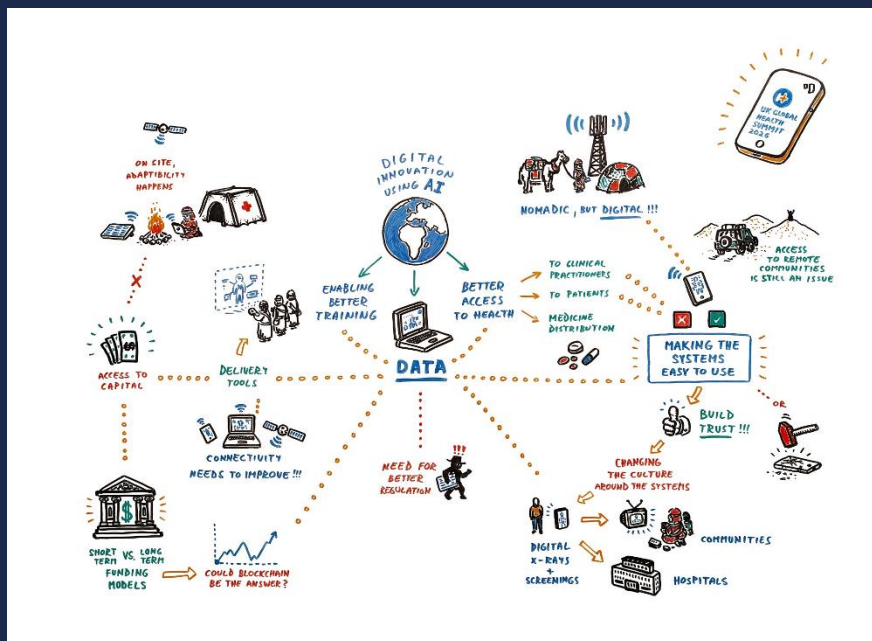


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Digital Transformation and AI in Global Health

UK Global Health Summit

Global Health Partnerships | Formerly THET
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1. Introduction

About the UK Global Health Summit 2026

The UK Global Health Summit 2026, held under the theme ‘Shaping Tomorrow’s Health, Together’, took place at the Royal College of Physicians, London, from 16 to 18 March 2026. Convened by Global Health Partnerships (formerly THET), the Summit brought together more than 300 delegates from across the globe, including government leaders, health professionals, diaspora associations, civil society organisations, academic institutions and private sector partners.

Building on the momentum of the UK–Africa Health Summit 2025, the Summit was structured across three interconnected days, each with a distinct focus:

- Day 1: A Globally Engaged UK Health System: exploring how the NHS, UK academia, voluntary organisations and private sector partners are working in equitable collaboration with countries across the Global South, including the launch of The UK’s Contribution to Health Globally (2026 Edition).
- Day 2: Celebrating Diaspora Leadership in Global Health: spotlighting the transformative role of diaspora and internationally recruited professionals in strengthening both the NHS and health systems worldwide.
- Day 3: Partnerships for Workforce Strengthening: showcasing concrete examples of global partnership working, including the Global Health Workforce Programme, the Commonwealth Antimicrobial Stewardship Programme and NHS England’s international work.

Alongside the main programme, a series of invitation-only satellite events took place, including this session on Digital Health and AI in Global Health.

The Satellite Session

On 17 March 2026, as part of the Summit’s satellite programme, a session on Digital Transformation and AI in Global Health was convened at King’s College London, Strand Campus. Facilitated by Richard Skone James (GHP, Director of Programmes) and Emily McMullen (King’s College London), the session brought together policymakers, implementers, researchers, clinical practitioners and technical partners — both in person and online.

The session was positioned explicitly as a space for honest reflection rather than polished showcase. Participants were invited to share what has worked, what has not, and what the global health community needs to do differently to move from promising pilots to sustainable, system-level digital transformation.

Scalability and sustainability of digital health projects remain persistent challenges — and were central themes shaping the conversation throughout the session.

2. Opening Remarks and Spotlight Presentations

The facilitated discussion was preceded by opening remarks from GHP and Ministry representatives from Kenya and Somaliland.



