



Global Health: A Plan, and Its Test in 2026

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This plan is an initial draft prepared with AI models. It is open for review by subject-matter experts and will be revised as they join the work and as world and national events change.

Introduction

Infectious disease is still among the largest causes of preventable death in the world. By the latest estimates from the World Health Organization and UNAIDS, about 610,000 people died of malaria and 1.23 million of tuberculosis in 2024, and 570,000 died of AIDS-related illnesses in 2025, a combined toll of roughly 2.4 million a year. Three quarters of malaria deaths in Africa are of children under five (WHO). The tools that prevent most of these deaths already exist and cost little by the standards of rich-country health budgets: insecticide-treated nets, antiretroviral drugs, TB diagnosis and treatment, and childhood vaccines.

Two further threats make global health a species-level problem. A new pathogen can spread worldwide within weeks; the WHO Director-General told the UN General Assembly in September 2026 that COVID-19 was linked to more than 20 million excess deaths between 2020 and 2023 and wiped more than US\$10 trillion from the global economy (WHO). Antimicrobial resistance (AMR) moves more slowly, wearing away the drugs that make surgery, childbirth and cancer treatment safe. The endemic diseases, pandemics and resistance all depend on the same foundations: surveillance, laboratories, paid health workers, supply chains and the international bodies that coordinate them.

This essay sets out a plan covering all three threats and tests it against 2025 and 2026, a period in which development assistance for health fell faster than at any time on record, the United States left the WHO, and an Ebola epidemic caused by a virus with no licensed vaccine spread across eastern Congo.

Where things stand

Measure	Figure	Source
Malaria cases, 2024	282 million	WHO World Malaria Report 2025
Malaria deaths, 2024	610,000	WHO World Malaria Report 2025

Measure	Figure	Source
People who fell ill with TB, 2024	10.7 million	WHO Global TB Report 2025
TB deaths, 2024	1.23 million	WHO Global TB Report 2025
New HIV infections, 2025	1.2 million	UNAIDS, July 2026
AIDS-related deaths, 2025	570,000	UNAIDS, July 2026
People living with HIV not on treatment, 2025	about 9 million of 41 million	UNAIDS, July 2026
Deaths attributable to bacterial AMR, 2021	1.14 million	GRAM study, The Lancet
Deaths associated with bacterial AMR, 2021	4.71 million	GRAM study, The Lancet

Malaria cases rose from 273 million in 2023 to 282 million in 2024, and the WHO African Region carried 94 percent of cases and 95 percent of deaths. Since 2000, malaria control has averted an estimated 2.3 billion cases and 14 million deaths ([WHO](#); [WHO](#)). TB incidence fell 12 percent and TB deaths 29 percent between 2015 and 2024, well short of the End TB milestones of 50 and 75 percent, though the African Region cut deaths by 46 percent over the same period ([WHO](#); [EATG](#)). New HIV infections have fallen 42 percent and AIDS-related deaths 57 percent since 2010 ([UNAIDS](#)).

The WHO's 2025 surveillance report found that one in six laboratory-confirmed common bacterial infections in 2023 resisted antibiotic treatment, rising to one in three in the South-East Asia and Eastern Mediterranean regions ([Health Policy Watch](#)). The Global Research on Antimicrobial Resistance (GRAM) study, published in The Lancet in 2024, estimated that bacterial AMR was directly responsible for 1.14 million deaths in 2021 and played a part in 4.71 million. Its reference forecast has attributable deaths reaching 1.91 million a year, and associated deaths 8.22 million, by 2050 ([PubMed](#)), which adds up to more than 39 million attributable deaths between 2025 and 2050 ([CIDRAP](#)).

The Institute for Health Metrics and Evaluation (IHME) estimated that development assistance for health, which pays for much of this work, dropped 21 percent between 2024 and 2025, from \$49.6 billion to \$39.1 billion. US funding fell 67 percent, more than \$9 billion, and the United Kingdom, France and Germany also cut ([Think Global Health](#)).

Part I: The plan

The plan has eight elements. The first two protect and extend what already works against malaria, TB and HIV. Elements 3 to 7 build defences against outbreaks, pandemics and drug resistance, and element 8 deals with financing and with health care in conflict zones.

