STAKEHOLDER INPUT TO THE WHO CONSULTATION ON THE REFORM OF THE GLOBAL HEALTH ARCHITECTURE

In response to: WHO Executive Board Decision EB158(20) - Reform of the Global Health Architecture and the UN80 Initiative

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Preamble

These inputs are submitted by an academic researcher with direct engagement in WHO Pandemic Accord intergovernmental negotiations in Geneva and expertise spanning international law, international relations, and global health policy. They draw on sustained scholarly analysis of the Pandemic Accord negotiating dynamics, the structural conditions reshaping global health governance, and the comparative literature on UN and multilateral institutional reform.

The overarching position advanced in these inputs is as follows: the WHO consultation process has been mandated at a moment of structural rupture, not cyclical disruption, in the global health order. The reform proposal and the joint process it initiates must be designed accordingly. Institutional recalibration within the existing architecture will be insufficient. What is required is a genuine redesign - one that honestly acknowledges competing normative priorities among Member States, embraces a confederal multi-level governance logic, and is robust to geopolitical fragmentation, including the absence of major powers from universal processes.

Feedback on Purpose, Scope and Principles

General assessment: The EB158(20) decision rightly identifies the need for a joint, inclusive, transparent, time-bound, resource-effective process hosted by WHO and led by Member States. The stated goals of streamlining mandates, improving coordination, and aligning financing

with country-led strategies are necessary starting points. However, the framing of purpose and scope requires sharpening in three respects.

On purpose: naming the structural rupture

The draft skeleton frames the reform as a response to 'declining development assistance' and ‘coordination failures’. This underestimates the problem. The global health architecture is experiencing a structural transition away from the US-led, aid-dependent, institutionally centralised model that has governed it since the 1960s. The COVID-19 pandemic and the subsequent geopolitical fragmentation, including the United States' withdrawal from WHO, the termination of major bilateral aid programmes, and the assertion of sovereignty-first health diplomacy by major emerging economies, represent a rupture in the political-economic conditions that made the previous architecture possible. The reform proposal should acknowledge this crisis in order to advance the reform realistically.

The Lyon Joint Political Declaration (7 April 2026), endorsed by 19 governments and major global health entities, rightly affirms that reform must ‘enable a fundamental shift towards country health sovereignty’ and ‘outline concrete transition strategies in support of countries’ self-reliance’. The purpose statement of the joint process should explicitly anchor itself in this framing.

On scope: the normative fragmentation problem

The Pandemic Accord negotiations demonstrated that Member States hold fundamentally different (and legitimately different) value positions regarding the purpose of global health cooperation. High-income countries emphasise global health security; middle-income countries prioritise equity in access to health technologies; and least developed countries foreground solidarity through predictable, unconditional financing. These are not negotiating positions to be reconciled by better drafting; they reflect genuinely different geopolitical histories and interests. The scope of the joint process must explicitly include a workstream on normative reconciliation: how can security, equity, and solidarity operate as complementary rather than competing logics within a reformed architecture? Without addressing this, any coordination or mandate-streamlining exercise will be built on a contested foundation.

On principles: proposed additions and reformulations

The following principles are recommended for explicit inclusion in the framework:

- Subsidiarity: governance authority should rest at the lowest viable level capable of delivering the relevant function. Global governance should be reserved for genuinely transboundary functions (pandemic surveillance, global public goods generation, and cross-border financing stewardship) while the vast majority of health system functions are properly governed at regional and national levels.
- Robustness to hegemonic defection: the reformed architecture must function effectively even when major powers withdraw from universal processes. This is not an abstract risk; it is the current reality. Design principles that assume universal participation will produce architectures that collapse when that assumption fails.
- Normative pluralism: the architecture should create governance spaces in which legitimate differences in national priorities (security, equity, solidarity) can each be pursued effectively, rather than demanding convergence on a single universal model that systematically advantages the most powerful actors.
- Country ownership as a constitutional principle, not a programmatic aspiration: this means genuine transfer of authority over priority-setting, resource allocation, and accountability mechanisms to national and regional bodies, not merely 'alignment' of external support behind national plans.
- Post-aid fiscal realism: the architecture should be designed for a world in which most countries already finance their health systems predominantly through domestic resources and in which external aid is a shrinking and unreliable supplement, not the defining logic of the system.