Opening remarks

Richard Skone James, Director of Programmes at Global Health Partnerships, opened the session by reflecting on GHP's own engagement with digital transformation. He noted that GHP's interest in digital health was significantly accelerated by the Covid-19 pandemic, which forced the organisation — like many others in the sector — to rapidly explore digital approaches to maintaining health partnerships and learning under conditions of extreme disruption.

He highlighted three areas of GHP's current digital work: the Pulse e-learning platform for health partnership practitioners; GHP's Digital Safeguarding Policy, updated in 2025; and GHP's broader digital strategy. His remarks framed the morning as an opportunity not just for external learning, but for GHP to deepen its own understanding of what effective digital health partnership looks like in practice.

This was followed by a short segment on “Leadership Perspectives: Digital and AI Transformation in National Health Systems”, where national health leaders shared brief reflections on implementing digital and AI transformation in practice. Contributions from Dr Andrew Toro (Ministry of Health, Kenya) and Idil Ismail Muse (Ministry of Health Development, Somaliland) highlighted national policy perspectives, implementation realities, and the opportunities and constraints shaping digital transformation efforts within their respective health systems.



Spotlight 1: Transforming cancer care in Ethiopia through Clinitouch

Rich Bryson (Spirit Health Foundation) and Nipun Jain (AstraZeneca Health Catalyst Network) presented a practical example of digital health innovation in cancer care in Ethiopia. The project is funded by AstraZeneca and implemented by Global Health Partnerships and Spirit Health Foundation. The presentation opened with a stark illustration of the challenge: in Ethiopia, 60 to 80

per cent of breast and prostate cancer cases are diagnosed at an advanced stage. Five-year survival rates stand at 25.8 per cent for breast cancer and 22 per cent for prostate cancer, compared to 85 per cent and 90 per cent respectively in high-income countries. Late detection was identified as the primary driver of this disparity.

The Clinitouch platform was presented as a response to this gap, creating a structured digital pathway from community-level screening through to earlier diagnosis and treatment across four stages: at-home and community screening by health extension workers using a digital questionnaire; automated risk scoring and referral flagging; confirmatory examination at primary health care level; and earlier diagnosis and treatment at oncology centres and hospitals.

The impact on frontline workers was significant. Health extension workers reported being able to conduct daily screenings at community level, synchronise data digitally, and rely on the embedded referral system to support monitoring and follow-up by team leaders and NCD outpatient staff. The presentation concluded with three headline learnings: sustainability, scalability and system change, framing the experience not as a solved problem but as a working illustration of what addressing these challenges requires.

Spotlight 2: Digital innovation in the Global Health Workforce Programme

Emily McMullen (King's College London) presented findings from a scoping review of digital health interventions across the Global Health Workforce Programme (GHWP) which she completed in January 2026. The GHWP is commissioned by the UK Department of Health and Social Care (DHSC) and delivered by GHP, as fund manager. Beginning in February 2024, phase one of the programme supported 41 health partnerships across Ghana, Kenya and Nigeria, of which 25 incorporated digital components and 11 intentionally used Digital Health Interventions to accelerate programme outcomes.

The scoping review mapped these interventions against the UN Sustainable Development Goals, WHO health system challenges and the WHO DHI Classification framework. Three deep case studies were produced alongside an investment prioritisation matrix. Key outcomes across the programme included measurable increases in training provision and service delivery, with the strongest results coming from approaches that combined digital tools with in-person delivery, peer support and adaptive design. The greatest system-level impact was achieved when structural enablers — such as solar infrastructure and curriculum embedding — were integrated from the outset rather than added later.

The review produced five formal investment priorities presented to participants as the framework for the discussion that followed: mainstream investment in power and connectivity infrastructure; stronger systematic evaluation of digital health interventions; investment in a broader range of digital tools for workforce planning and delivery; greater attention to demand-side barriers including user skills, trust and access; and enabling and incentivising reverse innovation so that LMIC-developed solutions can inform practice in the UK and other high-income settings.

The five investment priorities from the GHWP scoping review: infrastructure, evaluation, broader tools, demand-side barriers and reverse innovation — provided the framework that shaped the open discussion.