1. Keep the proven commodity programmes fully funded

Most of the nets, drugs, tests and vaccines that save these lives reach poor countries through two pooled funds, the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance, and through the US bilateral programme PEPFAR. The Global Fund asked for \$18 billion for 2026 to 2028 and said that amount would save about 23 million lives and cut combined mortality from the three diseases by 64 percent against 2023 levels ([Aidspan](#)). Gavi asked for \$11.9 billion for 2026 to 2030 to protect 500 million children and avert 8 to 9 million deaths ([Gavi](#)).

WHO credits insecticide-treated nets with a 70 percent reduction in malaria cases in Africa between 2000 and 2015, and seasonal malaria chemoprevention grew from about 170,000 children per monthly cycle in 2012 to 54 million in 2024 ([WHO](#)). A Lancet analysis of 133 countries found that higher USAID funding between 2001 and 2021 was associated with a 15 percent fall in all-cause mortality and a 32 percent fall in under-five mortality, about 91 million deaths averted in all, including a 65 percent reduction in HIV/AIDS mortality ([PubMed](#)). Donors should treat these programmes as the last items to cut when budgets shrink.

2. Put new tools into use quickly

New products can change the course of each epidemic if buyers are ready before approval.

- **Long-acting HIV prevention.** Lenacapavir, an injection given twice a year, suits people who cannot take a daily pill. In September 2025 Unitaid, the Clinton Health Access Initiative and Wits RHI agreed with Dr. Reddy's Laboratories to supply a generic version at \$40 a year in 120 low- and middle-income countries from 2027, and the Gates Foundation reached a separate agreement with Hetero Labs ([CHAI](#)).
- **Malaria vaccines.** WHO recommends two, RTS,S and R21. In pilots in Ghana, Kenya and Malawi, RTS,S was associated with a 13 percent fall in all-cause child mortality. By the end of 2024 the vaccines had been introduced in 17 countries, and at least 2.1 million children were vaccinated that year ([WHO](#)).
- **New-generation nets.** Nets with a second active ingredient protect better where mosquitoes resist pyrethroids, as they now do in 48 of 53 reporting countries; such nets made up 84 percent of the 168 million shipped to sub-Saharan Africa in 2024, up from 10 percent in 2019 ([WHO](#)).
- **Next-generation antimalarials.** Novartis's ganaplacide-lumefantrine (GanLum), developed with Medicines for Malaria Venture, would be the first major innovation in malaria treatment since artemisinin-based combination therapies were introduced more than 25 years ago. It cured 97.4 percent of patients in a phase III trial of 1,688 people in 12 African countries, against 94.0 percent for the standard treatment, and worked against parasites carrying resistance mutations ([Novartis](#)).

- **TB vaccines and diagnostics.** As of August 2025, 18 TB vaccine candidates were in clinical trials, six of them in phase III, alongside 63 diagnostic tests in development ([EATG](#)).

The Global Fund, Gavi and national programmes should agree advance purchase commitments so that each product reaches high-burden countries within two years of approval.

3. Build surveillance and outbreak response into every health system

Every country needs laboratories that can confirm a novel pathogen within days, trained rapid-response teams, genomic sequencing and a public-health workforce that is paid on time. The amended International Health Regulations (IHR), which entered into force on 19 September 2025, require governments to designate a National IHR Authority and create a “pandemic emergency” alert level above the existing public health emergency of international concern ([WHO](#)). The plan asks every state party to staff and fund those authorities, asks regional bodies such as the Africa Centres for Disease Control and Prevention to hold surge teams and stockpiles, and asks donors to budget for surveillance as a standing cost. Clean water and sanitation in clinics belong in the same package, since they prevent the infections that spread in health facilities (see [Air, Water and Sanitation](#)).

4. Finish the pandemic rules

The World Health Assembly adopted the WHO Pandemic Agreement on 20 May 2025 by 124 votes to none, with 11 abstentions. The agreement needs ratification by at least 60 countries, and it cannot open for signature until states adopt an annex setting up a Pathogen Access and Benefit-Sharing (PABS) system ([Health Policy Watch](#)). The annex carries the central bargain of the agreement: countries that share pathogen samples and genetic sequence data quickly receive a guaranteed share of the vaccines, tests and treatments developed from them, with manufacturers committing part of their production in real time. The plan asks WHO member states to adopt the annex at the earliest possible session and to ratify within two years.

