

Updates on the Task Force High-Level Workplan, Timeline and Workstreams

**Joint Process on the Reform of the Global Health Architecture (GHA)
Member State Consultation**

28 September 2026

Agenda

- 01** **Overview of the Work of the Task Force**

- 02** **Written feedback from August MS Consultation**

- 03** **Updates from Workstreams**

- 04** **Questions and Discussion**

Overview of the Work of the Task Force

Joint Process | Key Developments since end-June



17 Aug

1st Task Force meeting (Terms of Reference, ways of working)



18 Aug

Member States Consultation (including qns for Regional Committees)



27 Aug

TF selection process completed (Africa CDC as Regional Health Org)



Sep through end October

Regional Committees and Regional Consultations



3-4 Sept (in person)

2nd Joint TF meeting (Task Force workplan, workstream scopes & method of work)



28 Sept

Member States Consultation (including qns from Workstreams)

Overview of Written Feedback Following the August MS Consultation

- 4 Member States and one REIO
 - ❑ Cuba
 - ❑ Dominican Republic
 - ❑ Egypt
 - ❑ Spain
 - ❑ European Commission

Overview of written feedback following the August MS Consultation

Strong convergence I

- **Member State leadership and ownership:** Member State-led reform focused on national priorities, sovereignty and country ownership
- **WHO's central convening role:** WHO essential for a coherent reform process, with a central leadership role in global health.
- **Engagement of GHIs:** GHIs should be actively engaged, contributing experience and implementation lessons, while remaining accountable to Member States own country priorities.
- **Greater coherence and reduced fragmentation:** Reform should focus on reducing duplication, overlapping mandates, parallel structures, weak coordination, misaligned financing and unnecessary transaction costs across the global health ecosystem.

Overview of written feedback following the August MS Consultation II

Strong convergence II

- **Roles, mandates and functions:** clarifying the respective responsibilities of global, regional and national actors, including which functions are best performed at each level and by whom.
- **A stronger and more structured role for regions:** Regions as a critical bridge between global and country levels. Regional engagement strengthened through Regional Committees and other mechanisms, while preserving country ownership and intergovernmental oversight.
- **Transparent feedback loops:** Consultations should be accompanied by clear processes demonstrating how Member State and regional inputs are incorporated into analysis, recommendations and final outputs, strengthening trust and legitimacy.

The direction of travel is broadly shared. The design choices remain open. Differences focus on ambition and actor engagement

