Health Architecture Reimagined
Civil Society Organizations

A HOUSE BUILT TOGETHER, FIT FOR ALL:

GLOBAL CIVIL SOCIETY ON THE FUTURE OF HEALTH ARCHITECTURE



HEAR CSO
Synthesis Report 2026

HEAR CSO has identified key themes and directions from consultations to date that are highly relevant to ongoing and future global health reform processes and proposals.



Acknowledgements

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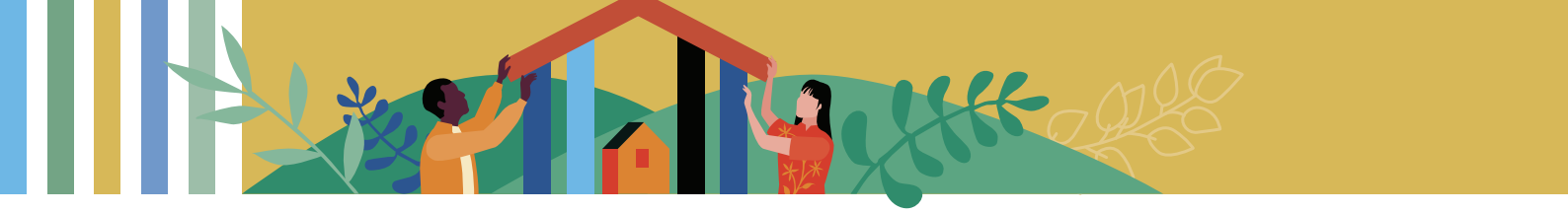
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Executive Summary

Members of communities impacted by health inequities[1] and civil society organisations have unique expertise in the development of institutions, governance structures, programs and financing mechanisms to support health equity. The present global health architecture includes numerous examples of inclusion, including representation on governing and advisory bodies of Gavi, the vaccine alliance, the Global Fund to Fight HIV, Tuberculosis and Malaria, Medicines Patent Pool (MPP), the Pandemic Fund, and the World Health Organization, and myriad regional and national health platforms and programs.

Yet for all of these instances of representation, meaningful inclusion–particularly of impacted communities–remains a challenge.[2] Individuals are asked to represent vast, diverse constituencies; civil society organisations lack resources for in-depth engagement; and representation does not always come with decision rights and leadership roles.

At a time when climate change, funding shortages, ongoing and emergent outbreaks and pandemics challenge the current global health architecture, proposals for reform abound. While civil society and impacted communities have participated in the development of some of these proposals, there has not been, to date, a systematic initiative focused solely on collecting and amplifying these views and voices. In the absence of such an endeavor, inclusion risks being insufficient for the task at hand.

The Health Architecture Reimagined Civil Society Organizations (HEAR CSO) Consortium launched in September 2025 with the aim of supporting members of communities impacted by health inequities and civil society working across sectors and issues around the world to develop ideas, aspirations and substantive proposals to inform diverse convenings on global health architecture.

1 The World Health Organization defines "health inequities" as "avoidable, unjust and preventable differences in health" that "stem from how society allocates resources and opportunities, reinforced by political choices and leadership." HEAR CSO's use of communities impacted by health inequities (shortened to "impacted communities") is guided by this definition, with "impacted" signifying direct, detrimental experience with these injustices. All people are affected by health inequities, regardless of access to quality health care. As WHO states, "Health equity is in everyone's interest." https://www.who.int/teams/social-determinants-of-health/equity-and-health/world-report-on-social-determinants-of-health-equity.

2 There are a range of resources developed and/or informed by people from impacted communities about meaningful engagement. In the context of health inequities, conflict, climate events, income and housing precarity, status as an internally displaced person, refugee or a person whose identity or behaviour is criminalised (sex work, drug use, same-sex sex, transgender or gender nonconforming identity), all shape lived experience. A flexible, open-ended definition that supports self- and community-identification of lived experience relevant to global health architecture reform is essential. See "Mainstreaming the Meaningful Involvement of People Living with or affected by HIV/AIDS into HIV/AIDS Programming," (https://www.catalogue.safaids.net/sites/default/files/publications/MIPA_Brochure.pdf), "Meaningful Engagement of People Living with Non-communicable Diseases, and Mental Health and Neurological Conditions (https://www.who.int/groups/gcm/meaningful-engagement-of-people-with-lived-experience), Briefing Note: Guide for Allies to Meaningful Partnership and Engagement with Sex Worker-Led Organisations (https://www.nswp.org/resource/nswp-briefing-notes/briefing-note-guide-allies-meaningful-partnership-and-engagement-sex). Principles for the Meaningful Involvement of Communities and Civil Society in Global Health Governance (https://governance-principles.org/)