Recommendations on Purpose, Scope and Principles

Recommendation 1: The draft proposal needs to explicitly acknowledge the structural, not cyclical, nature of the current transition, drawing on the framing of the Lyon Declaration and the Accra Reset.

Recommendation 2: Include normative reconciliation - how competing Member State value positions (security, equity, solidarity) can be made complementary - as an explicit scope item for the joint process.

Recommendation 3: Add subsidiarity, robustness to defection, normative pluralism, country ownership as a constitutional principle, and post-aid fiscal realism to the principles framework.

2. Feedback on Functional Areas for the Proposed Workstreams

The function-mapping imperative

The most consequential intellectual work the joint process can do is to produce a rigorous, evidence-based mapping of which health functions genuinely require global governance and which are more effectively governed at regional or national levels. This is the core insight of the function-based framework proposed by Rasanathan and colleagues (Nature Medicine, 2025), and it is more radical than it may appear. Accepting that most health system functions are properly regional or national requires WHO to redefine its own institutional role; from apex of a hierarchical system to custodian of a small set of indispensable global functions and convenor of a networked, multi-level architecture.

Based on the available evidence from the Wellcome regional dialogues, the EU/LM donor reflection process (which engaged nearly 500 stakeholders across five reform priority areas), and the Pandemic Accord negotiations, the following functional mapping is proposed:

Table 1: Proposed functional mapping for the reformed global health architecture

Governance level	**Core functions**	**Key actors and mechanisms**
Global (universal, binding)	Pandemic alert and response (IHR/Pandemic Accord); generation of global public goods (surveillance data, normative guidance, R&D standards); stewardship of cross-border financing instruments	WHO (normative/stewardship), Pandemic Fund, IHR compliance bodies, joint Finance-Health coordination mechanisms

Governance level	Core functions	Key actors and mechanisms
Regional (pooled, substantive)	Health system strengthening; pharmaceutical manufacturing and technology access; regional emergency coordination; solidarity financing; cross-border disease surveillance within region	African Union/Africa CDC, ASEAN health frameworks, CELAC, GCC, EU health institutions, regional development banks; Accra Reset mechanisms; SUSTAIN Initiative
National (sovereign, primary)	Domestic financing and resource mobilisation; health service delivery; primary health care; national health system governance; domestic accountability	National health ministries, finance ministries, domestic tax systems, national regulatory bodies

Recommended workstreams:
Based on this functional mapping, the following workstreams are recommended for the joint process:

- Workstream 1 - Function mapping and architecture audit: an independent, transparent mapping of which functions the current global health architecture performs, which functions are unperformed or duplicated, and how responsibilities should be redistributed across global, regional, and national levels. This should draw on the EU/LM donor process findings, the Wellcome synthesis paper (March 2026), and the Lusaka Agenda implementation review.
- Workstream 2 - Normative reconciliation and shared principles: a structured Member State dialogue to develop a shared framework for how security, equity, and solidarity can operate as complementary rather than competing governance logics, addressing the constitutional deficit revealed by the Pandemic Accord negotiations.
- Workstream 3 - Post-aid financing transition: development of concrete mechanisms for domestic resource mobilisation, regional solidarity financing, vulnerability-indexed lending, and the progressive transition away from aid-dependent health system models,

connecting to the Financing for Development (FfD4) process and UN tax convention negotiations.

- Workstream 4 - Regional architecture strengthening: a dedicated workstream to support regional health bodies, particularly the African Union and Africa CDC, as substantive governance actors rather than implementation arms of global mandates, including their integration into global coordination frameworks.
- Workstream 5 - Mandate rationalisation and fragmentation reduction: an evidence-based process to reduce duplication, merge overlapping platforms, and clarify comparative advantages among WHO, vertical funds (Global Fund, Gavi, Pandemic Fund), multilateral development banks, and bilateral donors, including consideration of which vertical programmes have served their purpose and can be transitioned into country systems.

Recommendations on Functional Areas

Recommendation 4: Adopt a function-based framing as the primary organising logic for the joint process, using the three-tier mapping (global/regional/national) as the analytical foundation.