5. Build the capacity to make countermeasures fast and everywhere

The Coalition for Epidemic Preparedness Innovations (CEPI) leads the “100 Days Mission,” endorsed by G7 and G20 leaders, which aims for safe, effective and accessible vaccines within 100 days of a new pandemic threat being identified ([CEPI](#)); the plan asks donors to fund the vaccine platforms and prototype candidates for each known viral family that make that target reachable. Supply in an emergency should not depend on export decisions by a few rich countries. Africa accounts for about 0.1 percent of global vaccine supply despite holding about a fifth of the world’s population, and Gavi’s African Vaccine Manufacturing Accelerator, launched in June 2024, makes up to \$1.2 billion available over

ten years, paying African manufacturers when a vaccine gains WHO prequalification and a top-up for each dose delivered ([Gavi](#)). The plan extends the approach to Latin America and South Asia and gives Gavi and CEPI standing budgets with pre-agreed release triggers.

6. Slow antimicrobial resistance at its sources

The UN political declaration on AMR, approved in September 2024, set targets for 2030: a 10 percent cut in deaths associated with bacterial AMR from the 2019 baseline, at least 70 percent of human antibiotic use drawn from WHO's lower-risk "Access" group, basic water and sanitation in health facilities in every country, reductions in antimicrobial use in farming, funded national action plans in at least 60 percent of countries, and \$100 million in catalytic funding ([WHO](#)). The plan adopts those targets and adds a priority taken from the GRAM forecasts. Better care for severe infections and wider access to existing antibiotics could avert 92 million deaths between 2025 and 2050, against 11.1 million from a new pipeline of drugs for Gram-negative bacteria ([PubMed](#)). In poor countries, infection prevention, vaccination and reliable supplies of ordinary antibiotics therefore matter more than new drugs.

7. Pay for new antibiotics without rewarding overuse

New antibiotics make poor commercial investments because doctors hold them in reserve and sell them in small volumes. WHO counted 90 antibacterial agents in clinical development in 2025, down from 97 in 2023; only 15 were innovative and only five worked against at least one of its "critical" priority bacteria ([WHO](#)). A "pull" incentive that pays for availability instead of volume addresses the problem. England's subscription scheme, piloted with two drugs from 2022, now pays fixed annual fees of £5 million to £20 million per drug, banded by clinical value, from a budget of £100 million a year, with contracts running for up to 16 years ([The Pharmaceutical Journal](#)). The plan calls on the United States, the European Union and Japan to adopt comparable schemes, which together would create a market large enough to sustain research, with developers required to register new drugs in low- and middle-income countries as well.

8. Move financing onto a durable footing and protect health in crises

In 2001, African Union governments pledged in the Abuja Declaration to spend at least 15 percent of government budgets on health. By 2022 only South Africa met that target, and 45 of 53 member states spent less than 10 percent; some low-income countries, such as Rwanda and Mozambique, allocated a larger share than richer neighbours, which suggests political choice matters as much as national income ([PubMed](#)). The plan asks middle-income countries to raise domestic health spending on an agreed, public schedule, while donors commit to multi-year funding for the poorest and most fragile states and phase support down over five to ten years. Where debt service crowds out health spending, debt relief should be part of the transition (see [Ending Poverty](#)). In war zones, the plan asks

donors to pay health workers' salaries directly when governments cannot, and asks parties to conflicts to guarantee access for vaccinators and outbreak teams (see [Ending War](#)).

Sequencing

The first two years should protect existing commodity programmes, adopt the PABS annex and staff national IHR authorities. Years two to five should bring lenacapavir, malaria vaccines, new-generation nets and GanLum to scale, establish pull incentives for antibiotics in the largest markets and build regional manufacturing. Middle-income countries should move to domestic financing over five to ten years, with public milestones so that the transition does not turn into a sudden withdrawal.

What makes it stick politically

Health security is the argument that crosses party lines in donor countries, because outbreaks travel. In 2026 a Bundibugyo Ebola case was treated in France and two patients diagnosed in Congo were treated in Germany ([WHO](#)). Commitments written into multi-year pledges and treaties survive changes of government better than annual grants, and the withheld US appropriation for Gavi was released in 2026 after pressure from senators of both parties ([CIDRAP](#); [Office of Senator Shaheen](#)).

