for Understanding the Global Health Architecture

This paper uses a five-actor model to describe the global health architecture (**Table 1**). While these categories do not capture every nuance of the system, they reflect the main groups that shape global health decision-making and implementation across borders.

The table has three columns. The first identifies each actor category, the second defines how that category is used in this analysis, and the third has examples of the institutions and entities. Together, these columns are intended not only to catalog the main actors, but also to clarify the basis on which they are grouped (by institutional character, lines of accountability, and role within the architecture).

Table 1: A Five-Actor Model of the Global Health Architecture

ACTOR	DEFINITION	EXAMPLES
Member state and treaty-based organizations	Intergovernmental bodies established through treaties or formal agreements between states, accountable to member governments.	WHO, UNICEF, African Union (AU)
Donor governments and bilateral aid agencies	Sovereign governments and their official development assistance (ODA) institutions, accountable to domestic political systems.	BMZ (Germany), JICA (Japan), FCDO (UK), AFD (France)
Multilateral financing institutions and pooled funds	Institutions that pool resources from multiple contributors and deploy them through structured financing mechanisms.	Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, the Global Financing Facility (hosted by the World Bank)
Country governments and public sector institutions	National and subnational public institutions responsible for policy, regulation, and service delivery.	Ministries of health, ministries of finance, national regulatory authorities
Non-state actors, including private sector entities	Non-sovereign actors operating outside formal intergovernmental structures, accountable primarily to boards, donors, markets, or communities: • Academic and research institutions • International and local NGOs/implementing partners • Philanthropic organizations • Civil society and community-based organizations • Private sector and commercial entities	Clinton Health Access Initiative, Gates Foundation, local CSOs, patient advocacy networks, pharmaceutical manufacturers



What Effect Has the Architecture Had?



While a full assessment of the global health architecture's overall value and impact is beyond the scope of this paper, it remains an important topic, and has been examined in a substantial body of work, including as early as Laurie Garrett's 2007 Foreign Affairs essay "The Challenge of Global Health."² For the purposes of this paper, we take as a starting point that, notwithstanding its shortcomings, the global health architecture has made transformational gains over the past 30 years.

At the system level, the WHO reports that since 1990 life expectancy has increased by ten years, under-five mortality has fallen by 60%, and maternal mortality has declined by 40%. These gains were supported by sustained coordination across global and national actors. Since 2000, cooperation among global health actors has saved over 55 million lives through broader vaccine access, prevented more than 25 million AIDS-related deaths, and prevented more than 12 million deaths from malaria. This coordination has been made possible by landmark governance agreements including the Framework Convention on Tobacco Control (2005), the International Health Regulations (adopted 2005, updated 2024), and the Pandemic Agreement (2025). This progress demonstrates that when diverse actors align behind shared goals, the architecture can prevent millions of premature deaths at scale.³

The value of the global health architecture does not lie in any single institution, but in the ability of diverse actors to align and deploy their comparative advantages in service of common goals. Its impact is generated by the coordination among them.

The five examples below illustrate how that coordination works in practice. Consistent with our starting point of examining the global health architecture through its net-positive contributions, they are presented primarily to illustrate where and how the architecture has added value. This framing should not obscure the fact that in each case also involved shortcomings and areas where the system could have worked better.

Drawing on these examples, as well as the broader literature, **Table 2** sets the core functions of an effective global health architecture and maps them to typical lead actors. These functions should not be understood as fixed to particular institutions, even if certain roles are often associated with specific actors – for example, WHO's normative leadership. In practice, different actors may perform different functions in different contexts, reflecting both the diversity of the architecture and the often uneven, adaptive, and improvised ways in which it operates. In subsequent sections, we explore how this improvisation may be applied more deliberately.



Table 2: Core Functions of the Global Health Architecture and Their Typical Lead Actors Today

FUNCTION	ROLE	LEAD ACTORS	HOW IT IS ENACTED
Normative leadership and collective direction	Sets shared priorities, standards, and strategic direction across the system.	Member state and treaty-based organizations.	Global norms, technical guidance, and convening functions.
Financing and resource mobilization	Secures, pools, and allocates resources for global and country health priorities.	Multilateral financing institutions and pooled funds; donor governments and bilateral aid agencies.	Grants, concessional finance, replenishments, and allocation decisions.
Market shaping and innovation	Guides development, supply, affordability, and uptake of health products and technologies.	Multilateral financing institutions and pooled funds.	Pooled procurement, volume guarantees, and demand shaping.
Regulation and quality assurance	Protects the safety, quality, and effectiveness of health products, services, and systems.	Member state and treaty-based organizations; country governments; public sector institutions.	Global standards and national and regional regulatory systems.
Implementation, technical cooperation, and capacity strengthening	Translates strategy, financing, and norms into delivery and stronger country systems.	Country governments and public sector institutions; non-state actors including private sector entities.	Country-anchored with external actors supporting delivery, technical assistance, and systems strengthening.
Surveillance and preparedness	Builds capabilities and coordination to detect and respond to health threats.	Country governments and public sector institutions; member state and treaty-based organizations.	National public health systems with global and regional actors supporting standards and coordination.
Coordination, advocacy, and accountability	Aligns actors and priorities and helps track and reinforce commitments.	Member state and treaty-based organizations; non-state actors including private sector entities.	Multilateral platforms, with advocacy and accountability reinforced by external stakeholders.



FUNCTION	ROLE	LEAD ACTORS	HOW IT IS ENACTED
Research and evidence generation	Produces and applies knowledge to inform policy, practice, and innovation.	Non-state actors, including private sector entities; member state and treaty-based organizations.	Research institutions, philanthropies, and product developers, with global actors translating evidence into guidance.
Data, monitoring, and learning	Uses data to track progress, guide decisions, and improve performance over time.	Country governments and public sector institutions; multilateral financing institutions and pooled funds.	Country systems shaped by global indicators, reporting requirements, and funder frameworks.