This report synthesises seven virtual regional convenings conducted in 2025 and the subsequent HEAR CSO Global Survey on the Future of Global Health Architecture that gathered 285 responses between December 2025 and February 2026. Altogether, HEAR CSO gathered nearly 415 inputs across 90+ countries and seven languages. These inputs reflect perspectives from respondents working across 23 thematic areas spanning health, health systems, and cross-sector priorities.

The findings show that the civil society and impacted communities that participated have diverse, varied and vibrant points of view about the current context and preferred futures for global health architecture. Honoring these differences, and acknowledging that no single report or initiative can speak for the totality of civil society and impacted communities, HEAR CSO has identified key themes and directions from consultations to date that are highly relevant to ongoing and future global health reform processes and proposals.





Key findings:

- **Civil society and impacted communities engaging with HEAR CSO's consultative processes show strong support for three pillars of a transformed global health architecture reform.**
  - An expansive definition of "global public goods" for global health encompassing data collection and surveillance systems, research and development, procurement mechanisms and much more.
  - Robust regional platforms for agenda-setting, negotiation and procurement, enabling countries and regions to exercise greater collective bargaining power in global health governance.
  - Health systems supported by increased domestic resources and centered on community-designed and -led services that leave no one behind.
- **Civil society and impacted communities engaging with HEAR CSO's consultative processes are in alignment on the need for ambitious, holistic transformation, and hold diverse views on short-term, institutional reforms.**
  - Specific reform pathways such as institutional mergers to reduce fragmentation or broader application of existing intellectual property flexibilities were lower priorities than overarching shifts in resourcing, conceptualisation and service delivery approaches.
  - Some reform pathways were polarising, with significant proportions of respondents ranking the same option as a high or low priority.
- **There is a significant gap between civil society and impacted communities' interest and readiness to engage in global health architecture reform and their actual access to reform processes.**
  - HEAR CSO found high levels of enthusiasm for and interest in engagement in global health architecture reform.
  - Consultation participants consistently affirmed the relevance and timeliness of the conversation, with regionally varied feedback about how to frame or approach the topic.
  - A readiness index constructed from respondents' familiarity with global health architecture concepts, institutions and reform processes suggests that 73% of respondents fall into moderate or high readiness categories, while 34% fall into the highest readiness category. Only 8.5% of respondents reported clear participation in processes explicitly framed as global health architecture reform, although 15% reported engagement in related governance or policy processes.

HEAR CSO is committed to working collaboratively, transparently and equitably with the diverse members of civil society and communities impacted by health inequities all around the world to develop and advance a shared agenda for meaningful change.
To learn more please visit: www.hearcso.org. To share feedback, ongoing work or get involved, reach out: info@hearcso.org

Acronyms

ACT-A	Access to COVID-19 Tools Accelerator
Africa CDC	Africa Centres for Disease Control and Prevention
AI	Artificial Intelligence
AMR	Antimicrobial Resistance
APCASO	Asia Pacific Council of AIDS Service Organizations
CLA	Causal Layered Analysis
CSO(s)	Civil Society Organisation(s)
EECA	Eastern Europe and Central Asia
FENSA	Framework of Engagement with Non-State Actors
Gavi	Gavi, the Vaccine Alliance
GDP	Gross Domestic Product
GHA	Global Health Architecture
GPI	Global Public Investment
HEAR CSO	Health Architecture Reimagined Civil Society Organizations
HIV	Human Immunodeficiency Virus
ITPC	International Treatment Preparedness Coalition
MENA	Middle East and North Africa
MPP	Medicines Patent Pool
NCD(s)	Non-Communicable Disease(s)
NTD	Neglected Tropical Diseases
PAHO	Pan American Health Organization
R&D	Research and Development
SEARO	South-East Asia Regional Office (of WHO)
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
WHA	World Health Assembly
WHO	World Health Organization

Part I. HEAR CSO 2025 Consultations Synthesis

Background

This section presents a synthesis of the common and distinct content emerging from seven virtual consultations conducted between October and December 2025 with civil society groups from Western Europe and North America, Africa, South Asia, Latin America and the Caribbean, Eastern Europe and Central Asia, Middle East and North Africa, and Asia Pacific regions.