Overview of written feedback following the August MS Consultation III

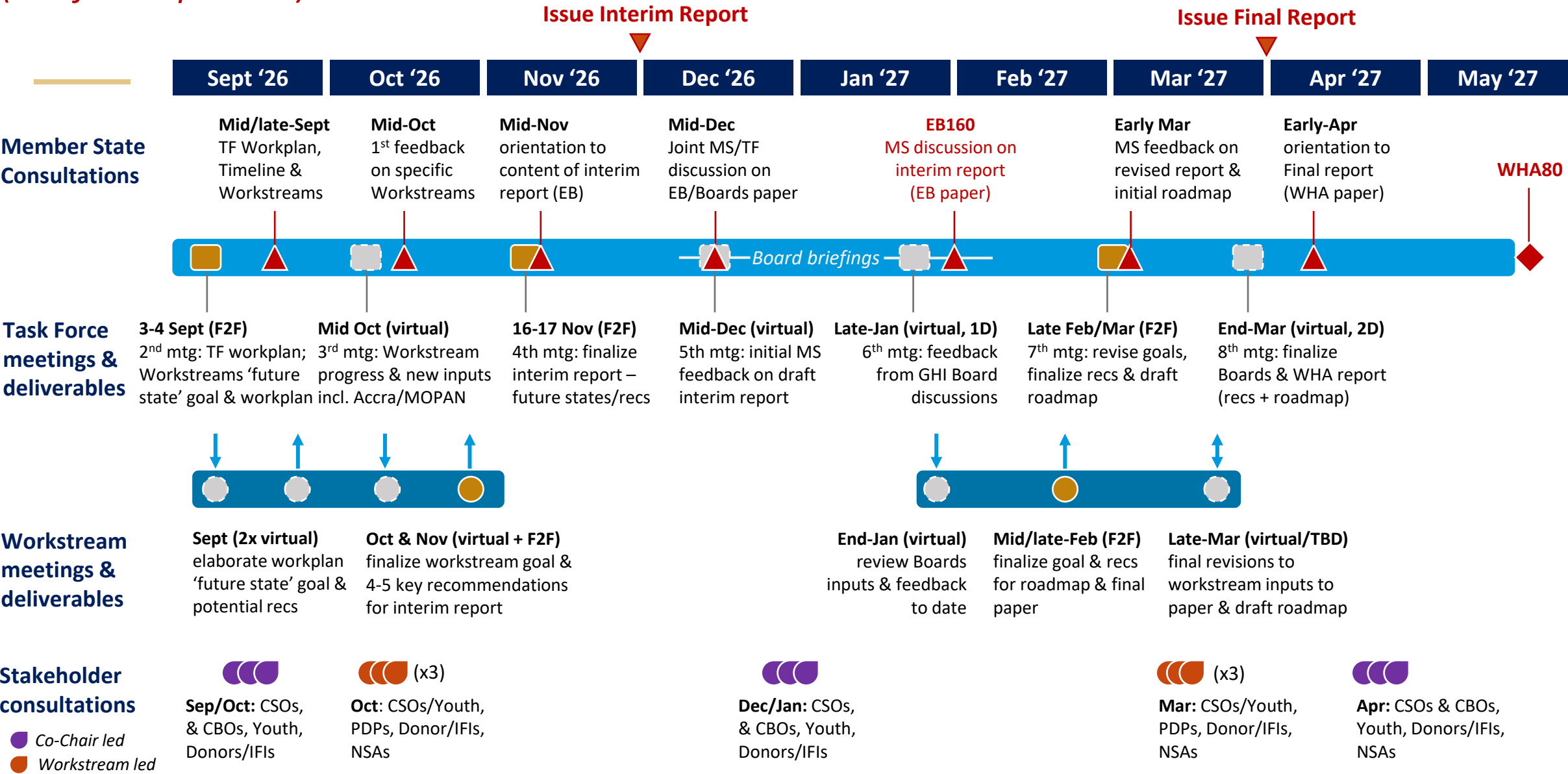
Areas requiring further discussion

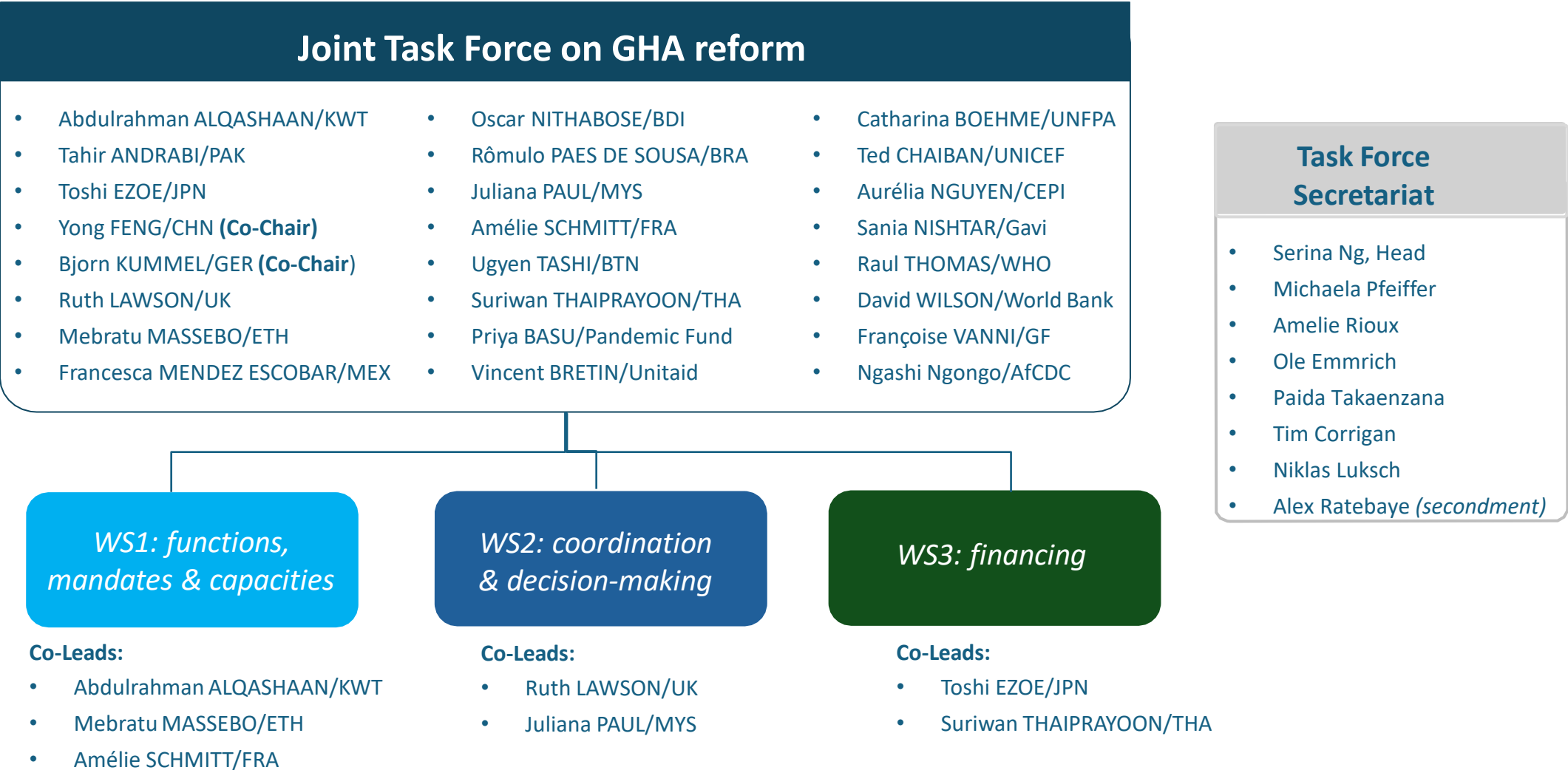
- **The role of GHIs:** *All positions preserve Member State leadership, but differ on the breadth and terms of GHI participation. From equal footing to defined roles, limits and coordination under Member State primacy*
- **Regionalization and Country Ownership:** *Support for a stronger regional role is broad, but views differ on the preferred mechanisms and safeguards*
- **Scope and Ambitions of Reform:** *The submissions suggest different expectations for how transformative and politically feasible the reform process should be.*