Polio Near-Eradication

More than 99% reduction in wild poliovirus cases since 1988, 20 million paralysis cases prevented, and projected \$50 billion in net benefits.^{4,5}

Following the 1988 World Health Assembly resolution to eradicate polio, the Global Polio Eradication Initiative (GPEI) was established as a partnership between national governments and core partners including WHO, Rotary International, the CDC, UNICEF, the Gates Foundation, and Gavi.⁶ The initiative succeeds by leveraging rather than duplicating the distinct capabilities of each member. WHO coordinates technical strategies across more than 200 countries; CDC builds surveillance systems capable of detecting dozens of vaccine-preventable diseases; Rotary mobilizes millions of volunteers for community outreach; and UNICEF manages the cold chain logistics to deliver vaccines in conflict zones and other hard-to-reach areas. These operational contributions are underpinned by Gavi's negotiation of vaccine prices down to just \$0.14 per dose and the Gates Foundation's \$5 billion investment in breakthrough research and development.⁷

Since GPEI's launch in 1988, wild poliovirus cases have fallen by more than 99%, from an estimated 350,000 cases annually across more than 125 endemic countries to endemic transmission remaining in just two countries, Afghanistan and Pakistan.⁸ GPEI is a blueprint for what the health architecture can achieve over the long term, even across shifting political priorities and funding cycles. International progress is possible when roles are clearly defined, accountability mechanisms are functional, and every actor understands that it cannot succeed in isolation.



Global Fund Partnership

70 million lives saved, 63% reduction in combined AIDS, tuberculosis (TB), and malaria mortality; \$2.7 billion invested in health systems in 2024 alone.^{9,10}

Table 3: Summary of Market-Shaping Successes

HEALTH PRODUCT	ACHIEVEMENT
Antiretrovirals (HIV)	99% price reduction
Bed nets	80% faster delivery timeline
Drug-resistant TB treatment	55% price reduction
Short-course preventive treatment	30% price reduction
First-line HIV treatment	25% price reduction
Diagnostic test cartridges	20% price reduction

Since 2002, the Global Fund has used a model that distributes responsibility across actors with different comparative advantages. Donor governments and private foundations provide core financing during replenishment cycles; partner country governments co-invest and lead program execution with implementing partner support; civil society represents affected communities; and technical partners, including WHO and UNICEF, provide programmatic and regulatory guidance.

The Global Fund uses a co-financing model that requires countries to commit additional domestic funding to health programs as a condition for receiving grants. This builds national ownership, strengthens accountability, and increases the capacity to sustain health gains beyond the grant period. Countries co-invest approximately \$800 million annually as a result.¹¹

Beyond direct funding, the Global Fund leverages its collective scale to reshape global markets, lowering costs of essential health tools and expanding access (**Table 3**).¹² The Global Fund model demonstrates that when financing architecture is designed around ownership and market accountability, health gains can outlast individual grant cycles.¹³

Access to COVID-19 Tools (ACT) Accelerator

1.9 billion vaccine doses delivered to 146 countries, 175 million COVID-19 tests distributed across 184 countries, and 75% of vaccines deployed in low-income countries.^{14,15}

Launched in April 2020, the ACT Accelerator introduced a structural innovation in pandemic response: rather than coordinating a single product, it simultaneously accelerated the development and equitable distribution of vaccines, diagnostics, and therapeutics across a unified partnership framework. This three-pillared structure convened governments, scientists, the private sector, civil society, and major global health institutions, including the Gates



Foundation, CEPI, FIND, Gavi, the Global Fund, Unitaid, Wellcome, WHO, and the World Bank, with UNICEF and the Pan American Health Organization (PAHO) as primary delivery partners for the COVAX facility.

WHO provided technical and regulatory guidance across all three pillars. The Global Fund and World Bank were major financing and implementation partners, mobilizing billions in funding and deploying market-shaping tools to lower costs. UNICEF managed global logistics, procurement, and last-mile delivery. Technical partners including Gavi, CEPI, FIND, and Unitaid drove research and equitable access strategies for their respective product areas.^{16,17}

By late 2022, the partnership delivered more than 1.96 billion vaccine doses to 146 nations and 175.7 million tests across 184 countries. These efforts accounted for 75% of all vaccines administered in low-income countries and most doses supplied to the African continent. Up to 40 countries launched vaccination campaigns they could not otherwise have initiated.¹⁸ The ACT Accelerator demonstrated that coordinating vaccines, diagnostics, and treatments in parallel rather than in sequence can compress the global response timeline even under extreme logistical pressure. While not perfect, elements of this model may have relevance for future health emergencies.

DRC Ebola Outbreak Response

Major Ebola outbreak contained in an active conflict zone, with more than 300,000 people vaccinated and response innovations contributing to a permanent global emergency stockpile.¹⁹

The 2018–2020 Ebola outbreak in the Democratic Republic of the Congo (DRC) – at the time the second-largest Ebola outbreak ever recorded – presented one of the most demanding operational contexts the global health architecture has ever faced. The outbreak unfolded amid active conflict and profound community distrust of outside medical interventions.

Containment required a governance structure that centered national leadership while drawing on the distinct capabilities of global and local actors. A unified strategic response plan, led by the DRC Ministry of Health, set the framework. Within it, WHO supported surveillance and clinical response; Gavi helped secure access to the investigational vaccine through advance purchase commitments; an international coordinating group managed rapid vaccine allocation; CDC strengthened surveillance and case-management capacity; and Médecins Sans Frontières adapted clinical delivery to bring Ebola and non-Ebola care closer to communities.^{20,21,22,23} The World Bank's STEP program complemented the health response by providing temporary employment to more than 50,000 community health workers and others, helping strengthen community engagement.²⁴

The outbreak was officially declared contained on June 25, 2020, after more than 300,000 people vaccinated and case fatality rates significantly reduced through two newly identified therapeutics.²⁵ Experience during this and other Ebola responses also contributed to the subsequent establishment of a global emergency vaccine stockpile, launched in 2021 and maintained at a target of 500,000 doses. The response illustrates how the architecture can combine national leadership, international coordination, financing, technical expertise, market shaping, and community-level delivery under exceptionally difficult conditions.

That achievement should not be read as evidence that the underlying vulnerabilities were resolved. In May 2026, DRC's seventeenth Ebola outbreak was declared in Ituri Province and subsequently spread across multiple provinces. As of July 30, WHO had reported more than 3,600 confirmed cases.²⁶ The recurrence underscores both the value of an architecture capable of mounting emergency responses and the continuing challenge of translating repeated outbreak investments into durable national and regional preparedness capacity.