Outreach

The regional consultations were open to all CSOs interested in participating. A global "launch call" attended by more than 300 civil society representatives shared this open invitation, and led to significant interest from across regions. In addition to the open call, participants were identified via mapping conducted through members of the HEAR CSO Steering Committee networks and collaboration with the conveners of the Wellcome Trust-supported multistakeholder meetings. Participant registrations were assessed on the basis of geography, focal area of work and other parameters to inform outreach prior to each call.

HEAR CSO worked with the following regional partners to conduct outreach for and facilitate the convenings. In the other regions, HEAR CSO Steering Committee members anchored outreach, and the Project Team led facilitation.

APCASO - Asia Pacific

Fundación Huésped - Latin America and the Caribbean

ITPC Eastern Europe and Central Asia - Eastern Europe and Central Asia

ITPC Middle East and North Africa – Middle East and North Africa



Approach

The consultations used Causal Layered Analysis (CLA), a participatory futures and systems-thinking method developed by Sohail Inayatullah. CLA invites participants to explore change across four interconnected levels: the litany, or the surface issues and narratives that dominate current discourse; the systemic layer, which identifies the social, economic, and institutional structures producing those issues; the worldview layer, which surfaces the cultural beliefs, ideologies, and power relations that shape the system; and the mythic or metaphorical layer, where deep stories, symbols, and collective emotions influence how people understand and experience the world.

Working through these layers enables participants to move beyond describing problems to reframing systems and imagining preferred futures—visions of what just and equitable global health governance could look like if underlying assumptions and power dynamics were transformed.

Participants then translated those visions into explicit and implicit actions: concrete policy reforms, governance changes, or social shifts needed to make preferred futures possible. These include tangible proposals such as the creation of regional health funds, institutional reforms, or leadership models, as well as the normative and cultural shifts required to sustain them.

Analysis across regions was organised using HEAR CSO's four domains of global health architecture: guidance and governance, coordination of global public goods access, financing, and implementation and delivery.

> ***Overall, HEAR CSO's seven regional consultations reached 139 participants from 54 countries representing 107 civil society organisations.***

Results: Participation

- Overall, HEAR CSO's seven regional consultations reached 139 participants from 54 countries representing 107 civil society organisations.
- No single disease or topic dominated more than one third of participants' self-identified area of work.
- Areas addressed included health systems, policy and rights-based approaches, primary health care, non-communicable disease, mental health and wellbeing, sexual and reproductive health and rights, access to medicines, pandemic preparedness and response, and infectious diseases including HIV and tuberculosis.
- More than 80 percent of participants reported having lived experience that informs their perspective on global health architecture.

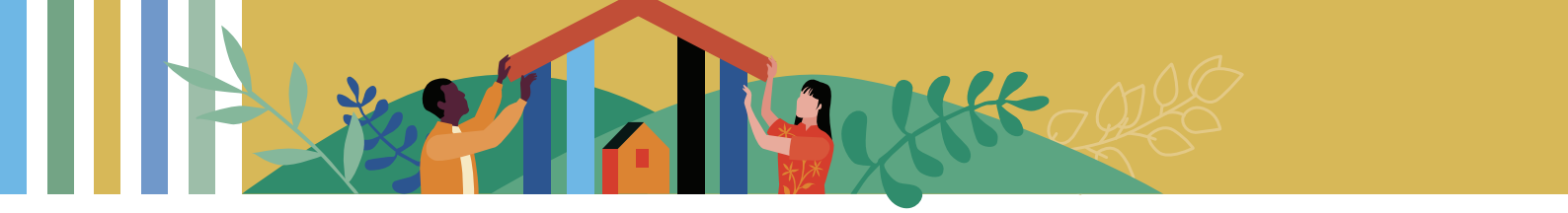


Table 1: Regional consultation participation and organisational reach. Countries counted by principal country of CSO operations

Consultation	# of Attendees	# of Countries	# of CSOs
Africa	27	11	21
Asia-Pacific	24	7	14
Eastern Europe and Central Asia	17	12	13
Latin America & Caribbean	9	6	6
Middle East and North Africa	12	5	9
South Asia	13	5	13
Western Europe and North America	37	8	31
Totals	**139**	**54**	**107**

Our analysis of participant demographics identified gaps in age, role/relationship to global health architecture and geography: younger participants, frontline community-based workers and early-career civil society professionals were under-represented, as were participants from the Caribbean, which experienced a hurricane on the day of the consultation. HEAR CSO activities in 2026 aim to fill some of these gaps.