GHA Joint Task Force Workplan and Timeline

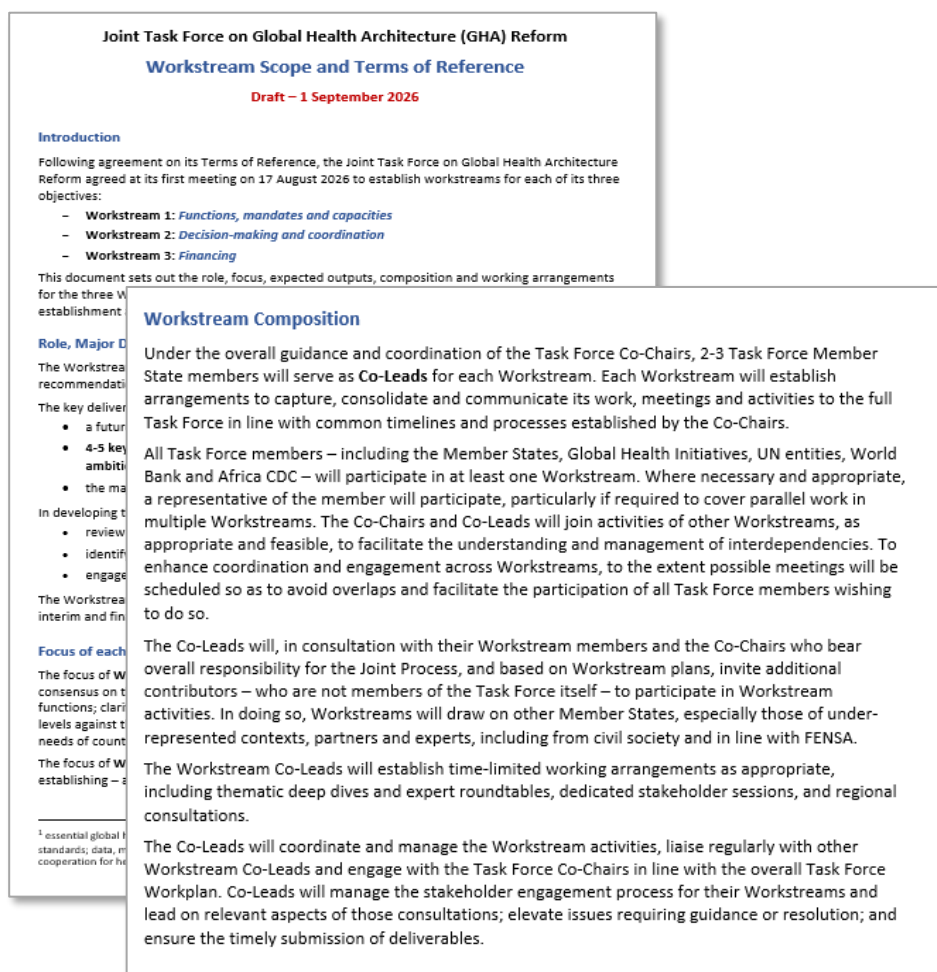
(as of 28 Sept 2026)