Rwanda Health System Transformation

67% reduction in under-five mortality in 15 years and malaria deaths reduced by more than 80%.²⁷

Following the 1994 genocide, Rwanda's health sector was devastated and left the country with the world's highest child mortality rate.²⁸ What followed was a health system transformation whose central lesson was about how international support was organized, rather than which interventions were deployed.²⁹

Rwanda's government consolidated all donor and NGO resources behind a single national health plan, ensuring that resources and expertise were aligned rather than duplicated and fragmented through parallel implementation. Partners aligned resources with national priorities rather than separate programmatic agendas. This was operationalized through performance-based financing tied to health outcomes; a national community health worker program that extended care to the village level; and a governance structure that gave the Ministry of Health authority over international resource deployment.

Between 2000 and 2015, measles deaths fell from 267 to near zero per 100,000; malaria deaths dropped by more than 80%; and Rwanda cut its under-five mortality rate by 67%, gains that have been sustained because they were built into national systems rather than donor-managed programs.³⁰ International partners supplied the supporting structure (financing, specialized expertise, and technical training) but the architecture they reinforced was Rwanda designed and owned. Because outside resources were channeled into a coherent national plan rather than dispersed across competing interests, each funding cycle added to the system's strength instead of its fragmentation.

Rwanda's health gains are significant and warrant recognition. However, they must be considered alongside concerns raised by international observers about human rights, political freedoms, and civic space. These issues are beyond the scope of this example but are critical for a balanced assessment of the country's development trajectory.

These five examples reflect the architecture's core strengths, with each participating organization contributing distinct and valuable functions. It extends beyond disease control to include market creation that makes medicines affordable, health system capacity that outlasts donor programs, and country ownership that promotes long-term sustainability. Generally, the architecture delivered where roles were clearly differentiated, especially where national governments had authority over implementation and accountability ran to outcomes rather than inputs. At the same time, these examples include instances in which the architecture fell short and required exceptional effort to compensate for its weaknesses, whether in equitable access, dependence on sustained external financing, fragmented coordination, or the difficulty of translating global commitments into durable national and regional capacity.

It is important to emphasize that in addition to the gains described above, the architecture's record includes serious failures that must be part of any balanced assessment. Primary health care and universal health coverage historically have been crowded out by vertical program funding. Equitable access to medicines and diagnostics has remained structurally uneven, with low-income, high-burden countries repeatedly disadvantaged in procurement and allocation. In many cases, country reliance on external financing has substituted for domestic investment rather than helping to build it. Fragmented coordination has also produced duplication, reporting burdens, and missed efficiencies that practitioners across the system have documented for years, and these are only some of the longstanding challenges that any meaningful transition must overcome.



The examples also surface one of the field's longest-running debates: whether the resources channeled through vertical, disease-specific initiatives, such as polio eradication and the Global Fund, would have produced equal or greater gains – including against those same diseases – had they been invested directly in strengthening basic health systems. The durability of Rwanda's systems-anchored gains, set against the recurrence of Ebola outbreaks in the DRC despite repeated response investments, shows why that question remains. This paper does not attempt to resolve the counterfactual, but the tension it reflects runs through the transition choices discussed in the sections that follow.

Despite their limitations, these examples demonstrate the architecture's capacity to generate meaningful results. Those results required a set of enabling conditions: stable multi-year donor commitments that allowed programs to plan beyond annual funding cycles; philanthropic anchors with the scale to absorb research and development risk and sustain innovation pipelines; and multilateral institutions with the authority to set standards and shape global markets. Those conditions are now uncertain, and what will replace them is unclear. Therefore, the question is whether the architecture can evolve to preserve what works, while adapting and building capacity to respond to emerging challenges rapidly and close gaps.

We expect that the following five trends will continue to reshape the architecture over the next ten years, not only as discrete developments, but also as compounding forces that will determine whether the system unifies or dissipates.



Five Trends Reshaping Global Health (2025–2035)



The next decade will indicate whether the global health architecture can evolve without eroding its core value. Many of the trends are underway. Some (donor nationalism, philanthropic sunsets) create immediate financing and governance pressures. Others (regional agency, technological disruption) avail possibilities for resilience and equity. The reduction in ODA funding has accelerated these dynamics but did not create them. It is critical that the actors in the ecosystem manage these shifts as deliberate transitions, with functions reassigned, markets protected, and delivery continuity preserved, rather than allowing a cascade into fragmentation, demand cliffs, and backsliding on hard-won gains.

Not all these shifts are inherently negative. Some, particularly the growing assertion of regional agency and the emergence of locally owned technological capabilities, examined in Trends 3 and 4, can be encouraged and cultivated, as they create real opportunity for an architecture that is more resilient, equitable, and anchored to emerge from the current state. The challenge is to steer the transition in ways that reduce risk while allowing those gains to emerge.

1 Retreating Donor Commitments and the Erosion of Global Health Solidarity

A wave of inward-looking politics is reshaping global health financing. In 2024, for the first time in nearly 30 years, the U.S., U.K., France, and Germany simultaneously cut ODA, with a further 9–17% drop projected for 2025. The United States went furthest: in 2025, it substantially dismantled USAID's operations, its primary bilateral aid agency, and cut U.S. development assistance by roughly two-thirds – a retrenchment of a different order of magnitude than the reductions announced by European donors. Bilateral health funding is expected to fall by up to 33%, dropping below pre-pandemic levels.³¹ The U.S. FY2026 budget proposal exemplifies this trend, seeking to cut bilateral global health funding by two-thirds and completely defund the WHO, Gavi, and the Global Fund.³²

What is changing is not simply the volume of funding, but the nature of funder behavior. Global health aid is increasingly treated as a domestic political instrument, subject to short-cycle political decisions, conditionalities,



and abrupt pauses. The system was not designed for this. Programs calibrated to multi-year funding cycles, supply chains structured around predictable procurement volumes, and surveillance networks dependent on joint funding agreements are structurally vulnerable when even one major funder reverses course, let alone when several do simultaneously. Even short-term gaps increase HIV-related deaths and interrupt vaccine rollouts for which there is no ready substitute.

