

Delivery Associates

FROM CONSENSUS TO CAPABILITY

Closing the operational gap between ambition and better health outcomes for communities.

A Perspective from Delivery Associates

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Our perspective

The global health architecture conversation has done its job. The Lusaka Agenda, the Future of Global Health Initiatives (FGHI) process, the five Wellcome-supported regional reform dialogues, and the discussions now underway at World Health Assembly (WHA) have produced real convergence: the system is too fragmented, too donor-driven, and too misaligned with national priorities. The direction of travel is agreed. What is missing is not more diagnosis. It is the delivery capacity that makes country leadership operationally possible.

That capacity is not being built. The dominant model of technical assistance substitutes for government function rather than building it, and the capability gap that justifies the substitution is reproduced by it. This is the cycle that has kept the architecture conversation stuck for twenty years. Naming it clearly, and investing to break it, is the work this moment calls for.

Why the current model isn’t working

The financing reset now underway is the most consequential since the early 2000s. The United States Agency for International Development (USAID) has been effectively dissolved as a development actor. The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) is in transition. European bilateral official development assistance (ODA) is contracting. Gavi, the Vaccine Alliance, is in its sixth replenishment cycle (Gavi 6.0) under tighter ceilings. The Global Fund to Fight AIDS, Tuberculosis and Malaria is entering its eighth replenishment cycle under stress. These are not cyclical pressures. They represent a fundamental contraction in the resources the current model was built around. The system cannot continue operating as it did.

The visible consequence is one that every minister and every program officer already knows: resource mobilization has become a dogfight. Governments manage 10 to 20 separately funded vertical programs, each with its own planning cycle, reporting format, and coordination structure, none aligned with each other and few aligned with national priorities. Ministries are pulled in multiple directions, burdened but not built. The bandwidth consumed by compliance is bandwidth not available for delivery.

In Nigeria’s malaria program alone, the World Bank, African Development Bank, and Islamic Development Bank fund different components of the same national effort, totaling $364 million across 13 states, with no central coordination and no government-owned view of the whole.[1] Each funder’s reporting requirements are met. The government’s ability to manage it as a coherent program is not.

This is not a failure of political will. It is a structural problem, and it has three reinforcing dimensions. One is political: health budgets compete with defense, education, and debt service, and ministries of health rarely win that competition without sustained backing from the center of government. A second is structural: decades of vertical programming have built parallel delivery systems with their own structures and incentives — systems that tend to absorb reform efforts rather than be changed by them. A third is informational: governments cannot lead what they cannot see, and health data systems remain fragmented with no consolidated view of what is being spent, where, and to what effect.

None of these is new. What is new is that the funding model that allowed them to coexist with on-paper commitments to country ownership is gone.

The fiscal dimension compounds all three. Across Africa, 32 countries currently spend more on debt service than on public health — in Angola the figure reached 60 percent of government revenues, in Senegal 39 percent.[2] Multilaterals cannot credibly champion country ownership while their debt conditionalities and risk ratings foreclose the fiscal headroom that ownership requires. Ghana’s $13 billion debt restructuring agreement, finalized in October 2024 after two years of negotiations, released the fiscal space that allowed the government to increase health sector investment — demonstrating what becomes possible when multilaterals prioritize debt relief as a health financing instrument, not just a macroeconomic one. Nigeria’s near-doubling of its health budget between 2024 and 2025, enabled by the Basic Health Care Provision Fund — which channels a mandatory one percent of the consolidated revenue fund directly to primary health care — and the National Health Insurance Authority (NHIA) Act, which extended coverage to informal workers, shows what governments can achieve in domestic resource mobilization when the legislative and institutional conditions are in place.

The Bridgetown Initiative has pushed multilateral lenders to expand concessional finance and reform how development capital reaches countries under stress. The World Bank’s evolution roadmap commits to faster, higher-volume lending better aligned with national priorities. The Pandemic Fund’s platform approach and Africa CDC’s New Public Health Order are building the institutional scaffolding. The direction is right. What is missing is the country-level delivery capacity that would allow governments to use these instruments — to walk into those platforms with their own data, their own sequenced priorities, and their own account of what they will do with resources.



What actually closes the gap

A minister who can answer the core five questions — what are we trying to achieve, how will we get there, how will we know we are on track at any given moment, if not what will we do, and how do we ensure lasting impact — with conviction and with evidence their system produces, has something most ministers do not. They have leverage. With the finance minister. With cabinet. With donors. Delivery capacity is not an administrative function. It is the foundation of political agency.