▲ MS consults ■ Task Force meetings
● Stakeholders ● Workstream meetings





Workstreams | composition



Co-Leads: 2-3 Task Force Member State members

Task Force Members:

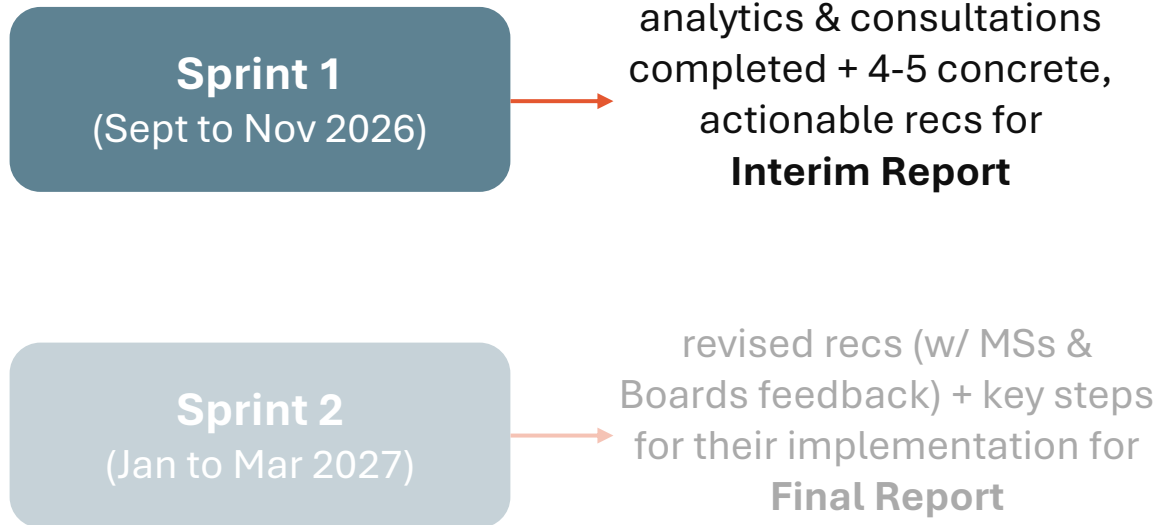
- all TF members – MSs, GHIs, UN entities, World Bank, Africa CDC – to participate in at least 1 Workstream
- where needed, a representative(s) will participate, esp. to cover parallel work in multiple Workstreams

Additional contributors:

- others who are not TF members will be invited to participate in Workstream activities;
- will draw on other Member States, esp. those of under-represented contexts, partners and experts, including from civil society and in line with FENSA.

Workstreams | key deliverables & time frame

Timeframe



Key deliverables

- 1 Future ambition or ‘future state’ for the objective area (i.e. envisaged change)
- 2 **4-5 actionable recommendations** to move from current state to the future state
- 3 Major implications (opportunities & risks) and implementation considerations

Workstreams | joint process objectives and focus*

3 Workstreams

The **objectives** of the joint process are to establish options and recommendations for:

**WS1: functions,
mandates & capacities**



(i) enhancing the alignment of the mandates and capacities of GHA actors with the essential GHA functions and across global, regional and national levels;

**WS2: decision-making
& coordination**



(ii) enhancing coordination and decision-making to strengthen collaboration, accountability and coherence across global, regional and country levels;

WS3: financing



(iii) aligning financing with national, regional and global priorities to advance national self-reliance and ensure sustainable and predictable support for global public health goods and regional functions.

Updates from Workstreams

Workstream 1: functions, mandates & capacities

Scope & Objectives

Objective

Include clarity on GHA functions by level and the relevant mandates and capacities of major actors, with options to address overlaps and gaps.