Recommendation 5: Establish the five workstreams proposed above, with Workstream 1 (function mapping) as the prerequisite that informs all others.

Recommendation 6: Commission an independent objective mapping of existing global health initiatives, assessing their relevance, redundancy, efficiency, and effectiveness against the agreed function map, as proposed by the International Health Policies analysis of the reform process.

3. Feedback on the Proposed Approach to Coordination of the Process

The convergence problem:

One of the most significant risks facing the joint process is not the absence of reform ideas but their proliferation. As the International Health Policies analysis of the reform landscape observes, there is now a ‘proliferation of initiatives undertaken by different actors to consider possible reforms’; the Lusaka Agenda, the Accra Reset, the Wellcome regional dialogues, the

EU/LM donor reflection process, the Sevilla Platform for Action, the SUSTAIN Initiative, and various UN80 working groups. The danger is that these become ‘parallel and contradictory processes that end up undermining the process or bypassing the multilateral nature of the exercise’. The joint process must actively prevent this through a credible convergence mechanism.

WHO's coordination role: steward, not driver

WHO's comparative advantage in this process is its convening authority and its unique legitimacy as the only universal health governance body. It is not the sole author of reform solutions. The coordination architecture should therefore reflect this: WHO should serve as the steward and secretariat of the joint process, not its intellectual driver. This means:

- Establishing a lean, independent technical secretariat to manage the joint process, with transparent governance and balanced representation from all Member State groupings.
- Explicitly recognising and integrating ongoing reform initiatives, rather than competing with or absorbing them, through a structured mapping of their findings and alignment with the joint process workstreams.
- Creating formal linkages between the WHO-hosted process and the UN General Assembly's Informal Ad hoc Working Group on the Mandate Implementation Review, ensuring coherence with the broader UN80 reform agenda.
- Establishing a clear protocol for how the findings of the Wellcome regional dialogues, the EU/LM process, the Accra Reset, and the Lusaka Agenda implementation review will be incorporated as substantive inputs, not just acknowledged.

Against ‘conversations among the like-minded’:

The current geopolitics of Global Health informs that conversations among the like-minded alone, no matter how well intentioned, will have limited success. The joint process coordination architecture must create genuine mechanisms for engagement with actors who are sceptical of or hostile to strong multilateral health governance, including Member States that have historically resisted binding global commitments, and major powers currently disengaged from the WHO framework. This is not a diplomatic courtesy; it is a design imperative. Any reformed architecture that functions only when all major powers are willing participants is not robust.

Recommendations on Coordination

Recommendation 7: Establish a lean, WHO-coordinated independent technical platform with balanced regional representation to manage process coordination.

Recommendation 8: Produce a published convergence map within the first 60 days of the process, documenting all active parallel reform initiatives and explicitly assigning their findings to relevant joint process workstreams.

Recommendation 9: Create formal linkages with the UN GA Informal Ad hoc Working Group and the UN80 process to ensure coherence and avoid duplication at the system level.

Recommendation 10: Design deliberate engagement mechanisms for sceptical and disengaged actors, not to just co-opt them but to ensure the reformed architecture accounts for their absence or partial participation.

4. Feedback on the Anticipated Timeline and Phases

The urgency paradox

The joint process faces a genuine paradox: the pace of geopolitical change and the scale of the financing crisis demand urgency, but the complexity of what is required (such as function mapping, normative reconciliation, regional architecture strengthening, mandate rationalisation) cannot be responsibly compressed into a single inter-sessional cycle. It should not be a lengthy process driven by an intergovernmental working group and a document written by the WHO Secretariat alone. The timeline must navigate between these failure modes.

Proposed phasing

The following three-phase approach is recommended:

Phase	Timeframe	Key outputs
Phase 1: Foundations	May 2026 - October 2026 (WHA79 to EB160)	Independent function mapping and architecture audit; convergence map of parallel reform initiatives; agreed normative framework

Phase	Timeframe	Key outputs
		(security/equity/solidarity reconciliation); establishment of five workstreams; secretariat operationalised.
Phase 2: Design and consultation	October 2026 - May 2027 (EB160 to WHA80)	Draft confederal architecture proposals across three governance tiers; regional consultations feeding into global synthesis; financing transition roadmap; mandate rationalisation options with independent costing; draft WHA80 resolution.
Phase 3: Endorsement and implementation	May 2027 - 2030 (WHA80 onward)	WHA80 resolution on reformed architecture; implementation compacts with regional bodies; phased transition of vertical programme functions; annual progress reporting to EB; mid-term review by 2029.