The Democratic Republic of Congo's Mashako Plan, launched in 2018, illustrates what this looks like in practice. The country had one of the largest zero-dose populations in the world. The response was not a new program. It was a change in how the system was run: performance reviewed regularly at the center, targets made explicit, follow-up immediate, with the government itself in authority over the process and partners working within it. Within 18 months, coverage in target provinces rose by more than 15 percentage points and supervision increased from roughly a third of facilities to over half.[3]

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Three connected capabilities made that possible. They are not technical checklists. They are the functions that determine whether a government can act with continuity, and whether partners have to work with it or around it.

1. Government-owned management systems

In most settings, the routines that shape performance sit outside government — in partner reporting lines, in parallel processes, in systems that produce outputs the ministry receives but does not use to make decisions. The Mashako Plan reversed that. The same routines that produced the data were used by the government to plan, track, and change direction. Rwanda has built the same inversion over a longer period: by investing in government-owned data infrastructure and aligning partner reporting to national cycles rather than the reverse, the Ministry of Health achieved a consolidated view of its portfolio that shifted the terms of engagement with donors. They report to the government's system now, not the other way around.

In a West African country where Delivery Associates has worked, the Ministry of Health's Delivery Unit produced consolidated performance evidence that changed the Ministry's standing with development partners. When the unit was producing, the conversation moved from compliance to partnership. The Ministry was a partner, not a supplicant. When it was not, it reverted. The difference was not the policy environment or the donor relationships. It was whether the government held a credible, government-owned view of its own portfolio.



2. Credible priorities across the whole portfolio

The decisions that determine health outcomes are rarely made in one place. Priorities get set in one forum, budgets negotiated in another, performance tracked somewhere else — each on its own timeline, with its own accountability structure. The result is that a minister can be held responsible for outcomes that depend on choices they never had a consolidated view of.

Closing that gap requires people who can step across program boundaries, assemble a picture from different systems, and put options in front of decision-makers before commitments become irreversible. In some settings, this function sits in a delivery unit. In others it is built directly into planning or budget offices. The institutional form matters less than what it produces: a government-owned view of the whole portfolio, with trade-offs made visible at the point they are taken.

Where that analytical capability exists, something shifts. Conversations with development partners change register — from compliance and reporting to negotiation. A government that can show its own consolidated evidence of what is being spent, where, and to what effect is not asking for support. It is setting the terms. That is the difference between ownership as a principle and ownership as a practice.

3. A coherent platform for investment

The third capability is what connects the first two to the conversation now underway about country platforms, sector-wide approaches (SWAps), and integrated financing frameworks. A government that owns its data and its priorities can bring uses and sources of funding into a single frame, external and domestic, with a shared evidence base it uses to give an account of return: first to its own people, then to the global community.

Nigeria is working toward this. The Basic Health Care Provision Fund and the National Health Insurance Authority Act create the structural conditions for it.[4] What it requires in addition is the management infrastructure to hold the platform together: the routines, the data systems, and the people at the apex of government who can maintain the view across programs and use it to make decisions. This is the intersection of the Bridgetown agenda and the country ownership agenda — and it is where sustained investment is still missing.



Two kinds of technical assistance

The choice funders face is between two models of technical assistance, and it has never been more visible than it is now.

One substitutes for government capability: seconded staff producing donor outputs on donor timelines, generating reports that flow upward to funders and are invisible to the government's own systems. The other builds it: civil servants on government payrolls, running government systems, with a full view of the portfolio, developing routines that persist after the funding cycle ends. The first is easier to justify to boards, easier to attribute, and easier to audit. It is also the dominant model — and it is the reason the gap it was designed to address has not closed.

The attribution problem is not incidental. It is the architecture. A government-owned, integrated system produces outcomes that are harder to attribute to any single funder. That ambiguity is a design feature of the current model, not a bug. The consequence is a self-reinforcing dynamic: funders require governments to demonstrate delivery credibility before receiving

the investment that would make that credibility possible. The design principle needs to reverse.

The most practical shift is a contracting decision, not a new institution. Fund civil servants on government payrolls rather than seconded staff on donor timelines. Invest in government-owned data systems rather than parallel funder dashboards. Accept that the most important results will be attributed to the government, because that is precisely the point.

The same logic applies to co-financing requirements. The principle is right — domestic resource mobilization matters, and governments should have skin in the game. But conditioning disbursement on domestic contribution before investing in the analytical capacity governments need to navigate that trade-off compounds the burden rather than building ownership. The sequence has to run the other way: build the capability first, then condition on its use.

Where philanthropic capital fits

Philanthropic capital occupies a structurally distinct position. It can fund institutional infrastructure that multilaterals cannot justify to their boards. It can absorb attribution ambiguity — investing in system-wide functions where no single funder gets clean credit. It can operate between replenishment cycles in ways that bilateral and multilateral funders cannot. That combination of risk tolerance, flexibility, and time horizon is precisely what building delivery capability requires.

This kind of work requires a partner that builds with government rather than for donors, operates at the apex of political authority where most technical assistance does not reach, and stays genuinely agnostic about content — not competing with the technical experts a minister already trusts, but making it possible for them to govern across those experts.