(WHA79(20))

Deliverables

- **Inception note:** team roles and division of labor, refined methodology and functional taxonomy, evidence-review plan, and engagement/consultation plan
- **1st batch of outputs:** evidence-base synthesis, gap analysis, transversal health-trends synthesis, and first-cut functional mapping including country case studies
- **2nd batch of outputs:** mandates mapping, normative practice mapping, access-ecosystem review, and UHC/HSS/humanitarian mapping
- **Draft report** with options & trade-offs
- **Draft recommendations**

Workstream 1 Composition (as of 28 Sept)

CO-LEADS	Abdulrahman Alqashaan Kuwait		Amélie Schmitt France		Cherinet Mebratu Massebo Ethiopia	
RAPPORTEUR	Ngashi Ngongo Africa CDC					
PARTICIPATING TASK FORCE MEMBERS	Adeel Khokar Pakistan		Fernando Espinosa Mexico		Mario Almeida Brazil	
					Oscar Nthiabose Burundi	
					Rob Whitby UK	
	Aurélia Nguyen CEPI		Francoise Vanni Global Fund		Johannes Ahrendts GAVI	
					Mikael Garnier Pandemic Fund	
	Soyoltuya Bayaraa UNFPA		Gaudenz Silberschmidt WHO		Vincent Bretin Unitaid	
EXTERNAL CONTRIBUTORS	Ding Yang China/ Co-Chair Observer		Gellila Mengistu Ethiopia/ Co-Lead Observer		Ibrahim Seleim Kuwait/ Co-Lead Observer	
					Sarah Bayle France/ Co-Lead Observer	
					Valentina Voican Germany/ Co-Chair Observer	
	The Workstream will engage with experts, institutions and other stakeholders that are not part of the Task Force, as needed per component and focus area, incl. MS (incl. national ministries of health and other national stakeholders), national finance ministries, humanitarian coordination mechanisms, civil society and patient organizations, regional health organizations, PDPs, research funders, regulators, manufacturers, industry, philanthropy, academia, learned societies.					
SECRETARIAT	Paida Takaenzana Secretariat focal point					

Workplan overview

- Purpose & Objective
- Current State & Future Ambition
- Framework for Analysis & Recommendations
- Evidence Base
- Workstream Composition
- Workstream Consultation Process
- Workstream Timeline

Joint Task Force on Global Health Architecture (GHA) Reform
Workstream 1: Functions, Mandates and Capacities

DRAFT Workstream 1 Plan

1. WORKSTREAM PURPOSE & OBJECTIVE

Workstream 1 is tasked with defining the essential global, regional and national health functions the global health architecture (GHA) contributes to — approached from a future-oriented perspective and grounded in country needs — with the aim of simplifying how countries engage with, navigate and drive that ecosystem. As Workstream 3 will address the financing function, Workstream 2 the coordination and decision-making, and the surveillance/health-security function is being taken forward through specific Member State negotiation processes. Therefore, Workstream 1 will, in addition to its foundational work on functions and mandates, focus on three functions and bring them together in an integrated way: i) the normative function; ii) research, development, innovation, market shaping, procurement and access; and iii) the functions underpinning universal health coverage (UHC), health systems strengthening (HSS) and humanitarian health responses— given their cross-cutting relevance to country capacities and service delivery. The three workstreams of the JTF will work closely together to ensure a cohesive approach, avoid fragmentation within the JTF, and identify any gaps.

Expected outputs

Workstream 1 will organize its work across two components, sequenced so that form follows function: (A) mapping of essential health functions, including three focus areas — (i) normative; (ii) R&D/innovation/market shaping/procurement/access; (iii) UHC-HSS-humanitarian response — and (B) evolution of core mandates. The Workstream aims at an indicative five to ten recommendations, organized around three to five overarching themes with supporting sub-bullets, that are practical, actionable and forward-looking, with a clear pathway from the current state to a defined future ecosystem grounded in subsidiarity — countries leading, regions coordinating, global institutions enabling and supporting. Consistent with the decision WHA79/24 and in alignment with the UN80 initiative's work on mandates, Workstream 1 will also formulate recommendations on more effective stewardship of mandates during their lifespan, drawing as appropriate on UN resolution RES80/251.