Where reasonable people disagree

- **Vertical programmes or health systems.** Disease-specific funds deliver measurable results quickly, but critics argue that they distort national priorities and leave primary care underfunded.
- **Speed of transition.** Some argue that aid dependence weakens domestic accountability and that firm deadlines push governments to invest. Others reply that many high-burden countries carry heavy debt service and cannot absorb the cost in five years.
- **Multilateral or bilateral channels.** Supporters of bilateral deals value influence and accountability to donor taxpayers; supporters of the WHO and the pooled funds value scale, pooled purchasing and legitimacy in recipient countries.
- **Pathogen sharing and intellectual property.** Many developing countries want binding benefit-sharing obligations on manufacturers. Pharmaceutical companies and some high-income governments argue that heavy obligations will slow research and deter participation.

Part II: The plan in the world of September 2026

Element 1: the funding collapse

UNAIDS reported that international HIV assistance fell from \$8.8 billion in 2024 to \$7.3 billion in 2025 (UNAIDS). In high-burden countries, funding for HIV testing fell 22 percent and funding for condoms 93 percent, and use of pre-exposure prophylaxis dropped 38 percent between 2024 and 2025 (Healio). Official development assistance for malaria fell 21 percent, largely because of US reductions; total malaria funding in 2024 was \$3.9 billion, 42 percent of the \$9.3 billion target, and most planned surveys were cancelled or postponed, though net and chemoprevention campaigns stayed largely on track (WHO). Global TB funding reached \$5.9 billion in 2024, about a quarter of WHO's target of \$22 billion a year by 2027, and WHO estimated that donor cuts could cause up to 2 million additional deaths and 10 million additional TB cases between 2025 and 2035 (EATG). The Lancet study of USAID's impact projected that, unless the cuts announced in the first half of 2025 were reversed, more than 14 million additional deaths could occur by 2030, 4.5 million of them among children under five (PubMed).

The Global Fund's eighth replenishment also fell short, raising \$11.34 billion at its summit in Johannesburg on 21 November 2025, against the \$18 billion target and the \$15.7 billion raised in 2022. The United States pledged \$4.6 billion and kept its rule of matching one dollar for every two from other donors (Aidspan). Later pledges brought the total to \$12.64 billion, and in February 2026 the Board allocated \$10.78 billion to countries for 2026 to 2028 and endorsed "defined, predictable transition timelines" for countries leaving Global Fund support (Global Fund). Gavi's June 2025 summit in Brussels raised more than \$9 billion of its \$11.9 billion target, led by \$1.6 billion from the Gates Foundation (Gavi). The United States made no pledge, and the administration withheld \$600 million that Congress had appropriated for Gavi until 29 July 2026, after Health Secretary Robert F. Kennedy Jr. objected to Gavi's use of vaccines containing the preservative thimerosal (CIDRAP; Office of Senator Shaheen).

Verdict on element 1. The Global Fund secured about 70 percent of its target and Gavi about 76 percent. Commodity campaigns such as nets and chemoprevention mostly survived, while testing, prevention, surveys and community outreach were cut first. Because those services find new infections and measure results, the damage will appear in later years' figures.

Element 8: the United States moves from multilateral to bilateral

The United States completed its withdrawal from the WHO on 22 January 2026, a year after President Trump announced it, and said it would work directly with countries and private and faith-based organisations instead (CDC). The WHO, which said the decision made "both the United States and the world less safe" (WHO), cut its 2026–27 base

budget by 21 percent, from \$5.3 billion to \$4.2 billion ([Health Policy Watch](#)), and planned to shed about 2,371 staff, a quarter of its workforce, by mid-2026 while still facing a \$1.05 billion funding gap for the biennium ([Health Policy Watch](#)).

The US replacement is the America First Global Health Strategy, released on 18 September 2025 after USAID was dissolved. It channels aid through five-year bilateral memoranda of understanding under which US assistance falls year by year and partner governments take on rising shares of the cost ([Brookings](#)). By 11 September 2026, 35 countries had signed. The agreements total \$24.1 billion over 2026 to 2030, with partner countries contributing 39 percent, and US funding for those 35 countries is \$7.5 billion, or 34 percent, lower than over 2021 to 2025 ([KFF](#)). South Africa, which accounts for more than half of Africa's lenacapavir users, was not offered an agreement, and Zambia and Zimbabwe discontinued negotiations ([Think Global Health](#)). Namibia became the first country to announce a planned exit from PEPFAR, with full responsibility for its HIV response from 2028 ([Bush Center](#)). Brookings has criticised the agreements for ending community testing and services for adolescent girls, sex workers and orphans unless countries pay for them, and for clauses on US access to national health data and links to mineral deals ([Brookings](#)). Supporters say the agreements give countries predictable plans and push them toward ownership.

