World Health Organization

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The World Health Organization (WHO) presents its compliments to Member States and has the honour to refer to decision WHA79(20) (2026) on the Reform of the global health architecture and the UN80 Initiative; document A79/24 and its annex on the same topic.

Decision WHA79(20) includes the request to the WHO Director-General to establish the proposed joint process to support reforms of the global health architecture in line with document A79/24. In keeping with this decision, the WHO Director-General is requested to establish a task force, of whom 14 members will be representatives of WHO Member States, two from each WHO region, as well as two additional members from the regions providing the Co-Chairs. The Co-Chairs are to be composed of one representative from a developing country and one representative from a developed country.

To conform with this requirement, WHO requests interested Member States to submit nominations for WHO Member State representatives on the task force to the Regional Director
... of their respective regions by 15 July 2026. The attached Terms of Reference outline the profile and selection process for Task Force members, including for Member States representatives, as well as its purpose and objectives, functions and deliverables, and proposed method of work.

Additional clarification can be obtained from the WHO Secretariat at the following email: HQGBSDirectorsOffice@who.int.

The World Health Organization takes this opportunity to renew to Member States the assurance of its highest consideration.

GENEVA, 22 June 2026

... ENCL.: (1)

Joint Task Force on Global Health Architecture (GHA) Reform

Terms of Reference

18 June 2026

1. Background

Although the current GHA contributed substantively to improving health and well-being, the world has changed profoundly in terms of national health sovereignty and country and regional capacities; disease burdens and health risks (incl. humanitarian); science, AI and digital technologies; and the financing landscape. Today's GHA is complex, with power imbalances, fragmentation and duplications that limit country ownership and impact, cause inefficiencies, and have triggered a wide range of perspectives, dialogues and initiatives on GHA reform.

In May 2026, the Seventy-ninth World Health Assembly (WHA) established a one-year, Member State-led, WHO-hosted Joint Process on GHA Reform with representatives of relevant United Nations entities and global health initiatives, the World Bank and regional health organizations, and in consultation with civil society and stakeholders. The aim of the Joint Process is to support the transformation of the GHA into a more country-led, coherent and inclusive ecosystem that responds more effectively and efficiently to the specific and collective needs of countries and communities to meet current and future health challenges.

2. Purpose and objectives

The purpose of the Joint Task Force on GHA Reform ("the Task Force") is to develop options, recommendations and, for its final report, a potential implementation road map for the consideration of the governing bodies of WHO and partner organizations. The Task Force itself is not a decision-making body. The options and recommendations would be in line with each of the three objectives of the Joint Process as follows:

(1) **Functions, mandates and capacities** – to enhance alignment of the mandates and capacities of GHA actors with global health functions, and across global, regional and national levels.

(2) **Coordination and decision-making** – to strengthen collaboration, accountability and coherence across global, regional and country levels.

(3) **Financing** – to align financing to advance national self-reliance and ensure sustainable and predictable support for essential regional functions[1] and global public health goods.

[1] Including, but not limited to: regional policy coordination and governance, regional disease surveillance and health security, transboundary threats, technical support and surge capacity, pooled procurement.

The scope of work will be global and cover all essential global health functions;[2] national, regional and global levels; and both current and future public health priorities.

3. Functions and deliverables

In carrying out its mandate the Task Force will:

- **Establish a workplan** and finalize its method of work, adhering to the principles agreed in the Annex to WHA document A79/24 *Proposal for a joint process to support reforms of the global health architecture* ("Joint Process Proposal"), while ensuring the agility to move efficiently from consultation and analysis to actionable recommendations.

- **Develop specific outputs** in support of the objectives, including:

  – mapping of: (i) essential GHA functions at global, regional and country levels; (ii) mandates and capacities of major GHA actors; (iii) GHA governance and collaboration mechanisms; and (iv) GHA financing flows at each level; and

  – options to address: (i) overlaps and gaps for functions; (ii) enhance coordination and decision-making within and across levels; (iii) improve financial support for national plans, aid transitions, and key regional and global functions.