2. CURRENT STATE & FUTURE AMBITION

Current state: key challenges, gaps and constraints

- Persistent challenges of role clarity and coordination across the evolving GHA, including the distribution of responsibilities and their accountabilities between global, regional and country-level actors, and the alignment of mandates and financing;
- Institutional capacities do not always keep pace when functions are delegated or transferred, or when the science evolves or health needs change; subsidiarity requires that such transfers and evolution be accompanied by adequate support and financing;
- Multiple concurrent institutional reform and prioritization processes, against a backdrop of reduced available funds, may create duplication and leave gaps, or increase institutional competition;
- Conflicts of mandate persist between regional and global levels, illustrated by the coexistence of continental public health emergencies and PHEICs, which has at times prevented clarity of leadership on emergency responses;

Timeline

Step	Due Date
Draft and finalize inception note	22 – 25 September 2026
First batch of deliverables drafted and finalized	27-30 September 2026
Stakeholder engagement and targeted consultations	1-30 October 2026
Second batch of deliverables drafted and finalized	23 – 28 October 2026
Stakeholder engagement and targeted consultations	29 October – 6 November 2026
Draft report with options and trade-offs	10 November 2026
Incorporate Workstream / Task Force / Member State feedback to produce draft recommendations	20 November 2026
Review and drafting of final report	26 November 2026

WS 1: Functions, Mandates & Capacities

- From a country perspective, which areas of essential health functions at the global, regional and national level levels are most impacted by overlap or duplication, including where institutional mandates and responsibilities are unclear, and how is this best addressed in practical terms? Which functions are best delivered at each level to ensure complementarity and added value to countries? Are there examples of best practice or lessons learnt that could inform institutional reform?
- As we consider the evolving health challenges, which gaps in the essential health functions (national, regional and global) at national, regional and global levels most urgently need addressing, and how might that change over time, and where are the biggest capacity gaps? Where are the most significant capacity gaps, and which level or institution should primarily be responsible for addressing them? How should these functions, capacities and institutional mandates evolve over time as health challenges change?

Workstream 2: Coordination and decision-making

Objectives and key deliverables

Objective

Provide an overview of current GHA governance and collaboration mechanisms, with options to enhance coordination and decision-making within and across levels

(WHA79(20))

Deliverables

- Future ambition, or “future state”
- 4-5 actionable recommendations to move from current state to future state
- Major implications of recommendations (e.g., opportunities & risks) and implementation considerations

Workstream 2 Composition (as of 28 Sept)

CO-LEADS	Ruth Lawson United Kingdom	Juliana Paul Malaysia
	Romulo Paes de Sousa Brazil	Alexandre Ratebaye Africa CDC
TASK FORCE MEMBERS	Hannah Burris Gavi	Saul Walker CEPI
	Abdourahmane Diallo WHO	Mikaela Hildebrand UNFPA
EXTERNAL CONTRIBUTORS	Revati Phalkey International Institute for Global Health, United Nations University	Vicki Blackman Barbados
	Jean Gitau Kenya	
SECRETARIAT	PLANNED REPRESENTATION 2 CSO representatives (Global North and Global South), 1 more Country representative from SIDS (to be confirmed), Multilateral Development Bank (to be confirmed)	
	Amélie Rioux Lead Secretariat focal point	Tim Corrigan

Workplan overview

- Purpose & Objective
- Current State & Future Ambition
- Framework for Analysis & Recommendations
- Evidence Base
- Engagement approach
- Timeline

Joint Task Force on Global Health Architecture (GHA) Reform Workstream 2: Coordination and decision-making

Draft Workplan

1. WORKSTREAM PURPOSE & OBJECTIVE

In accordance with WHA decision WHA79(20) (May 2026), Workstream 2 will aim to provide an overview of current GHA governance and collaboration mechanisms, with options to enhance coordination and decision-making within and across levels.

In line with the *Workstream Scope and Terms of Reference* (2 September 2026), the workstreams have been tasked with developing:

- The future ambition, or “future state”, for the objective area—that is, the envisaged change.
- Four to five actionable recommendations to move from the current state to the future state.
- The major implications of those recommendations—including opportunities and risks—together with implementation considerations.

The Workstream Scope and Terms of Reference further specify that the focus of Workstream 2 (Coordination and Decision-making) will be on enhancing—or, if needed, establishing—appropriate decision-making and coordination mechanisms at global, regional and country levels to strengthen collaboration, accountability and coherence in support of country needs.

To support this objective, the workstream will identify gaps, challenges, constraints, effective practices and opportunities in existing governance, decision-making, accountability and coordination mechanisms and processes within and across global, regional and country levels. This will provide the basis for understanding the current state of the GHA, clarifying the future ambition and identifying recommendations to move from the current to the future state. The workstream will remain flexible as the analysis develops, including to reflect links and interdependencies across the three workstreams.