Verdict on element 8. The US agreements and the Global Fund's transition timelines both adopt the goal of element 8, domestic financing on a schedule. The pace is set by the donor's budget more than by each country's fiscal capacity, and the Abuja record shows how far most African budgets are from absorbing the cost. The plan should also now assume a smaller WHO concentrated on norms, emergencies and data.

Element 4: the pandemic agreement stalls on its annex

Negotiators missed the May 2026 deadline for the PABS annex, and the World Health Assembly extended their mandate, with the outcome to go to the Assembly in May 2027 or to a special session earlier ([WHO](#)). A further session in September 2026 advanced the text without concluding it ([WHO](#)). At the second UN General Assembly High-Level Meeting on Pandemic Prevention, Preparedness and Response on 25 September, leaders welcomed a political declaration that is to be forwarded to the General Assembly for formal adoption, and WHO said that adoption of the annex at the May 2027 Assembly is necessary before member states can begin ratifying the agreement ([WHO](#)).

Verdict on element 4. Entry into force has slipped by at least a year. The annex will decide who receives vaccines first in the next pandemic, and settling the remaining trade-offs will need the attention of heads of government.

Elements 3, 5 and 8: Ebola in eastern Congo

The most serious outbreak of 2026 is an epidemic of Ebola disease caused by Bundibugyo virus, a species for which no licensed vaccine or specific treatment exists. The Democratic Republic of the Congo declared the outbreak in Ituri province in mid-May, cases were confirmed in Uganda, and WHO determined on 17 May 2026 that it was a public health emergency of international concern (WHO). As of 23 September, Congo had reported 7,890 confirmed cases and 3,799 deaths, a case fatality ratio of 48.1 percent, in seven provinces, three quarters of the cases in Ituri (WHO). Cases fell in Ituri over the preceding three weeks but rose 73 percent in North Kivu. About one in three new infections was identified only after the person had died in the community, and children under five were dying at a rate above 60 percent (UN News).

Conflict in Ituri and the Kivus has hampered contact tracing and access (WHO). In July, staff at Bunia General Hospital and at an Ebola treatment centre in Rwampara went on strike, saying some had not been paid since the outbreak began (STAT), and in August dozens of health workers in Bunia protested wages unpaid since mid-May (Al Jazeera). As of mid-September, WHO put the response's funding gap at \$1.1 billion (Bush Center).

On 1 June CEPI committed more than \$60 million to three Bundibugyo vaccine candidates, \$50 million of it to Moderna (CEPI). The first volunteer received Moderna's candidate in a phase 1 trial in Canada on 3 August, 78 days after the emergency was declared, and Moderna has agreed to make at least 500,000 doses available to low- and middle-income countries at access prices if the vaccine is licensed (CEPI). A treatment trial began enrolling patients on 2 July, and on 27 August Congo began vaccinating health workers with Ervebo, which is licensed against a different Ebola species and may not protect against Bundibugyo (WHO).

Verdict on elements 3, 5 and 8. A vaccine entered human trials within the 100-day window, which supports the platform approach in element 5, but efficacy results and doses at scale are still months away; a prototype vaccine for each known Ebola species, tested before an outbreak, would have changed the first months of this one. The strikes support element 8's provision for paying health workers directly in conflict zones.

Element 2: malaria faces resistance and an invasive mosquito

Biological threats to malaria control grew while funding fell. Artemisinin partial resistance is confirmed in Eritrea, Rwanda, Uganda and Tanzania and suspected in Ethiopia, Namibia, Sudan and Zambia. In some high-transmission parts of Uganda more than half of parasites carry resistance-associated mutations, and the partner drugs lumefantrine and amodiaquine look increasingly vulnerable (WHO). *Anopheles stephensi*, an invasive urban mosquito from South Asia, has been reported in nine African countries. A genomic study published in Science on 26 June 2026 found that it arrived in Africa already resistant to

the main insecticides used in nets and indoor spraying ([LSTM](#)). WHO also names climate change, conflict and humanitarian crises as drivers of malaria resurgence ([WHO](#); see also [Climate and the Environment](#)).