3. Framing the Discussion

Emily McMullen opened the discussion by connecting digital health to the broader goal of universal health coverage (UHC). She framed digital tools not as ends in themselves but as enablers of more effective, efficient and equitable health systems, noting the particular pressure created by shifting disease burdens and constrained funding environments.

Participants emphasised three core questions that shaped the discussion throughout:

- What can we learn from projects that have already been implemented in real-world conditions?
- Why do scalability and sustainability continue to elude so many promising initiatives?
- How can AI and digital tools be deployed more effectively, and with what safeguards?

The session drew on the diverse experience of attendees working across Kenya, Uganda, Somaliland, Ghana, Zimbabwe, Nigeria, the UK and beyond, representing government ministries, NGOs, international organisations, academia and the private sector.

4. Key Themes from the Discussion

Digital health as a systems challenge

Across the discussion, there was strong consensus that digital health is fundamentally a systems issue, not a technical one. The tools exist; the barriers lie in the environments in which those tools must operate. Participants consistently returned to the idea that deploying technology into a weak system does not strengthen that system — it exposes its weaknesses.

Representatives from the Ministry of Health, Kenya, described the government's work to coordinate a large-scale \$800 million initiative integrating 37 service elements, including the development of health interoperability standards and a point-of-care system now deployed in one county for over a decade. This experience underlined that sustainable digital health requires not just tools but standards, governance and long-term institutional commitment.

Digital health was framed not as an end in itself, but as a critical tool for advancing universal health coverage, one that must be effective, efficient and equitable.

Infrastructure and access as foundational barriers

Connectivity, device access and structural inclusion barriers were identified as persistent and under-addressed constraints. One participant framed the challenge in four interconnected buckets: connectivity, access to capital, access to knowledge, and the ability to have a digital identity. They argued that these are not separate issues but a compounding system of exclusion, and that addressing only one without the others limits the impact of any digital intervention.

The participant pointed to India as a model of what government-led infrastructure investment can achieve: providing digital identity and wallets to 99% of the population and near-universal connectivity. He challenged participants to think beyond individual tools and toward the enabling environment that makes those tools useful.

Across several country contexts, mobile penetration and familiarity with mobile money were identified as important enablers for digital health adoption. One participant noted that national strategies are increasingly prioritising the digitalisation of healthcare systems, with an emphasis on embedding good practices from the outset. However, it was also recognised that nomadic and rural populations face distinct access challenges, and that mobile-first approaches alone are not sufficient to reach all communities.

A recurring insight across the session was that access to digital health tools cannot be separated from access to connectivity, identity, financial systems and opportunity. These are interconnected prerequisites, not separate issues.

Pilot fatigue and the challenge of scale

One of the most widely shared frustrations across the session was the prevalence of short-term pilots that fail to reach systemic scale. Participants described a recurring cycle in which proof-of-concept projects are funded, show early promise, and then stall due to a lack of sustained, multi-year investment, leaving limited continuity for communities and health workers, and little long-term evidence of impact.

Participants reflected on real-world examples of digital ecosystem ambitions in LMICs, noting that user-driven demand, where adoption is based on genuine usefulness rather than top-down mandates, is a key determinant of whether a tool endures.

A further perspective highlighted that, in a context where minimum viable products can be developed rapidly, the primary constraint is not speed of development but the relevance and quality of content, which must be shaped by users. Embedding digital tools within broader programmes with clear objectives and longer timeframes was seen as more likely to deliver sustainable outcomes than standalone, grant-funded pilots. It was also noted that co-creation with governments, recognising their technical expertise, significantly increases the likelihood of ownership and continuity beyond external funding cycles.

While pilots can establish proof of concept, the critical and often unmet challenge is building something that genuinely functions within existing health systems at scale.

Financing in an ODA-constrained environment

The funding landscape was a recurring backdrop to discussions of sustainability. Participants noted that most digital health initiatives rely on short-term project funding that is insufficient for the iterative, long-term work needed to embed technology into health systems.