Shared Assessments of the Present and Visions for the Future

Across the consultations, participants articulated a current context defined by inequities in funding, access to medicines, tests and vaccines, and decision-making power, particularly for civil society groups. Colonial histories and legacies, capitalism and environmental degradation figured as defining elements in all consultations, with notable regional variations in the characterisation of roles and responsibilities. For instance, both Latin American and African participants articulated clearly how they felt their region was perceived by people from other geographies, whereas South Asia and Western Europe/North America consultations did not include this type of reflection on external perceptions. The stories and soundbites of the present in all regions included a profound sense of collapse, calamity, scarcity and loss of progress. At the same time, and in all regions, community-led and -defined programming, visions and agendas were identified as sources of power and energy.

December 2025 consultations with civil society from the Middle East and North Africa, Eastern Europe and Central Asia, and the Asia Pacific region reinforced these shared assessments while sharpening their urgency. Across all three regions, participants described intensified funding volatility, shrinking civic space, and growing uncertainty linked to geopolitical instability and the retreat or restructuring of global health institutions. Health systems were widely experienced as fragmented and reactive, with long-term needs deprioritised in favor of crisis-driven responses.

In Eastern Europe and Central Asia, participants emphasised the combined effects of reduced international funding, anticipated or ongoing reductions in the presence of global institutions, and heightened repression, stigma, and legal barriers affecting community organisations. In Asia and the Pacific, participants highlighted widening inequities, politicised decision-making, donor withdrawal from middle-income countries, and health systems that often treat access to care as a privilege rather than a right. In the Middle East and North Africa, participants described systems oriented toward emergency response rather than sustained wellbeing, shaped by protracted conflict, displacement, securitised global priorities, and chronic underinvestment in primary care, noncommunicable diseases, and mental health.

Across these regions, community knowledge, lived experience, and community-led monitoring were consistently identified as among the most trusted sources of information and accountability, and as essential foundations for more equitable, resilient, and people-centered health systems.

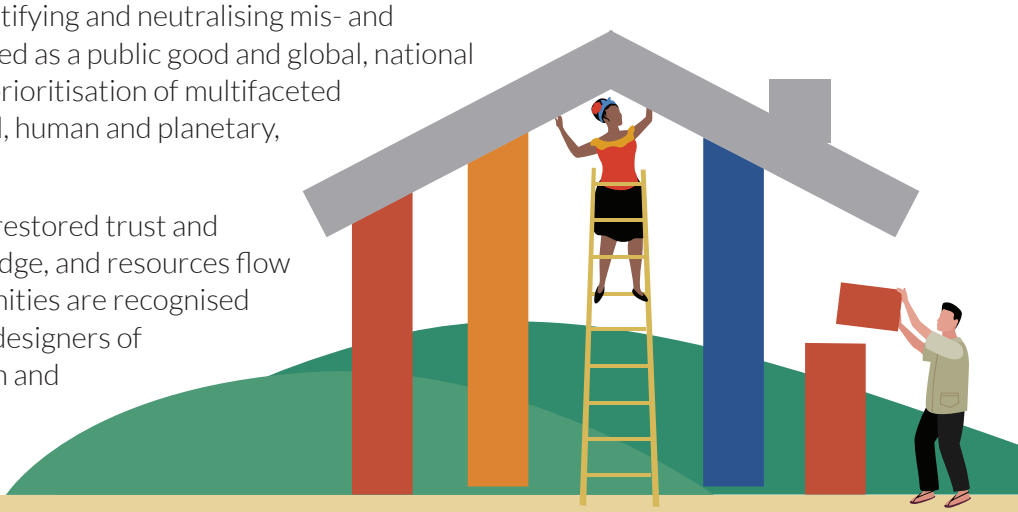
Shared visions of the future:

- A global health architecture that is participatory, with communities as co-decision-makers.
- Systems that are equitable, with fair distribution of resources and power.
- Approaches grounded in community realities, not imposed from outside.

Turning to the preferred futures, participants across consultations shared aspirations for a global health architecture that is participatory, equitable, and grounded in the realities of communities. In this preferred future, interdependence leads to equitable distribution of resources across geographies and communities, with regionally specific funding and governance structures that embed and include civil society fostering South-South collaboration including on technology transfer and manufacturing. This South–South collaboration complements and balances North–South partnerships.