The immediate priority is not to reverse these trends – that is beyond the ability of any single actor – but to build in enough structural resilience to absorb them. That may mean multi-year transition compacts rather than year-to-year disbursements, domestic financing pathways that grow as external support recedes, and regional procurement and surveillance platforms that reduce dependence on any one funder’s political cycle. The window for that kind of deliberate design is now; reactive responses after a funding cliff are far more costly and far more likely to produce lasting damage.

2 Evolution of Philanthropy in Global Health

Philanthropy is shifting to more catalytic, time-bound models with finite lifespans. In May 2025, the Gates Foundation announced it would spend more than \$200 billion before closing in 2045. As one of the largest and most influential funder in global health, the Gates Foundation’s “spend-down” creates both opportunity and risk: front-loaded spending can accelerate outcomes, but programs long sustained by the foundation have a finite horizon, raising questions about what will sustain innovation pipelines, data platforms, market incentives, and catalytic delivery after 2045. Gavi’s governance frameworks increasingly signal an expectation that philanthropic contributions should have defined horizons (catalytic rather than permanent), a shift that reflects growing sector-wide pressure to prioritize systemic change over indefinite service provision.³³

This moment of philanthropic transition is also making room for new entrants. As traditional Western philanthropies wind down or reorient, there is more opportunity for philanthropic actors from low- and middle-income countries (LMICs) to step in. Emerging foundations and high-net-worth donors across Africa, Asia, and Latin America are increasingly positioned to bring not just financing but contextual legitimacy and proximity to the communities they serve – a shift already visible in the growing health portfolios of institutions such as the Dangote Foundation in Nigeria and the Tata Trusts in India.

The next 20 years will likely mark a transition from centralized philanthropic dominance to a more distributed, multi-actor ecosystem. Realizing that potential – rather than simply inheriting a funding gap – requires deliberate cultivation of these new entrants, gradual cross-sector planning, and deep stakeholder buy-in to preserve public health gains. The immediate priority is to map where philanthropic withdrawal creates structural gaps rather than manageable reductions – and to begin building the multilateral, regional, and domestic anchors that can absorb those functions before – not after – the cliff arrives.

3 Expanding National/Regional Agency in Financing, Regulation, and Manufacturing

Perhaps the most consequential shift underway is the growing assertion of health sovereignty, particularly African, prioritizing domestic control over resources and reducing dependency on the Global North. Building on COVID-19 lessons, AU institutions and member states are driving a structural shift toward co-ownership of financing, regulation, and production. This effort is encapsulated in initiatives such as the Africa’s New Public Health Order, the Accra Reset, and the Lusaka Agenda, which was created by the GFF, Gavi, and the Global Fund to align global health initiatives and bilateral partners behind a single country platform rather than parallel investment plans.³⁴



Regulatory autonomy is advancing through the now-operational African Medicines Agency (AMA), while Gavi's African Vaccine Manufacturing Accelerator provides market incentives for African-produced vaccines. New financing mechanisms are also emerging, including the proposed Latin America and the Caribbean Health Justice Fund for cross-border health priorities and a proposal for 11 high-income Asian nations to commit 0.5% of their budgets to health-oriented aid, signaling a more multipolar aid landscape.³⁵ Alongside manufacturing and financing, countries are strengthening primary health care as the foundational infrastructure for self-reliance, reframing health as a long-term public investment rather than donor-driven aid. This movement emphasizes country-led strategies in which national governments define primary health care priorities, and bodies such as WHO regional offices and Africa CDC assume technical roles previously held by centralized global actors.³⁶

If managed well, this will enhance resilience, equity, and sustainability. If mismanaged, it risks fragmentation and uneven capacity. As a result, the immediate task is not to assess if regional institutions are ready today, but to identify what will help them become ready. That means investing in the governance frameworks, financing mechanisms, and technical capacity that will help them take a larger role. This time between the current assertion of regional agency and genuine regional capability is when the most consequential choices will be made.

4 Technological Disruption

Digital health and AI are increasingly being deployed in global health. Advanced analytics, exemplified by the AI@Gavi strategy, are converting vast datasets into actionable insights for immunization equity, enabling precision microplanning to reach “zero-dose” children.³⁷

Genomic sequencing capacity has expanded to 46 African countries, enabling real-time outbreak tracking anchored in homegrown institutions rather than external surveillance systems.³⁸ At the system level, the UN80 initiative includes a proposed joint technology accelerator platform to modernize digital and AI capacities across UN entities, while AI is being piloted to remedy operational inefficiencies such as automating grant application development and optimizing supply chains.³⁹

Parallel to these innovations is a critical movement toward data sovereignty, in which data is treated as essential national infrastructure rather than a tool for global reporting. Frameworks such as the African Health Data Governance Framework are enabling countries to maintain control over their own data and reduce reliance on foreign repositories, ensuring that the insights generated by these new tools serve national instead of external priorities.⁴⁰

These advances signal a shift from technology as an external input to a locally owned capability. However, this transition has risks including equity gaps in access, algorithmic bias, and fragmented surveillance systems to undermine the interoperability upon which global health security depends. Averting these risks while accelerating the transfer of technical capacity to national and regional institutions will help this trend strengthen – not strain – the broader architecture.

The practical implication is that technology governance cannot be treated as a downstream concern. Decisions made now about who owns data platforms, which interoperability standards are adopted, and how AI tools are procured and validated will shape the architecture's power dynamics for decades. Countries and regional bodies that establish clear data governance frameworks early will be positioned to reap the benefits of technological disruption on their own terms; those that do not may become data-generating inputs to systems owned and interpreted elsewhere. The priority should be to ensure that the speed of technological adoption does not outpace the development of the governance infrastructure needed to make it equitable and accountable.



5 Intersecting Systemic Pressures: External Shocks as Accelerants

The four trends above are unfolding within compounding external shocks: climate change with its broad potential health system consequences, pandemic risk, and geopolitical instability, which amplify their effects and narrow the margin of error.