Three investments are missing from the current architecture and well-suited to philanthropic capital. The first is government analytical capacity to make trade-offs across funding streams — not donor-facing reporting, but a government-owned view of its own portfolio. The second is data infrastructure that governments control: consolidated tracking that gives ministries visibility across all sources and results, rather than parallel funder dashboards. The third is the institutional routines that make accountability real — predictable performance review cycles chaired by senior political leadership, not compliance reporting to external funders.

None of these produce first-order health outcomes in year one. They improve the probability that constrained resources translate into outcomes over time. The measurable shift is institutional: reduced reporting burden, faster disbursement, clearer authority, higher budget execution rates, more predictable performance routines. Some philanthropic funders have begun moving in this direction — funding performance management systems inside government health ministries, building the routines and data practices that allow governments to track their own progress. The results so far are largely institutional rather than epidemiological. That is exactly what early-stage capability investment looks like.



Equally important is clarity about what philanthropic capital should not do. Continued investment in commodity financing — including family planning — fills gaps that no other actor covers at scale, and that role should be preserved. What it must avoid is assuming that more subject-matter expertise is the binding constraint. In many settings it is not — or at least not the primary one. Without the systems to analyze data across programs, surface trade-offs, and act on findings, even well-resourced technical expertise cannot translate into coherent decisions. The scarcer investment, and the more consequential one, is in the management infrastructure that allows governments to use what they already know.

What needs to change

Countries should continue to prioritize delivery capability: government-owned management systems, credible priorities across the portfolio, and a coherent platform for engaging partners and accounting to their own citizens. This is what the Bridgetown agenda, the Lusaka Agenda, and the New Public Health Order are all pointing toward. It is also what ministers have been asking for. The priority now is building the systems that make it real.

Donors and multilaterals should prioritize it, even where attribution is more difficult, and align the financing architecture so the fiscal room exists in which capability can be exercised. That includes examining how vertical funding streams can be better coordinated under government-owned platforms, rather than continuing to operate as parallel systems with separate accountabilities. Debt treatment, concessional terms, and co-financing sequencing are not separate conversations. They are preconditions for the country ownership the architecture has been promising for two decades.

> ***Countries should continue to prioritize delivery capacity.***

Those who sit between governments and funders — advisors, consultants, implementing partners — need to be judged on a single test: whether the governments they work with leave the engagement more capable of governing their own health systems than when they arrived. The architecture will be remade by those who pass it.

About Delivery Associates

Delivery Associates (DA) is a global social impact consultancy specializing in transforming the public sector. With over a decade of experience and a foundation in Deliverology®, DA guides leaders through every phase of implementation: strategy formulation, execution, and evaluation. DA partners with governments, philanthropies, and international organizations, employing actionable strategies to achieve sustainable, lasting outcomes. This paper draws on DA's experience across 17+ countries in Africa, South Asia, and Latin America, and on the outcomes of the five Wellcome-supported regional dialogues on global health architecture reform.[5]

Acknowledgments

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End notes

[1] Nigeria malaria investment: World Bank, "Nigeria Immunization Plus and Malaria Progress by Accelerating Coverage and Transforming Services (IMPACT) Project," Project ID P167156, $196 million; African Development Bank, project financing plan, $68.3 million; Islamic Development Bank, $100 million contribution to 13-state malaria program; total $364.3 million. Nigeria 2025 Proposed Health Budget analysis, Development Research and Projects Centre (DRPC) Nigeria, January 2025; Federal Ministry of Health and Social Welfare press statement on health sector self-reliance MoU; Nigeria Health Watch, 2024.

[2] Heinrich Böll Stiftung, "Debt-Led Development in Africa: A Folly That Hinders True Progress," November 2025; African Development Bank, Annual Meetings 2024 statement on debt resolution. Angola debt figure from ISS African Futures, "Indebted and Underfunded," June 2025; Senegal figure from UNAIDS, "Domestic Revenues, Debt Relief and Development Aid," September 2024.

[3] Democratic Republic of Congo Ministry of Health, Mashako Plan implementation data, 2018–2020; DA monitoring records.

[4] Federal Republic of Nigeria, National Health Insurance Authority Act, 2022 (signed into law 19 May 2022); National Health Act, 2014, Section 11 (establishing the Basic Health Care Provision Fund, with a mandatory annual federal government grant of at least 1% of the Consolidated Revenue Fund directed to primary health care); National Health Insurance Authority, "Basic Health Care Provision Fund," nhia.gov.ng.

[5] Wellcome Trust-supported regional dialogues on global health reform, 2025: Africa, Latin America and the Caribbean, Asia Pacific, Europe and North America, Middle East and Central Asia. Synthesis: 'From Rethinking to Reform,' March 2026.



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