In the preferred future, trust and transparency are restored through open data access, structured approaches to identifying and neutralising mis- and disinformation. Health is treated as a public good and global, national and regional indices reflect a prioritisation of multifaceted wellbeing (mental and physical, human and planetary, communal and individual).

The future imagined is one of restored trust and balance, where power, knowledge, and resources flow both ways, and where communities are recognised not as beneficiaries but as co-designers of the systems that govern health and wellbeing.





Myths and Metaphors

The metaphors developed through the Causal Layered Analysis process capture how participants understand change—not only in technical or policy terms, but as shifts in meaning, identity, and power. *Note: The Eastern Europe and Central Asia convening adapted the methodology and did not generate this analysis.*

***Table 2:** Myths and Metaphors*

Region	Metaphors and Deep Stories	Interpretive Notes
Africa	The Peaceful Elephants and Thriving Grasshoppers; The Living Shield; The Wellspring	A vision of protection, interdependence, and shared survival. Power is cooperative rather than extractive, and wisdom is grounded in community and nature.
Latin America and the Caribbean	A Renovated Architecture Built on Restored Trust; Bridges of Hope; Mother Earth and the Circle of Life	Renewal and repair are central themes. The region's metaphors call for healing historical fractures and rebuilding institutions as spaces of trust.
South Asia	Millions of Lamps Dispelling Darkness; The Thread of Healing; The Web of Compassion	Imagery centers on illumination, community connection, and collective resilience.
Western Europe and North America	The Human Family; The Commons; Community Tames the Tech Goliath	The focus is on solidarity, shared responsibility, and ethical restraint. Power is recast through empathy and cooperation.
Asia Pacific	Health at Everyone's Fingertips	A future where health is a right rather than a privilege, enabled by meaningful community leadership, equitable access to care and information, regional collaboration, and systems that reach people wherever they live.
Middle East and North Africa	The Perennial Olive Tree	A vision of health systems rooted in solidarity and shared responsibility, shifting from crisis-driven responses toward long-term resilience, equity, and care that sustains communities across generations.

Pathways to Preferred Futures: Shared and Regional Actions and Milestones, 2025–2030

The table below reflects milestones and activities explicitly identified and implicitly suggested during HEAR CSO in-person consultations and the futures-mapping work conducted prior to them. An implicitly suggested activity may refer to a policy reform or systemic change required to achieve a preferred outcome, such as expanded civil-society involvement in governance. This is a working, living pathway document that will be validated and expanded as the consultative processes continue.

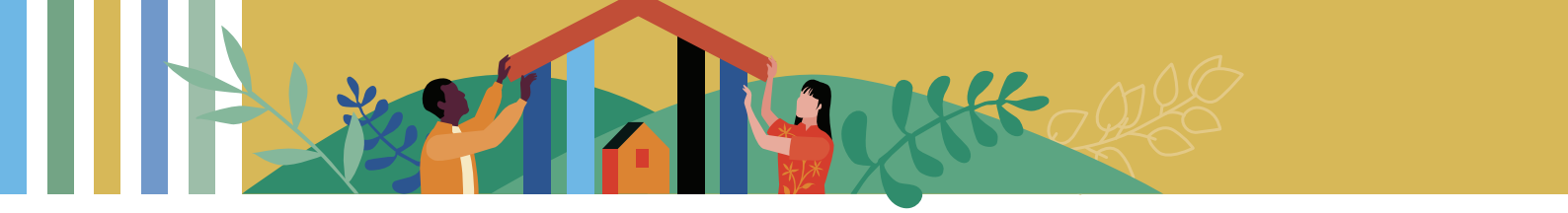
Table 3: *Regional Actions and Milestones*

Domain	Shared Milestones	Actions and Priorities Per-Region	Indicative Activities
Guidance and Governance	Establish co-governance structures linking governments, communities, and civil society. Reform global and regional health bodies (WHO and regional offices including PAHO and SEARO, African Union and its agencies, Africa CDC to institutionalise participation, transparency, and accountability. Strengthen legal and policy frameworks that recognise civil society as co-decision-makers.	**Africa:** Multistakeholder governance inclusive of CSOs adopted as the norm at every level of national health systems and in the context of regional fund(s) - see financing; governance inputs by CSOs supported via expansion of social-contracting and accountability mechanisms. **Latin America:** Formal CSO participation in PAHO/WHO reform and regional dialogue structures. **South Asia:** Joint planning and oversight bodies integrating ministries and CSOs. **Western Europe/North America:** Inclusion of non-state leadership in global coordination platforms and treaty-design processes. **MENA:** Health governance prioritises solidarity and long-term wellbeing over securitised, crisis-driven decision-making. **Asia Pacific:** Community leadership and civil society oversight replace politicised decision-making and shrinking civic space. **EECA:** Governance reform prioritises meaningful participation of communities in decision-making amid shrinking civic space, repression, and reduced presence of global institutions.	Governance review and reform design. Operationalised co-governance and transparency systems.