Climate change is already reshaping disease burden and straining health system capacity to deliver services. Vector-borne diseases are expanding into new geographies,⁴¹ while extreme weather events disrupt cold chains, damage infrastructure, and displace populations.⁴² By 2050, according to World Bank data, climate change could lead to excess health costs in LMICs of at least \$21 trillion.⁴³

Even after COVID-19, pandemic preparedness is fragile. Any future pandemics or even the rise of antimicrobial resistance will stress the same functions now at risk from donor withdrawal and philanthropic sunsets: surveillance networks, regulatory harmonization, and pooled procurement. Geopolitical instability compounds this, as conflict disrupts immunization programs and supply chains,⁴⁴ while authoritarian governance can reject multilateral norms and weaken the accountability fabric the architecture depends on.⁴⁵

These trends do not operate in isolation; they reinforce and compound each other. Donor retreat and the Gates Foundation's 2045 spend-down may hollow out core functions including market-shaping mechanisms and last-mile delivery. But that same financing cliff forces a reckoning. If African and regional institutions can accelerate domestic resource mobilization, operationalize regulatory reliance through AMA, and establish regional pooled financing before external support ends, the result could be a more resilient, locally anchored system.

Conversely, if these transitions are reactive rather than managed – if volume guarantees collapse before regional procurement scales, data sovereignty fragments surveillance interoperability, or implementation capacity is lost before domestic budgets absorb the load – the architecture fragments. Markets lose confidence, suppliers leave, and coverage backslides. The next pandemic finds a weaker system than that which stumbled through COVID-19.

The architecture was designed for a more stable world. The next ten years may not offer that stability, and managing these five trends deliberately is not simply a matter of optimization; it is a prerequisite for survival.



Navigating the Transition: Preserve Functions, Protect Markets, and Lock In Gains



As we saw in the examples above, the global health architecture must perform specific functions to connect resources, knowledge, and action across borders, so instead of asking which organizations should exist, this section asks which functions must be performed and who is best positioned to deliver them in the future global health architecture. This functional lens reveals opportunities for new actors including national governments, regional bodies, private sector entities, and civil society to assume roles previously dominated by traditional players.

Each function below is described by current state, challenges to transition, what is at stake if the function fails, and strategies for maintaining performance as the architecture evolves.



Table 4: The Global Health Architecture at a Crossroads: Challenges and Ways to Overcome Them

FUNCTION	CORE CHALLENGE	ADDITIONAL POTENTIAL CONSEQUENCES	NAVIGATION STRATEGY	SAMPLE NEXT STEP
Normative leadership, policy, and collective direction	Normative authority is fragmenting as regional bodies gain influence and multilaterals face fiscal pressure and declining convening power.	Loss of coherence across standards, guidance, and collective action.	Preserve WHO as the global norm-setter while giving regional institutions such as Africa CDC and PAHO clearer roles in adaptation and implementation. The priority is not to replicate global norm-setting at regional level, but to build a more explicit division of labor between global standard-setting and regional translation.	Formalize and resource the WHO-Africa CDC joint technical working group model across additional functional areas, starting with disease surveillance and regulatory guidance.
Financing and resource mobilization	Retrenchment and eventual decline of concentrated philanthropic funding may cause a fragmented transition from pooled financing.	Service disruption, weaker procurement leverage, and reversal of hard-won health gains.	Shift donors, multilateral funds, and major philanthropies to multi-year transition compacts that pair declining external support with domestic resource mobilization, co-financing, and system strengthening. At the same time, build regional pooled financing mechanisms before financing contraction forces disorderly substitution.	Apply the Gavi co-financing logic and the GFF's compact models, which avail millions in domestic funding for women and children, incremental domestic contributions against explicit milestones with floors to transition compacts being negotiated now.
Market shaping and innovation	Demand uncertainty and fragmented procurement risk supplier exit, reduced competition, and stalled innovation.	Higher prices, stockouts, weaker supply resilience, and thinner innovation pipelines.	Protect core market-shaping functions by deepening coordination between Gavi, the Global Fund, regional procurement platforms, and country purchasers. Prioritize pooled forecasting, coordinated procurement, and selective use of volume guarantees, especially where markets are thin or strategically important.	Gavi and the Global Fund could conduct a joint supplier vulnerability assessment across the highest-risk product markets and establish a volume commitment framework before the next major procurement cycle. Proactive management here is measured against stockouts and price spikes.



FUNCTION	CORE CHALLENGE	ADDITIONAL POTENTIAL CONSEQUENCES	NAVIGATION STRATEGY	SAMPLE NEXT STEP
Regulation and quality assurance	Uneven regulatory capacity and fragmented approval pathways continue to slow access and weaken quality oversight.	Weaker trust in products, exit of current manufacturers, and missed opportunities for regional manufacturing.	Strengthen regulatory reliance through regional mechanisms such as AMA, while maintaining WHO's role in prequalification and global standards. Help national regulatory authorities move from isolated approval functions to interoperable regional oversight systems.	Produce a jointly published WHO-AMA reliance roadmap that national regulatory authorities can act against, with a three-year target to double active NRA participation in AMA work-sharing pathways using WHO prequalification as the interoperability anchor.
Implementation, technical cooperation, and capacity strengthening	Responsibility is shifting to domestic systems faster than financing, operational capability, and institutional readiness are being built.	Service disruption, weak execution, and loss of confidence in country-led transition.	Manage transition over a realistic time horizon, with country governments, donors, and multilateral funds linking financing shifts to explicit investments in public systems, workforce capability, and execution capacity. International NGOs and technical partners should increasingly move from substitute delivery to targeted, time-bound capacity support.	Capacity absorption assessments (e.g., benchmarking budget execution, procurement readiness, and health workforce coverage) could be required as a condition of any transition timeline. Graduation would then be declared against demonstrated capacity, not assumed.
Surveillance and preparedness	New surveillance investments risk creating parallel systems, while weak interoperability and data sovereignty concerns constrain trust and coordination.	Slower outbreak detection, weaker cross-border response, and a more fragile global early warning system.	Build a federated model in which national systems and regional bodies are operational first responders, while WHO remains the integrator of standards, intelligence, and escalation. Financing should increasingly reward readiness, interoperability, and participation in regional simulation and review mechanisms.	Finance and operationalize the AU's Integrated Disease Surveillance and Response framework (including cross-border data-sharing agreements and regional simulation exercises) rather than designing new architecture. The bottleneck is funding and political commitment, not design.