- **Engage in monthly consultations** with WHO Member States on the development of potential options and recommendations for GHA reform, in line with the objectives of the Joint Process, and ensure Member State perspectives inform the work of the Task Force on an ongoing basis, including through written submissions and feedback between consultation sessions. The Task Force would also meet with the WHO Civil Society Commission and the WHO Youth Council on a bimonthly basis, and engage broader stakeholder constituency groups – as detailed in the Joint Process Proposal – on at least a quarterly basis.

- **Engage in briefings** or consultations, as applicable, with governing bodies and leaders of Task Force partner organizations, and of other relevant entities as deemed appropriate by the Task Force, to inform viable options for the three objectives of the Joint Process and facilitate the development of specific recommendations for each.

- **Develop two reports**, including an interim report to be finalized by November 2026 and a final report to the Eightieth World Health Assembly, to be finalized by April 2027. The interim report will include proposed options for each of the three objectives for consideration by the WHO Executive Board and governing bodies of partner organizations. The content of the final report, which will include specific recommendations for each objective and a proposed road map for implementation, will be discussed with all Member States prior to its submission to the governing bodies of partner organizations in advance of the Health Assembly.

[2] Setting norms, technical guidance and standards; data, monitoring and knowledge; surveillance and health security; product innovation and access; development cooperation for health (including health systems strengthening); and humanitarian emergency response.

4. Membership and selection

The Task Force will be established by the WHO Director-General by 31 July 2026. It will have up to 25 members, including 14 country representatives nominated by WHO Member States, two from each WHO region[3] and two Co-Chairs. There will be one representative each from WHO, UNFPA, UNICEF, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi, the Vaccine Alliance, Coalition for Epidemic Preparedness Innovations, the Pandemic Fund, Unitaid and the World Bank; and one representative from a regional health organization. One additional United Nations entity representative may be invited by consensus of the Task Force.

The WHO regional groups, and the United Nations entities, global health initiatives, World Bank and regional health organizations,[4] will be invited by to submit nominations by 15 July 2026.

Profile of Task Force members

The collective criteria for the overall Task Force include: a balance of geographical representation, gender, institutional perspectives, and country contexts, including low-, middle-, and high-income countries, as well as fragile settings and small island developing States.

The individual criteria for members include: senior leadership experience in health; substantial expertise relevant to global health architecture reform; ability to contribute to strategic and systems-level analyses; experience in multilateral processes and consensus-building; a commitment to equity and country ownership; and the independence and integrity to act in the interests and objectives of the Joint Process.

Examples of the level of experience and skills that would be consistent with these attributes are contained in the Annex. All members must be able to dedicate the substantive time required for the in-person and virtual Task Force meetings for up to 12 months. All proposed members will be assessed for potential conflicts of interest in line with the standard WHO process. Upon appointment, Task Force members will serve in the collective interests of the Joint Process, informed by their national, regional and/or institutional perspectives.

Selection of members

WHO headquarters will facilitate the overall selection process including inviting nominations by 15 July 2026 and finalizing membership to reflect a balance across the collective criteria for the Task Force, including and especially gender, geography and context. The Director-General will appoint the Task Force members by 31 July 2026.

WHO regional offices will support the selection process for each regional group, receiving Member State nominations in line with the individual criteria above and as further detailed in the Annex to this document. In consultation with its Member States and WHO headquarters, and to ensure a balance across the collective criteria for the Task Force, each regional office

[3] As decided and agreed by WHO Member States during the consultative process on design of the Joint Process.

[4] A regional health organization is defined as an established, multicountry institution whose primary purpose is to promote, coordinate, support, and improve health outcomes and health systems across a region.

will help finalize a list of three country representatives, the first two of which will become Task Force members; the third will become a member only if another from that group is nominated as a Co-Chair.

WHO headquarters will support the selection of the regional health organization representative, inviting nominations and finalizing the selection in line with the individual and collective criteria for Task Force members outlined above, and taking into consideration the capacity to reflect the perspectives of different geographical areas.

The Director-General of WHO will invite each of the major health actors on the Task Force to nominate a representative in line with WHA decision WHA79(20) (2026), and above timeline and criteria.