GanLum is the main new answer to drug resistance. Novartis said in November 2025 that it would seek approval as soon as possible ([Novartis](#)); no approval had been publicly reported by late September 2026.

Verdict on element 2 for malaria. Resistance has made new tools urgent. WHO advises multiple first-line therapies to reduce drug pressure, and Burkina Faso, Eritrea, Malawi, Rwanda and Uganda are adapting its resistance strategy; the Global Fund and national regulators should be ready to procure GanLum on approval.

Element 2: HIV prevention arrives during a funding crisis

By April 2026 lenacapavir had been delivered to nine African countries, support was being extended to 12 more, and the United States and the Global Fund had set a joint goal of reaching 3 million people by 2028 ([Global Fund](#)). The Global Fund expects initial generic supply in late 2026 and broader availability in 2027 ([Global Fund](#)). UNAIDS says only a few thousand people are using the drug, while 20 million need access to antiretroviral-based prevention, and it warned that without urgent action more than 3 million people could become infected by 2030 ([UNAIDS](#)).

Verdict on element 2 for HIV. Generic supply at \$40 a year should settle the question of price from 2027, but lenacapavir reaches people through the testing and outreach services that the cuts under element 1 removed, and South Africa, the country with the most users, has no US agreement.

Elements 6 and 7: antimicrobial resistance

On 12 December 2025 the US Food and Drug Administration approved zoliflodacin (Nuzolvence), a single-dose oral treatment for gonorrhoea and the first new class of drug against the infection in decades. It was developed by GARDP, a non-profit, with Inoviva Specialty Therapeutics, and GARDP is seeking approval in low- and middle-income countries ([STAT](#)). England's expanded subscription contracts were due to begin in March 2026 ([The Pharmaceutical Journal](#)). In the United States, the PASTEUR Act, which would create federal subscription contracts worth \$75 million to \$300 million a year for up to ten years, was reintroduced in the House by a bipartisan group of representatives in February 2026 ([IDSA](#)) and in the Senate on 24 June 2026 by Senators Michael Bennet, Todd Young and colleagues ([Senator Bennet](#)). Neither chamber had passed it by late September. The independent evidence panel on AMR that the 2024 declaration requested for 2025 had not been established by April 2026, when consultations were still under way ([ReAct](#)).

Verdict on elements 6 and 7. One new antibiotic class reached the market through a non-profit partnership and England's pull incentive expanded, but the US scheme is still a bill and AMR remains the most neglected of the three threats relative to its forecast toll.

Part III: Revised priorities

In order, the priorities for the next six to twelve months are:

1. **Close the Ebola funding gap and pay the responders**, including health workers in eastern Congo, and finance Bundibugyo vaccine and treatment trials through to efficacy results.
2. **Protect prevention inside shrinking programmes**, keeping HIV testing and outreach, TB case-finding, and malaria net and chemoprevention campaigns ahead of lower-value spending.
3. **Make transitions realistic** by revisiting co-financing schedules country by country, adding debt relief where debt service crowds out health budgets, and finding a path for countries outside the US agreements, starting with South Africa.
4. **Adopt the PABS annex, at a special session before May 2027 if possible**, so that the Pandemic Agreement opens for signature and ratification can begin.
5. **Get new tools into procurement**, preparing for GanLum and multiple first-line therapies where artemisinin resistance is confirmed and funding the outreach that generic lenacapavir will need in 2027.
6. **Enact antibiotic pull incentives**, through the PASTEUR Act or an equivalent in the United States and comparable schemes in the European Union and Japan.

Conclusion

The record since 2000, including 14 million malaria deaths averted and AIDS-related deaths more than halved since 2010, shows that the tools against infectious disease work. The events of 2025 and 2026 left the plan's logic intact while showing how much of it depended on one donor and on institutions that can lose a quarter of their staff in a year.

The immediate risk is that governments cut prevention and surveillance first, because those services show their value only when something goes wrong. In eastern Congo a virus with no licensed vaccine reached a conflict zone where health workers went unpaid, and the first vaccine candidate to enter human trials, 78 days after the emergency was declared, was built on an mRNA platform developed before the outbreak.

This essay reflects reporting available in late September 2026; the Ebola epidemic, the PABS negotiations and US appropriations for fiscal year 2027 are moving quickly, and some figures may soon be out of date.

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