FUNCTION	CORE CHALLENGE	ADDITIONAL POTENTIAL CONSEQUENCES	NAVIGATION STRATEGY	SAMPLE NEXT STEP
Coordination, advocacy, and accountability	Platform proliferation, donor fatigue, and weakening political commitment are eroding coordination and independent accountability.	More duplication, weaker collective action, and less pressure to sustain commitments.	Rationalize coordination platforms and clarify institutional roles, rather than adding new mechanisms. At the same time, protect the independent advocacy and accountability role of civil society and community and other non-state actors through dedicated funding and formal roles in governance processes.	A time-bound joint audit of existing coordination platforms (led by WHO, Gavi, the Global Fund, the GFF, and UNICEF) could map overlap and propose rationalization, targeted for completion before the next World Health Assembly.
Research and evidence generation	Core evidence functions are too dependent on a narrow set of funders and externally driven priorities.	Weaker priority-setting, less credible evidence for decision-making, and widening gaps in analytic capacity.	Shift key evidence public goods to more durable multilateral and multi-donor ownership while investing in regional research institutions, academic networks, and country-embedded analytic capability. The objective should be a research architecture that is more distributed and decision-relevant.	The Gates Foundation could identify two or three evidence platforms where it is the sole or dominant funder and initiate structured handover to multi-donor stewardship before 2030, establishing the template before the 2045 horizon makes it urgent across the portfolio.
Data monitoring and learning	Parallel reporting systems, weak interoperability, and unresolved data governance limit trust and usability.	Poor visibility into performance, weaker comparability, and slower course correction.	Move toward shared standards and federated governance, with data primarily stewarded by country governments but structured for regional and global aggregation when needed. WHO, the World Bank, and regional institutions should focus less on owning data platforms and more on setting standards, financing interoperability, and improving routine system quality.	WHO could lead a time-bound process to adopt common data exchange standards, building on FHIR and OpenHIE frameworks, with country adoption incentivized through aligned Global Fund and Gavi reporting requirements. Compatible standards are a prerequisite for federated governance.



Managed transitions require more than stated intent. They depend on phased reductions in external support tied to demonstrated absorptive capacity, alongside contingency mechanisms to prevent coverage gaps if the transition moves faster than domestic systems can absorb. The Gavi graduation model offers the most developed template: co-financing requirements rise incrementally and are tied to explicit milestones in domestic budget growth and execution capacity, with technical assistance accompanying rather than following each stage. PEPFAR's co-investment frameworks reflect a similar logic. The lesson from both is that handover without these mechanics – milestones, floors, a trigger for contingency financing – typically produces the funding cliff it was designed to prevent. Backsliding on hard-won gains has already begun. Structured transition must anchor global health architecture evolution assumptions to prevent further erosion and reverse consequences of ODA funding cliffs. The question is no longer whether the architecture needs reform, but what it needed to navigate the next ten years and rebuild what has been lost.



Five Priorities for the Decade Ahead



The pressures, trends, and next steps outlined in **Table 4** point to a common theme: across functions as diverse as norm-setting, financing, market shaping, surveillance, research, and implementation, the priority is to preserve the capabilities that have historically driven change while adapting to a shifting political and financial environment.

The future architecture is unlikely to be defined by a single reform or wholesale replacement of existing institutions. It will depend on choices about roles, responsibilities, and incentives; stronger regional and national capabilities that do not fragment global public goods; and more intentional investment in the governance, financing, and coordination mechanisms needed to manage transition over time. Some degree of decentralization is inevitable and in many cases desirable. The key question is whether it leads to a system that is clearer in its allocation of roles, more resilient and equitable, and better able to connect financing, authority, and implementation. The considerations below are intended to inform these choices and the discussions about them.

1 Identify functions the system cannot afford to lose and be clear that not every function should decentralize.

The starting point is functional continuity, not institutional preservation for its own sake. Some functions, including normative guidance, pathogen surveillance, pooled risk management, and selected global public goods will continue to require institutions with global legitimacy, scale, and convening authority, particularly WHO, the World Bank, and major pooled mechanisms like the GFF. Others, especially market-shaping, implementation, and selected financing functions, should progressively shift to regional institutions, country governments, and more distributed ownership



models. The strategic task is to distinguish between functions that must remain globally pooled and those that should move closer to regions or countries. The first step is for WHO, the World Bank, and the major pooled funds to map which functions lack a credible alternative anchor and begin transition planning there.

2 Institutionalize regulatory and quality reliance before fragmentation outpaces trust.

As manufacturing, procurement, and implementation become more widely distributed, quality assurance must be more networked without becoming more fragmented. This means accelerating mechanisms such as AMA work-sharing and mutual recognition, strengthening post-market surveillance, and linking procurement eligibility to trusted reliance pathways. The goal should be a coherent regulatory ecosystem in which WHO and regional and national regulatory authorities have complementary roles that preserve efficiency and trust. A practical near-term suggested target is five additional national regulatory authorities participating in AMA work-sharing pathways by 2027, with WHO prequalification and normative guidance as the interoperability standard.

3 Protect frontline outcomes as the architecture rebalances.

The greatest risk in transition is not institutional discomfort, but loss of essential outcomes. Therefore, financing and institutional reform should be anchored in sentinel indicators such as immunization coverage, HIV treatment continuity, TB treatment success, skilled birth attendance or contraceptive prevalence, and malaria test-and-treat performance, with explicit contingency financing to prevent service breaks. Donors, multilateral funds, and country governments should make continuity of core delivery platforms a protected priority throughout the transition. Before the next replenishment cycle, all should agree on a small set of non-negotiable coverage floors and the contingency financing instruments that will be triggered if they are breached.

4 Plan now for the eventual reallocation of Gates Foundation capital.

The architecture has benefited enormously from large-scale philanthropic funding, but in some areas it has also become structurally dependent on it, particularly where the Gates Foundation has been the sole or dominant funder. The ecosystem, including the foundation itself, should identify where critical public goods, market incentives, data platforms, or product-introduction efforts are overly reliant on Gates funding and begin structured handover planning well before 2045. The objective should be more resilient institutional anchoring through multilaterals, regional institutions, and, where appropriate, phased domestic co-financing. A first step could be a joint mapping exercise (e.g., convened by the Gates Foundation with key multilateral and regional counterparts) to identify the top ten functions for which Gates is sole or dominant funder.