Coordination of Global Public Goods Access	Expand regional manufacturing of medicines, diagnostics, and vaccines. Develop open-science, IP, and knowledge-sharing frameworks grounded in equity. Create global and regional mechanisms for ethical technology and AI governance.	**Africa:** Regional regulatory cooperation and open-data transparency. **Latin America:** South–South research and open-knowledge networks; regional regulatory and production capacity. **South Asia:** Digital health and adolescent information platforms. **Western Europe/North America:** Global R&D and AI-governance frameworks; equitable-access agreements replacing TRIPS. **MENA:** Regional preparedness and interoperable health information systems are central to managing conflict, displacement, and cross-border health threats. **Asia Pacific:** Equitable governance of digital health tools and AI addresses geographic, linguistic, and technological divides. **EECA:** Regional coordination safeguards access to HIV treatment and prevention as donor funding declines. Community and regional networks sustain continued access to essential medicines and countermeasures as global mechanisms for coordinating the HIV response evolve.	Regional and South-South knowledge-sharing systems developed. Continued expansion and refinement of ethical digital health systems and solutions embedded in a decolonised governance structure.



Financing	Establish regional and thematic health funds with shared governance by governments and civil society. Commit to sustainable domestic financing targets and mechanisms such as debt restructuring, progressive taxation, and community-managed financing.	**Africa:** Establishment of regional and community-managed health-fund components under a continental 'Health Sovereignty' framework; implementation of the Health Sovereignty Index to track equitable financing flows. **Latin America:** Launch of a Latin American Regional Health Fund with CSO co-management. **South Asia:** 5% of GDP allocated to health; South Asian Mental Health Fund. **Western Europe/North America:** Unity Fund for key and marginalised populations; advocacy for tax and debt-justice frameworks. **MENA:** Financing mechanisms recognise and resource the funding and resources required for hosting displaced populations. **Asia Pacific:** Continued eligibility for multilateral support for countries within the region, reflecting differences in economic status between and within nations. **EECA:** Financing priorities focus on direct funding for community-based organisations, diversification of funding sources, and donor policies not limited by World Bank income classifications.	Fund(s) and capitalisation in the context of expansion of innovative financing approaches and continued, if reduced, contributions from traditional donors, potentially grounded in the "GPI" approach to foreign aid. Expansion and iteration of global, regional and national financing systems.



Implementation and Delivery	Strengthen human-resource capacity, leadership, and service-delivery models that reflect local priorities and community realities. Institutionalise youth leadership, gender equity, fair work, and the inclusion of lived experience as expertise.	**Africa:** Leadership programs for people with disabilities; integration of traditional healers and community providers in service delivery. Integration of traditional and biomedical strategies and interventions. Intentional expansion of digital tech to bridge urban-rural health divides. Continued community-led monitoring. **Latin America:** Community analysts embedded in regional observatories and disease-surveillance systems. **South Asia:** Youth-led accountability and fair-work frameworks for health workers. **Western Europe/North America:** Partnerships linking cultural, scientific, and faith-based leadership in digital and ethical-health initiatives. **MENA:** Service delivery shifts from temporary humanitarian responses to integrated, preventive systems, including mental health and NCD care. **Asia Pacific**: Blended models of primary, community-based, and digital care are developed that meet needs for scale, coverage in remote and rural regions, and workforce constraints. **EECA:** Community-led monitoring is institutionalised as a core component of health systems, directly informing service delivery and quality improvement. Health services are sustained and adapted to ensure uninterrupted access to HIV treatment and prevention while actively addressing stigma, discrimination, and restrictive legal environments.	Inclusive delivery models that actualise objectives of "integration" (across diseases, mental and physical health, urban/rural and key population identities) are institutionalised, evaluated and implemented with community input. New indicators on wellbeing, health, equity and sovereignty developed to track and assess needs, gaps and achievements across systems.