From a humanitarian innovation perspective, it was acknowledged that short-term funding can play an important role, particularly in crisis settings where rapid data collection and response are critical. However, participants emphasised that when digital health is intended to strengthen health systems, short-term funding alone is not adequate. There was a clear call to move beyond pilot-driven approaches towards more coordinated and sustained investment, enabling organisations not only to test innovations but also to navigate the wider donor landscape and secure long-term support.

The context of reduced ODA, following significant cuts to major donor programmes, added further urgency. Several participants flagged that the withdrawal of US global health funding is creating acute gaps in countries that had structured their health system development around that support.

The broader problem is not a lack of innovation but a lack of systematisation — the sector's tendency toward short-term programming constrains the ability to scale and sustain what works.

Workforce realities and the primacy of usability

The discussion repeatedly returned to the human dimension of digital health, emphasising that tools are only as effective as their adoption by the health workers who use them. Participants noted that many digital ecosystems are developed without sufficient input from end users, resulting in solutions that are overly complex, poorly aligned with clinical workflows, or ultimately unused.

A strong consensus emerged around a user-demand approach: tools that succeed are those shaped by genuine user needs, beginning with clearly defined problems rather than predetermined solutions. Usability and simplicity were consistently identified as critical factors, with intuitive tools far more likely to be adopted regardless of their technical sophistication.

Examples shared during the session highlighted the importance of taking a whole-system approach to digital adoption. This includes working across policy, institutional capacity, individual digital skills, and enabling infrastructure. Starting with a needs assessment and designing for how users actually engage with technology was seen as essential. Approaches that prioritised accessibility, such as visual interfaces over text-heavy systems, were found to be more effective across diverse user groups. Building internal capacity, for example by identifying local champions or focal points, was also highlighted as a key factor in sustaining digital initiatives beyond initial funding.

The discussion also raised important ethical considerations around the use of AI in clinical decision-making. Participants reflected on the distinction between tools that support clinical judgement and those that may inadvertently direct or override it. This prompted wider reflection on power dynamics within health systems and the extent to which existing regulatory and ethical frameworks are equipped to manage the growing role of AI.

User-centred design is not optional. Tools that are usable and intuitive gain adoption; those that are not, regardless of their technical sophistication, do not.

Evidence, evaluation and data sovereignty

Participants consistently identified a gap in systematic evaluation. There is a substantial body of digital health activity in LMICs, but relatively limited rigorous evidence published on what works, under what conditions, and why. This gap makes it difficult to make the case to funders for sustained investment and means that lessons from failed or stalled initiatives are rarely captured or shared.

One attendee offered a structured framework for thinking about digital health maturity across three progressive tiers. The foundational tier covers core infrastructure: systems such as DHIS2, electronic health records, and health information exchange, areas where substantial investment has been made but interoperability remains an outstanding challenge in most countries. The functional tier addresses how that infrastructure is actually used: analytics, data for decision-making, and the shift from data collection to data utilisation. The frontier tier encompasses machine learning, AI and emerging technologies such as blockchain, which are most useful when applied to specific, well-defined needs rather than deployed broadly. The example of a blockchain pilot in Zimbabwe was shared, designed to verify antenatal care attendance in a performance-based financing programme, which both strengthened data integrity and created potential cost savings.

Another participant described their organisation's work using AI for TB detection from chest X-rays in an LMIC, combining clinical expertise, local data and AI capability as a model for generating evidence in context.

One participant highlighted ongoing national efforts to develop health interoperability standards alongside initiatives to train AI models using locally relevant clinical data. Work is also underway to ensure alignment with data protection legislation, reinforcing the importance of data sovereignty as a fundamental and non-negotiable component of sustainable digital health systems.

A key challenge for the sector is moving from solution-first thinking to problem-first thinking, clearly defining what a tool is trying to solve, and for whom: patients, health workers or system administrators.

AI as co-worker, not replacement

Participants shared a range of perspectives on the application of AI in global health, highlighting both emerging opportunities and areas of active experimentation.

There was a strong emphasis on the importance of starting with clearly understood user needs, rather than with the technology itself. AI initiatives were described that aim to operate at a health system level, testing how these tools can be integrated into broader service delivery and workforce contexts.