5 Build regional institutions as strategic counterparts within a more balanced architecture.

A more regionally anchored architecture will work only if local institutions are empowered to do more than channel funds or support delivery. Over time, they should have stronger roles in norm adaptation, pooled financing, procurement, surveillance, regulatory reliance, and political coordination, while global institutions continue to provide legitimacy, comparability, and stewardship of shared public goods. Hence, the strategic task is not simply to shift responsibilities downward, but to build regional institutions as credible counterparts within a more distributed but still interdependent global system. A first step would be to thoughtfully route a larger share of bilateral and multilateral financing directly through Africa CDC, AMA, and regional procurement platforms. This would not only signal intent but would also be a way to build the transaction volume those institutions need to become operationally credible.



Considerations for the Five Actor Groups in Navigating Transition



Over the next few years, debates about the future of the global health architecture will continue at many levels, but that future ultimately will be shaped by how its principal actors answer questions of role, capability, and transition in practice. The considerations below are framed with this in mind but are not intended as prescriptive instructions or exhaustive agendas for each group of actors. Rather, they are practical recommendations made with the understanding that context, institutional realities, and political constraints will shape how change is ultimately pursued. They indicate areas where thoughtful action could help the architecture become more resilient, less fragmented, and better aligned to the realities of the next ten years.

1 Member state and treaty-based organizations

Member state and treaty-based organizations, particularly WHO and relevant regional intergovernmental bodies, may be most effective if they continue to focus on the functions only they can perform with legitimacy and scale (i.e., setting normative standards, coordinating global surveillance, and convening collective action). In this context, the priority may be more about clarifying comparative advantage, codifying where authority is best held globally, and where adaptation and execution could fall to regional and national actors, rather than preserving legacy operational roles.

In practice, this could mean three things. First, WHO could continue to strengthen its role as custodian of global norms, data standards, and technical legitimacy, while creating more structured pathways for regional adaptation rather than relying on informal downstream interpretation. Second, treaty-based and regional bodies could work toward more explicit divisions of labor across global, regional, and country levels, especially in surveillance, preparedness, and regulatory reliance. Third, member states may need to back these institutions with more predictable financing and clearer political mandates, so that expectations of global stewardship more closely match capacity.



2 Donor governments and bilateral aid agencies

Bilateral donors may wish to move from short-cycle funding models that can perpetuate dependency even when transition is the stated goal. Over the next ten years, one of the most constructive roles for bilateral actors could be to support transition itself, financing the shift from externally managed programs to stronger domestic and regional systems through multi-year, milestone-based support rather than year-to-year volatility.

That would suggest a somewhat different operating model. The Foreign, Commonwealth & Development Office, the German Federal Ministry for Economic Cooperation and Development, the Japan International Cooperation Agency, and peers could increasingly use multi-year financing envelopes tied to practical transition benchmarks including domestic budget growth, execution rates, regulatory strengthening, monitoring and evaluation, and procurement readiness. They could also channel a larger share of resources through national and regional institutions, while maintaining fiduciary discipline through stronger due diligence and risk management instead of additional procedural layers. Just as importantly, bilateral donors might consider defining success less by disbursement alone and more by whether countries are becoming more fiscally resilient, operationally capable, and less vulnerable to funding shocks.

3 Multilateral financing institutions and pooled funds

Multilateral financing institutions and pooled funds, including Gavi, the Global Fund, GFF, and the World Bank, could begin preparing for a more disciplined role in the architecture based on the functions they are best positioned to protect. A key challenge will be avoiding institutional drift – retaining operational roles by default even where regional or country actors may be better placed to lead.

The practical agenda could be that multilaterals design multi-year transition instruments that support domestic resource mobilization, fiduciary strengthening, absorptive capacity, and continuity of critical system functions as donor support recedes. They could also preserve and deepen their market-shaping role through pooled forecasting, volume commitments, and demand visibility, especially in product markets in which fragmentation could quickly undermine supply and affordability. In parallel, they may wish to co-create bridge mechanisms with regional institutions and development banks so that surveillance, supply systems, and core delivery platforms do not fall into a financing gap during transition.

4 Country governments and public sector institutions

The central opportunity for governments and public sector institutions is to turn the principle of country ownership into concrete institutional and financial arrangements. This would mean treating transition not simply as an external event to be managed by donors, but as a domestic state-building agenda involving budget choices, institutional reform, regulatory strengthening, and clearer accountability for results. The countries most likely to navigate this period successfully may be those that move earliest and most deliberately to embed externally financed gains into national systems.

Immediate priorities must be approached practically. Ministries of health and finance, procurement agencies, and national regulatory authorities could establish domestic budget pathways for functions that cannot remain externally



financed indefinitely, particularly routine care delivery, workforce, surveillance, and essential procurement. The GFF is a leading model for country-led prioritization across funders. Graduation and co-financing requirements from Gavi and the Global Fund can be used to accelerate fiscal planning, rather than interpreted solely as evidence of donor withdrawal. At the same time, national institutions could invest more deliberately in the mechanics that make sovereignty credible, including better budget execution, stronger oversight, interoperable data systems, and regulatory and procurement capabilities that allow countries to participate in regional platforms rather than remain dependent on parallel external channels.

5 Non-state actors, including private sector entities

Non-state actors, including NGOs, philanthropies, academia, civil society, and the private sector, could increasingly position themselves as enablers of transition rather than permanent substitutes for public systems. Their comparative advantage is likely to remain significant, but it may be most valuable when it helps the architecture solve coordination, evidence, accountability, innovation, and systems design challenges that neither governments nor multilaterals can on their own.

