Is the Global Health Architecture Responsible for Africa's Comparatively Poor Health Indices?



In November 2025, a meeting in Kigali convened by Amref Health Africa and sponsored by Welcome Trust examined how the Global Health Architecture (GHA) impacts African health systems and explored reforms that could better support Africa.

A conclusion emerged early: Africa's comparatively poor health indices are not primarily caused by the GHA. They stem largely from weaknesses in political and technical leadership within African health systems. This was underscored by comparisons with Southeast Asian countries that gained independence the same time as African nations. Operating under the same GHA, these countries have advanced further—because of stronger, more consistent national leadership.

I have witnessed these dynamics over decades in national and global health leadership. At independence, Africa was optimistic and leaders displayed ambition. The late 1960s and 1970s brought economic decline—falling commodity prices, rising oil costs, and political upheaval. Cold War dynamics condoned emergence of military dictatorships, and by the 1980s Africa was heavily indebted and reliant on external assistance.

With this dependence foreign advisers embedded themselves in ministries who, despite good intentions, contributed to an erosion of local autonomy and self-confidence. Over time, this fostered a culture of deference and non-assertiveness among some African leaders—an issue that persists today.

Donor countries naturally seek assurance that their aid is used effectively. However, experience shows that when African governments articulate clear priorities and lead decisively, donors follow. During my tenure as Development Partner Coordinator for Uganda's health Sector-Wide Approaches, we built strong relationships with development partners. Uganda became a "donor darling" because the Ministry of Finance negotiated firmly and we upheld partnership principles. Other African countries have succeeded similarly by maintaining clear direction and disciplined leadership. When results are visible under country-led programs, donors readily sustain or increase support.

Africa also commands respect in global institutions when we arrive well prepared. My experience on the boards of the Global Fund, GAVI, and the Stop TB Partnership, is that well-coordinated African delegations can shape decisions and direction.

One dimension often neglected in discussions of health system performance is the political context. Health outcomes reflect political choices. In many African countries, health is listed as a priority in policy documents, but this is rarely matched by commensurate investment. Public financing remains far below commitments such as the Abuja Declaration. Health workers are chronically underpaid, leading to low morale, attrition, and migration. Many countries rely heavily on donors for essential medicines, vaccines, and basic supplies—undermining sovereignty and long-term planning.

Short electoral cycles further encourage leaders to favour visible, quick-impact projects over long-term system strengthening, such as training health workers or improving supply chains. Frequent turnover of health ministers, patronage-based appointments undermine reform. Fragmented political coordination also weakens Africa's negotiating power in global health forums. These political determinants explain why Africa often struggles to assert its interests within the GHA.

What, then, is the way forward? The question is not whether the GHA is responsible for Africa's health challenges, but how African countries can strengthen leadership to better navigate and benefit from it. Three actions are critical.

First, Africa needs stronger political and technical leadership for health. Delegations to global meetings must arrive well prepared, understand the issues, and articulate coherent African positions. The African Union, Regional Economic Communities, professional associations, and think tanks can amplify these positions. Health must also become an electoral issue—over which leaders gain or lose elections.

Second, leadership development must be institutionalized. ACHEST, for example, worked with the East, Central and Southern Africa Health Community to create a Handbook for Health Ministers and to brief delegations attending the World Health Assembly. These efforts improved clarity and confidence but lapsed due to lack of funding. Such initiatives should be revived and embedded in health governance structures.

Third, Africa needs stronger capacity for health workforce planning. A major gap exists in linking workforce needs to disease burden. Countries need planners who can determine how many midwives, neonatologists, and obstetricians are required to manage millions of annual births—and adjust training programs accordingly. Without this technical foundation, political commitments cannot translate into improved services.

In conclusion, Africa's health challenges cannot be attributed to the GHA. The central issue is the strength of political and technical leadership within African health systems. When leaders are clear, assertive, and well prepared, donors align with national priorities and Africa's influence in global health grows. African countries should invest in building leadership capacity. With stronger leadership, Africa can shape the GHA to advance its priorities and deliver better health outcomes our people deserve.

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