The discussion also highlighted the intersection between digital health and financial inclusion, particularly in improving access to care for underserved populations. Approaches such as voice-based AI were noted as having potential to reduce barriers for individuals with lower literacy levels or limited digital experience.

Examples were shared of AI being used to support workforce development, including adapting clinical guidelines and embedding learning tools within local training systems. These approaches were seen as contributing to the retention and distribution of specialist knowledge within country contexts.

Participants also reflected on the growing range of AI applications across humanitarian and global health settings, including initiatives focused on strengthening data use, improving decision-making, and addressing wider determinants of health such as food security. Across these examples, there was a consistent emphasis on ensuring that AI is applied ethically, responsibly, and in ways that respond to clearly defined needs.

The most promising framing for AI in health is as a co-worker, augmenting the capabilities of health professionals rather than replacing them and always keeping the patient at the centre.

Context specificity and reverse innovation

A thread running through the entire session was the importance of context. Participants challenged the tendency to treat 'low- and middle-income countries' as a monolithic category: the needs of a nomadic community in Somaliland, a peri-urban clinic in Kenya and a parliamentary health committee in Zimbabwe are profoundly different.

Equally, the session challenged the directionality of innovation. Participants pointed out that LMIC health systems have developed approaches to delivering care under conditions of extreme resource constraint that have direct lessons for health systems in wealthier countries. Reverse innovation, learning from LMIC experience to improve global practice, was identified as both undervalued and underexplored.

5. Key Reflections

Six overarching insights emerged from the session:

01	Digital transformation is fundamentally a systems challenge, not a technical one. Tools alone cannot substitute for strong governance, infrastructure and institutional capacity.
02	Infrastructure, access and identity remain critical enablers that must be addressed alongside tool development, not assumed to be in place.
03	The current model of short-term pilots contributes to fragmentation, fatigue and wasted learning. Multi-year, systematised approaches are needed.
04	Usability and user-centred design are essential for adoption. Health workers who are already overstretched will not use tools that create additional burden.
05	Data sovereignty and evaluation must be built into programmes from the start, not treated as afterthoughts.
06	Context specificity matters deeply. LMIC experience and innovation deserve recognition as a contribution to global practice, not just a recipient of it.

6. Next Steps

The session was the first in a planned series of discussions on digital health and AI convened by Global Health Partnerships. In closing, the facilitator articulated a clear vision: rather than convening a single session, the aim is to build a sustained convening space where practitioners from across disciplines; ministries of health, technology developers, clinicians, funders, and affected communities, can have these conversations together rather than in silos. The framing was direct: these conversations currently happen separately in ministry meetings, in industry partnerships, and within health institutions. Bringing them into genuine dialogue is itself a missing piece of the digital health puzzle.

Participants indicated strong appetite for continued engagement. The following thematic areas were identified as priorities for future sessions:

- Data governance, sovereignty and evaluation frameworks — including how governments can ensure legislative alignment as digital health initiatives scale.
- Ethics of AI in health — including power dynamics, the distinction between advising and directing clinical decisions, and accountability frameworks.
- Digital health in conflict and fragile settings — what sustainable solutions look like when infrastructure is disrupted and funding is volatile.
- The digital divide — how ministries avoid urban-centric approaches and ensure that rural and marginalised communities are not left further behind.
- Sustainable industry partnerships — what equitable collaboration between large technology suppliers and LMIC health systems can look like.
- Peer learning exchanges connecting practitioners working on similar challenges across different country contexts, with a hybrid format to ensure global participation.

7. Conclusion

This satellite session provided an honest space for a community of practitioners to engage with the realities and not just the promise of digital transformation in global health. The diversity of voices in the room, from government ministries and parliamentary committees to NGOs, academic institutions, private sector partners and diaspora networks, demonstrated the need for further cross-sector collaboration and discussion.

The session made clear that the technology is rarely the limiting factor. Sustainable digital transformation in global health requires strong systems, long-term investment, user-centred design, data sovereignty and coordinated partnerships. It also requires a willingness to learn from what has not worked and to listen carefully to the communities and health workers who bear the consequences when it doesn't.

Sustainable digital transformation requires strong systems, long-term investment, user-centred design, and coordinated partnerships, not just innovative technology.