For the Gates Foundation and other philanthropies, this could mean identifying where they are sole or dominant funders of critical public goods, analytic platforms, or market incentives, and beginning structured handover planning well before a cliff emerges. For civil society and community actors, it may mean protecting independent advocacy and accountability roles even as funding models evolve (e.g., following the GFF's model of prioritizing civil society engagement in country and global governance, and direct financing for civil society's advocacy and accountability role). For academic and research institutions, it could mean building more regionally rooted and decision-relevant evidence platforms. And for the private sector, especially manufacturers, diagnostics firms, and technology companies, it may mean engaging earlier with regional procurement, regulatory reliance, and federated data architectures so that they become strategic partners in a more distributed system rather than suppliers to a fragmenting one.

Conclusion

A common thread runs across all five actor groups: if the current transition is navigated strategically, the next phase of the global health architecture is likely to reward clarity of function more than competition. Actors that can sharpen their comparative advantage, invest early in transition capacity, and build more deliberate forms of interdependence will be better able to shape an architecture that is more resilient, balanced, and fit for purpose than the one now under strain.

That outcome, however, is unlikely to emerge automatically. The choices described above require strategic clarity and operational capacity to act in real time in specific country and institutional contexts. The challenge is not simply to preserve what exists or dismantle it in favor of something new without careful thought. If managed well, this period of strain could become a moment of renewal, one in which the global health architecture emerges more resilient and regionally grounded and better equipped to overcome challenges.





Kinaura Partners: Built for This Transition

Kinaura Partners is a global consulting firm built differently by design. We help purpose-driven companies and organizations navigate complexity and move big ideas into real-world outcomes. The pressures described in this paper are affecting our clients, including a bilateral agency recalibrating its strategy as ODA budgets contract; a multilateral fund preparing for a replenishment cycle in a changed political environment; and a national government that must absorb functions previously funded externally. These clients have a common need: expert guidance that goes beyond frameworks and reaches the level of operational reality, including what to do, in what sequence, with which partners, and how to protect what matters most during the transition.

What Makes Kinaura the Right Partner for this Moment:

Institutional literacy with cross-system perspective: Kinaura combines deep institutional literacy with a perspective that extends beyond a single institution. We have worked closely with the Gates Foundation, the Global Fund, Gavi, WHO, and bilateral funders, including in embedded and advisory capacities that provide firsthand insight into how these organizations make decisions and navigate trade-offs. This cross-institutional lens allows us to initiate difficult conversations on shared transition costs and topics that may be difficult to raise within any one institution, and to support clients whose interests do not always fully align.

Depth at the architecture level: Most consultants work within institutions. Kinaura works on the relationships between them. We help design the practical mechanisms that transition depends on – co-financing compacts, demand forecasting arrangements, pooled procurement frameworks, and regulatory reliance pathways – with enough operational specificity to be implemented, not just proposed.

Proximity to implementation: We do not hand off at the strategy stage. We assess where transition risks are building through demand forecasting, supplier risk mapping, and early identification of fragile product markets, then help clients act before gaps become crises. Our global talent network means we can move from diagnosis to implementation in the regions and systems where work is done.

We have a values-grounded, strategically relevant approach: Kinaura is built on locally led, institutionally grounded solutions. In this transition moment, that is more than a matter of principle. It is a practical advantage that shapes how we advise, which partnerships we encourage, and where we challenge approaches that risk reproducing the dependency they are meant to reduce.





How We Support a Global Health Architecture in Transition

Donor transition and financing strategy: Helping bilateral agencies, multilateral funds, and country governments design and execute the transition from externally managed programs to domestically anchored systems. This includes multi-year compact design, milestone-based financing structures, domestic resource mobilization, and the budget execution and oversight systems countries need to absorb resources.

Philanthropy handover planning and new entrant support: Helping major philanthropies map where they are sole or dominant funders of critical public goods, develop structured handover plans before cliff events emerge, and identify successor funders – including emerging philanthropies from LMICs – whose contextual legitimacy and proximity to communities can fill gaps that Western philanthropies cannot. We also help entrant foundations build the governance, portfolio design, and partnering models that make funding genuinely catalytic rather than dependency-creating.

Regional sovereignty and platform governance: Advising regional institutions on the governance design, decision rights, co-financing structures, and accountability mechanisms that will determine whether platforms such as the AMA, regional procurement networks, and emerging pooled financing mechanisms become credible counterparts in the global architecture or remain underpowered intermediaries. We help fill the gap between the assertion of regional agency and autonomy and the operational capacity needed to make it real.

Digital health strategy and data governance: Helping partners navigate the intersection of AI-enabled health tools, data sovereignty frameworks, and governance structures needed to ensure technology benefits national systems rather than reproducing dependency on external platforms. This includes working with country governments and regional bodies on data governance policy, interoperability design, and access to digital health infrastructure.

Climate and health financing integration: Identifying where climate adaptation and health system investment needs converge and designing financing approaches that mobilize new resources without creating parallel structures. In an era of compounding external shocks, integrated financing is not simply efficient; it is a prerequisite for systems that can absorb the next disruption without backsliding.

Global health architecture navigation and institutional positioning: Helping organizations define their role in an evolving global health architecture by clarifying their comparative advantages, which functions they are best suited to lead, and how they should adapt as responsibilities shift across global, regional, and national actors. This includes supporting strategy on institutional positioning, transition planning, partnership models, and leadership choices.

This paper reflects conditions as of mid-2026. The Ebola outbreak in Ituri Province referenced herein was ongoing at the time of writing; readers are encouraged to consult WHO and Africa CDC for current developments.





About Kinaura Partners

Kinaura Partners (formerly Global Health Visions) is a woman-owned global consulting firm specializing in social impact, strategy, systems change, and evidence-based transformation. Founded 18 years ago, Kinaura comprises more than 80 core team professionals supported by a global network of over 1,000 experts. We work alongside philanthropies, governments, multilateral institutions, and civil society to design strategies, build coalitions, and drive measurable progress across health, climate, sustainability, and equity.

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Work with Us

If this paper's trends and ideas are relevant to your work, whether you are navigating transition, managing financing pressure, planning for spend-down, or building new regional capacity, we would welcome the opportunity to discuss how Kinaura could support you. Please contact Timothy Attoye, Managing Director of Global Health Institutions Strategy and Partnerships (timothy.attoye@kinaura.com) or Nathan Perkins, Director of Global Health Resource Mobilization (nathan.perkins@kinaura.com).



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