2. CURRENT STATE & FUTURE AMBITION

A preliminary assessment, based on a review of findings from existing reform initiatives, identifies the following key challenges, gaps and constraints in the current state of the GHA in relation to governance, decision-making and collaboration:

- The global health architecture is characterized by fragmentation, duplication, complexity and weak coordination, which undermine its effectiveness across global, regional and country levels.
- Accountability remains focused primarily on individual organizational performance rather than collective outcomes and overall system performance.
- In the absence of collective accountability, the current GHA is designed to address a narrow set of health priorities while failing to build the global, regional and national systems required to address emerging threats and future health burden.

Timeline

DATE	ACTIVITIES	EXPECTED DELIVERABLES
By 14 Sept 2026		High-level workplan ☒
By 18 Sept 2026	Workstream composition established [in progress]	Key questions drafted ☒
By 2 Oct 2026	2nd WS2 meeting held ☒ Issue invites for focus group discussion/key informant interviews and open call for evidence	Key questions tested and finalized [in progress] ToR for evidence pieces drafted, sourcing route agreed [in progress]
By 9 Oct 2026	3rd WS2 meeting held First round of focus group discussions/key informant interviews completed	
By 21 Oct 2026	4th WS2 meeting held	Consolidated evidence, preliminary recommendations
By 23 Oct 2026	Second round of focus group/key informant interviews/triangulation with wider processes completed	
By 30 Oct 2026	5th WS2 meeting held	Final interim report of whole TF finalized

WS 2: Questions

- Where do the decision-making or collaboration structures that exist today contribute to or help to overcome system fragmentation and inefficiencies? How do they contribute to or impede accountability for health outcomes?
- What do you need out of these mechanisms and what are your top 5 priorities for a reformed decision-making/collaboration/accountability structure?

Workstream 3: Financing

Objective & key deliverables

Financing Workstream 3

OBJECTIVE¹

To align external financing with national, regional and global priorities to advance national self-reliance and ensure sustainable and predictable support for global public health goods and regional functions.



KEY DELIVERABLES¹

Generate an overview of major existing GHA financing flows, with options for improving support for national plans and budgets, national aid transitions, and key regional and global GHA functions.

EXPECTED OUTPUTS²

01

The future ambition, or “future state”, for the objective area that is, the envisaged change.

02

4-5 actionable recommendations to move from the current state to the future state.

03

Major implications (opportunities & risks) and implementation considerations

Basis for the options & recommendations:

- Outputs of completed and on-going reform processes;
- Additional analyses as required;
- Consultations with all WHO Member States including representatives from health finance, and other arms of government, as relevant;
- Perspectives of relevant stakeholders.

¹ As set out in WHA79/24 (May 2026) ² In line with the Workstream Scope and Terms of Reference (1 September 2026)

Workstream 3 Composition (as of 28 Sept)

CO-LEADS	Suri Wan Thailand		Toshi Ezoe Japan		
	Benjamin Schreiber UNICEF				
	Ugyen Tashi Bhutan	David McConalogue United Kingdom			
PARTICIPATING TASK FORCE MEMBERS	Alice Sabino CEPI	David Wilson World Bank	Thiago Luchesi GAVI	Priya Basu Pandemic Fund	Klaus Simoni-Pedersen UNFPA
	Charlotte Diez Global Fund	Aliko Ahmed Africa CDC	Susan Sparkes WHO		
	Makiko Yoneda Japan/ Co-Lead Observer				
EXTERNAL CONTRIBUTORS	Non-Task Force members, including experts in finance and health that can contribute a national, regional and global perspective, with emphasis on low-income and lower-middle-income country experience				
SECRETARIAT	Ole Emmrich Secretariat focal point				

Workplan: framework for analysis

Financing Workstream 3

The Workstream's analysis will be objective and evidence-based. It will examine the different sources, purposes and channels of global health financing, from a country perspective, across the following dimensions:

01	02	03	04	05
Sources	Levels	Coordination / Alignment, incl. between health & finance	Types of financing required	Adaptability
The respective and evolving roles of domestic, regional and international financing, and where that financing is focused across country income levels and regions.	Financing for global, regional and country-level functions, and the boundaries between them.	How financing arrangements (e.g. instruments, channels, and planning cycles) align with current and future health needs, priorities and capacities, including alignment between	Recurrent, capital/investment, emergency/surge financing including contingent or pre-arranged at risk financing	How financing instruments can remain adaptive as capacities, institutions and priorities evolve (e.g. eligibility, co-financing ratios, transition timelines).