This phasing is deliberately ambitious at the front end (function mapping and normative reconciliation within the first six months) because these foundational outputs are prerequisites for all subsequent design work. Without them, Phase 2 consultations will rehearse the same normative disagreements that have characterised the Pandemic Accord negotiations rather than building on a shared analytical foundation.

Recommendations on Timeline and Phases

Recommendation 11: Adopt the three-phase approach (Foundations/Design/Endorsement) with Phase 1 running from WHA79 to EB160 (May-October 2026) and producing function mapping, convergence documentation, and normative framework as non-negotiable prerequisites for Phase 2.

Recommendation 12: Set WHA80 (May 2027) as the target for Member State endorsement of the reformed architecture framework, providing a credible and urgent but not impossible timeline.

Recommendation 13: Commission the independent function mapping as the first deliverable of Phase 1, with a published report within 90 days of the process launch.

5. Feedback on the Stakeholder Engagement Strategy

Structural inclusion, not consultative courtesy: Stakeholder engagement in global health reform processes has historically followed a predictable pattern: formal consultation opportunities are created, civil society and academic voices are heard, and the resulting outputs largely reflect the preferences of the most powerful institutional actors. The joint process must break this pattern through structural inclusion - building diverse voices into decision-making authority, not merely into consultative procedures.

Differentiated engagement by actor type

Different categories of actor require different engagement architectures:

- Member States: the Informal ad hoc Working Group model is overly slow and susceptible to procedural obstruction by powerful states resistant to reform. A more effective mechanism is a structured Member State Steering Group with equitable regional representation, meeting at defined intervals with clear decision-making authority over process outputs.
- Regional bodies: the African Union/Africa CDC, ASEAN, CELAC, the GCC, and the EU should be engaged as co-architects of the regional governance tier, not as implementation partners of global decisions. This requires formal representation on the joint process Steering Group and dedicated workstream co-leadership roles.
- Civil society: The CSOs especially in LMIC-based civil society networks should be engaged through structured written inputs, dedicated consultation sessions, and formal observer status - not through the generic FENSA framework, which has consistently produced tokenistic rather than substantive engagement.
- Academic and epistemic communities: researchers with direct expertise in global governance reform, international law, and health systems should provide structured technical inputs to Workstream 1 (function mapping) and Workstream 2 (normative reconciliation), where their comparative advantage is greatest. This should include explicit outreach to scholars from the Global South and North alike and to researchers in international relations and political economy, not just global health specialists.
- Disengaged major powers: dedicated diplomatic engagement, separate from the formal joint process architecture, should explore the conditions under which currently disengaged major powers could be brought into or at least not actively undermine the reformed architecture. This engagement should be transparent and documented.

Knowledge equity in the process

The Wellcome regional dialogues engaged thought leaders from five regions to develop reform visions rooted in regional realities. The joint process should build on this foundation by ensuring that the knowledge inputs informing the function mapping and normative reconciliation workstreams are genuinely global in origin, not predominantly produced by Northern academic institutions and consultancies. This requires proactive commissioning of analytical inputs from LMIC-based institutions and explicit quality weighting toward regional and Southern expertise.

Recommendations on Stakeholder Engagement

Recommendation 14: Establish a Member State Steering Group with guaranteed equitable regional representation and clear decision-making authority, replacing the slower intergovernmental working group model.

Recommendation 15: Provide regional bodies (AU/Africa CDC, ASEAN, CELAC, GCC, EU) with formal co-leadership roles in the regional architecture workstream and representation on the joint process Steering Group.

Recommendation 16: Ensure civil society engagement through structured, substantive roles, not FENSA-framework courtesy consultation, with formal observer status and defined input rights at key decision points.

Recommendation 17: Proactively commission analytical inputs for the function mapping and normative reconciliation workstreams from LMIC-based institutions and researchers from the Global South.