Selection of Co-Chairs

The Co-Chairs will be selected by the 12 country representatives, with one each from a developing and developed country, and from two different regions. The Co-Chairs will have experience leading complex multilateral processes; understanding of the global health governance; ability to build consensus across diverse stakeholders; strong facilitation and communication skills; and demonstrated ability to operate with impartiality, integrity, and inclusive leadership.

Within two weeks of establishing the Task Force, the Director-General will convene a meeting of the 12 country representatives for the purpose of selecting the Co-Chairs.

5. Method of work

The Task Force will meet at least monthly, with a number of these sessions expected to be conducted in-person, contingent on sufficient resources to support the participation of members from lowest income countries as required. Working sessions are expected to last 2–3 days. Additional meetings will be convened as required.

The work of the Task Force will be conducted in English. Member State consultation sessions will be conducted in all six official WHO languages, to the extent possible; both the interim and final report of the Task Force will be issued in all six official WHO languages.

In developing its deliverables, options and recommendations, the Task Force will make maximum use of existing evidence and analyses wherever possible, drawing in particular on the outputs of recent and ongoing reform processes. The Task Force can commission additional analyses as required. The Task Force may choose to establish time-limited working groups or other arrangements to support each of the specific objectives of the Joint Process. Such arrangements may include the use of partnerships and experts, particularly from civil society, who are not members of the Task Force itself.

The Task Force will engage ongoing related initiatives including the UN80 Initiative, Lusaka Agenda, Accra Reset Initiative's High-Level Panel on Reform of the GHA and Governance, African High-Level Ministerial Committee on Global Health Architecture Reform (AHLMC), and Health Architecture Reimagined Civil Society Organizations (HEAR CSO).

The Task Force will operate on the basis of consensus; if consensus cannot be reached, the recommendation supported by the majority of country representatives will be advanced, with dissenting opinions documented.

Stakeholder consultations will be organized in line with the WHO Framework of Engagement with Non-State Actors, as appropriate, and applicable engagement frameworks of participating organizations.

The Task Force will be supported by a WHO secretariat that will operate under the guidance of the Co-Chairs, which will provide coordination and logistical support, synthesize inputs, prepare documents, draft outputs, commission additional analytics as required and facilitate information-sharing and stakeholder engagement.[5]

6. Duration and timeline

The Task Force will be established by 31 July 2026 and operate through May 2027 in line with the Phases outlined in the Appendix to the Joint Process Proposal and the workplan developed by the Task Force itself.

[5] A separate and distinct mechanism will be established to coordinate the internal work and contributions of WHO across its three levels in support of the Joint Process.

Annex

Profile of Task Force members – Individual criteria

Examples to illustrate the expected level and nature of the experience, competencies and skills required of potential members of the Joint Process Task Force for each of the major attributes:

- **Senior leadership experience in health** demonstrated in one or more of the following or related contexts: national health governance, health policy-making and health system strengthening; international health cooperation; multilateral organizations; development finance for health; global health partnerships and initiatives.

- **Relevant expertise for GHA Reform** through an understanding of global health functions and substantial knowledge and experience in one or more of the following/related areas: global health governance; health financing and development assistance; health security; health systems strengthening; health diplomacy; institutional reform and organizational effectiveness.

- **Strategic and systems thinking** with demonstrated ability to analyse complex institutional arrangements; understand interactions across organizations and governance structures; identify practical options for reform; balance technical, political and operational considerations.

- **Multilateral and consensus-building experience** through demonstrated and successful experience in intergovernmental cooperation and negotiations; governing bodies of international organizations; multi-stakeholder processes; consensus-building among diverse constituencies.

- **Commitment to country ownership and equity** with a demonstrated understanding of the perspectives and priorities of countries; equity and inclusion considerations; considerations for low-resource settings; sustainable and locally led approaches to health development.

- **Independence and integrity** with the ability to act in the interests of the objectives of the Joint Process; disclose actual, potential, or perceived conflicts of interest; adhere to applicable WHO ethics and integrity requirements.