The framework will be applied to both the current state and the future ambition, and will work from typified country contexts — for example, LIC, LMIC, SIDS, fragile and conflict-affected, humanitarian — rather than a single country view, and complemented by a regional lens.

Engagement process

Financing Workstream 3

Consultation will run through two channels: **thematic deep dives and expert roundtables; and stakeholder consultations.** Focus on strong convergence from the existing reform initiatives.

Stakeholder	Rationale
Ministries of Finance and Health of LICs and LMICs including SIDS	The primary perspective the analysis is built from. Finance ministries to be engaged directly, given the framework's distinction between the two viewpoints.
CSOs and youth	Testing recommendations against community and equity considerations, including community financing.
PDPs, donors and IFIs, non-state actors	Refining options on external financing, transitions and co-financing, and testing their feasibility with those who would implement them.
Humanitarian settings	Ensuring recommendations are differentiated for fragile and conflict-affected contexts.
Private sector	Informing the treatment of private financing and its boundaries within scope.
Regional health organisations	Informing the treatment of regional functions, particularly in regions with no equivalent to PAHO or Africa CDC.

Timeline & progress so far

Financing Workstream 3

PROGRESS SO FAR	1 Sept 2026 Workstream Scope & Terms of Reference	3-4 Sept 2026 2nd Joint Task Force meeting	15 Sept 2026 1st Workstream meeting; Workstream Plan agreed
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Indicative and subject to confirmation of actual dates.

Date (TBD)	Activities	Expected deliverables
15th Sept 2026	1st Workstream meeting	Current state and future ambition & option ideas
8 Oct	2nd WS meeting	Development of initial mapping, future ambition & WS options (high level recommendations)
	Stakeholder consultations	Feedback on current state and future ambition & option/rec
2nd week of Oct 2026 (12-16 Oct WB Annual meeting, Bangkok)	1st thematic deep dives & Expert roundtable	Present initial data sources and mapping and seek expert input – to support initial mapping of global health flows: different sources, purposes, and channels of global health financing
23rd Oct 2026	2nd thematic deep dives & Experts roundtable	WS options/rec for interim report
28th Oct 2026	3rd WS meeting	Finalise WS options and recommendations
16-17 Nov 2026	TF meeting	Finalise interim report

WS 3: Financing

- How well do current global health funding streams meet national needs, alignment, and efficiency goals? *Specify stream; rate adequacy, coordination, predictability, flexibility, alignment with national plans/budgets, equity, and transaction costs.*
- What changes to financing arrangements would most support more equitable, predictable and sustainable financing, with stronger country ownership and self-reliance? *Briefly share key lessons from both successful and challenging aid transitions.*

Discussion Questions

Discussion Questions *(written feedback can be submitted by 2 October to ghatf-secretariat@who.int)*

Delegations to also provide their expectations on the scope and nature of the Interim Report to be produced by end of November 2026

WS 1: Functions, Mandates & Capacities

From a country perspective, which areas of essential health functions at the global, regional and national level levels are most impacted by overlap or duplication, including where institutional mandates and responsibilities are unclear, and how is this best addressed in practical terms? Which functions are best delivered at each level to ensure complementarity and added value to countries? Are there examples of best practice or lessons learnt that could inform institutional reform?

As we consider the evolving health challenges, which gaps in the essential health functions (national, regional and global) at national, regional and global levels most urgently need addressing, and how might that change over time, and where are the biggest capacity gaps? Where are the most significant capacity gaps, and which level or institution should primarily be responsible for addressing them? How should these functions, capacities and institutional mandates evolve over time as health challenges change?

WS 2: Coordination and decision-making

Where do the decision-making or collaboration structures that exist today contribute to or help to overcome system fragmentation and inefficiencies? How do they contribute to or impede accountability for health outcomes?

What do you need out of these mechanisms and what are your top 5 priorities for a reformed decision-making/ collaboration/accountability structure?

WS 3: Financing

How well do current global health funding streams meet national needs, alignment, and efficiency goals? Specify stream; rate adequacy, coordination, predictability, flexibility, alignment with national plans/budgets, equity, and transaction costs.

What changes to financing arrangements would most support more equitable, predictable and sustainable financing, with stronger country ownership and self-reliance? Briefly share key lessons from both successful and challenging aid transitions.

Thank you

Contact details GHA Task Force Secretariat: ghatf-secretariat@who.int