6. Additional Comments and Inputs

The Pandemic Accord as a test case for reform coherence: The Pandemic Accord, concluded in 2025, provides an immediate and concrete test of the joint process's seriousness. The Accord's implementation architecture is currently incomplete: the United States withdrawal as a signatory, unresolved questions about the pathogen access and benefit sharing annex, and persistent normative disagreements about equity obligations all require resolution mechanisms

that a reformed architecture must provide. The joint process should explicitly address how the Accord's implementation architecture connects to the broader reformed GHA, rather than treating the Accord as a parallel track. Allowing these to develop as separate streams would reproduce exactly the fragmentation the reform process is intended to correct.

Against institutional nostalgia: Several reform proposals, including some elements of the Pate, Kaberuka and Piot analysis (Think Global Health, 2026), recommend closing or merging specific institutions (UNAIDS closure by end-2026, absorption of vertical programme functions into WHO and the Global Fund). These are legitimate options that should be on the table. The joint process should resist the institutional nostalgia that has historically blocked reform; the tendency of institutions, their staff, and their member state champions to resist changes that reduce their budgets or mandates regardless of whether those institutions are delivering value. The independent function mapping recommended above is the appropriate evidence base for these decisions.

Designing for a world without US leadership

The most significant design constraint for the reformed architecture is that it must function robustly in the absence of US participation. This is not a hypothetical: the United States is currently absent from WHO, absent from the Pandemic Accord, and signalling a bilateral, transactional approach to health diplomacy. The Lyon Declaration (April 2026) demonstrates that significant multilateral action can be taken without the United States. The joint process should design governance mechanisms and financing instruments that do not require US participation as a precondition for effectiveness, while remaining structured to accommodate re-engagement if and when political conditions change. A confederal architecture that binds global governance only to genuinely transboundary functions (and devolves substantive authority to regional and national levels) is structurally more robust to this condition than a centralised WHO-led system whose effectiveness depends on universal participation.

Connecting to the broader multilateral reform ecosystem

The joint process will be more credible and durable if it explicitly connects its outputs to parallel multilateral processes rather than treating global health reform as a stand-alone exercise. Specific connections to be formalised include: the Financing for Development (FfD4)

Seville process and its implications for health financing; the UN tax convention negotiations, whose outcomes will directly shape the fiscal space available for domestic health investment; the climate COP30 process and the health-climate nexus; and the UN80 mandate review, which will determine whether broader UN system rationalisation creates opportunities or risks for the WHO-hosted reform.

Summary of all recommendations

No.	Area	Recommendation
1	Purpose	Revise draft proposal to acknowledge structural rupture, drawing on Lyon Declaration and Accra Reset framing.
2	Scope	Include normative reconciliation (security/equity/solidarity) as explicit scope item.
3	Principles	Add subsidiarity, robustness to defection, normative pluralism, country ownership as constitutional principle, and post-aid fiscal realism.
4	Functions	Adopt function-based, three-tier governance mapping as primary organising logic.
5	Functions	Establish five workstreams: function mapping, normative reconciliation, financing transition, regional architecture, mandate rationalisation.
6	Functions	Commission independent objective mapping of global health initiatives against the agreed function map.
7	Coordination	Establish lean independent technical secretariat with balanced regional representation.
8	Coordination	Publish convergence map of parallel reform initiatives within first 60 days.
9	Coordination	Create formal linkages with UN GA Informal Ad hoc Working Group and UN80 process.
10	Coordination	Design deliberate engagement mechanisms for sceptical and disengaged actors.

No.	Area	Recommendation
11	Timeline	Adopt three-phase approach: Foundations (WHA79–EB160), Design (EB160–WHA80), Endorsement and implementation (WHA80 onward).
12	Timeline	Target WHA80 (May 2027) for Member State endorsement of reformed architecture framework.
13	Timeline	Commission independent function mapping as first deliverable, published within 90 days.
14	Stakeholders	Establish Member State Steering Group with equitable regional representation and clear decision authority.
15	Stakeholders	Provide regional bodies with formal co-leadership roles, not just consultative status.
16	Stakeholders	Ensure civil society substantive engagement beyond FENSA-framework courtesy consultation.
17	Stakeholders	Proactively commission analytical inputs from LMIC-based institutions and Global South researchers.

End of submission

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