Part II. Future of Global Health Architecture Survey Findings

Background

The HEAR CSO Global Survey on the Future of Global Health Architecture was designed to expand opportunities for civil society and impacted communities to share perspective and priorities for global health architecture reform, beyond the spaces created in the 2025 virtual convenings. The highly-participatory Causal Layered Analysis methodology used for the convenings is not readily adaptable into an on-line survey format. Therefore, the HEAR CSO Project Team designed a survey that used a combination of fixed choice and open-ended questions to solicit perspectives on the present and priorities for the future.

Approach

The Project Team drew the inputs to which survey takers responded from the outcomes of the regional consultations and from a range of recently-published proposals for global health architecture reform pathways. Several participants in the consultations shared that both the term and the processes related to global health architecture were not well or widely understood. In order to gather more information, the Project Team added a survey section that queried respondents' familiarity and engagement with global health architecture to date. An agree/disagree scale was used to gather participants' views of the present context. In the "reform pathways" section of the survey, participants were asked to rank order five to six highly-condensed reform proposals derived from HEAR CSO consultations and relevant publications.

> ***In total 301 submissions were received. After data cleaning and removal of duplicate or incomplete entries, 285 unique responses were retained for analysis.***

The survey was piloted in English between 8-16 December 2025. During this period three respondents completed the survey and an additional three reviewers provided written feedback on question clarity, wording and overall flow without completing the full questionnaire. Feedback from the pilot informed revisions to wording, clarification of instructions and adjustments to the framing of several questions to improve consistency in interpretation. The final survey was launched on 22 January 2026 and closed on 2 March 2026. In total 301 submissions were received. After data cleaning and removal of duplicate or incomplete entries, 285 unique

responses were retained for analysis. To support broader participation, the survey was translated and made available in 10 languages: English, Arabic, French, Indonesian, Khmer, Mongolian, Portuguese, Russian, Sinhala and Spanish. Responses were received in English, Arabic, French, Spanish and Russian.

The survey was distributed through a HEAR CSO webinar, partner organisations and civil society mailing lists, and was shared by participants in regional consultations to encourage responses from organisations working across different regions and health focus areas. Participation was voluntary and respondents could complete the survey anonymously.

Results: Participation

This survey gathered perspectives from 285 respondents representing civil society organisations, impacted communities, community networks, and global health actors working across more than 70 countries. Respondents work across a wide range of health issues including HIV, primary health care, sexual and reproductive health, non-communicable diseases and climate-related health risks.

Around 97% of respondents were classified as civil society based on the resources HEAR CSO used for its working definition.[3] Additionally, nine respondents identified themselves as associated with public institutions, multilateral bodies or local consulting firms, technically classified as private sector. Importantly, eight of the nine reported either lived experience or working closely with impacted communities. The remaining respondent identified as working in global health advocacy and implementation, so still sits within the broader ecosystem this analysis is trying to capture. HEAR CSO therefore retained these responses in the analysed data set.

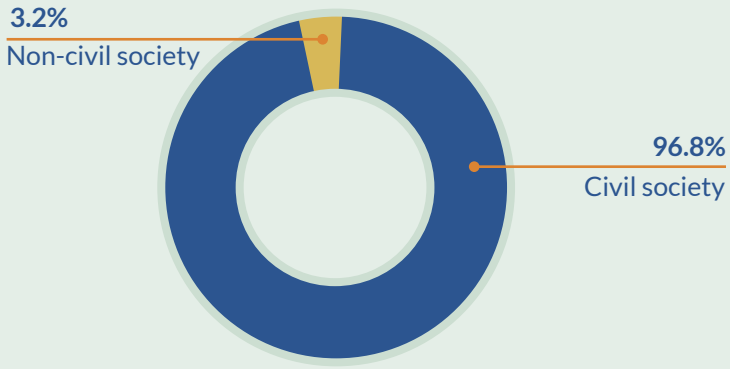


3 Civil society in this context includes community groups, national NGOs, international NGOs, coalitions, advocacy organisations, academic organisations and professional associations. For reference see Civil Society Space and the United Nations Human Rights System: A Practical Guide

Organisational representation

This distribution strongly reflects the objective of the HEAR CSO consultation process, which aims to centre civil society and impacted community voices in discussions on global health architecture reform while also capturing perspectives from actors involved in governance and policy processes.

Figure 1. *Civil society representation among survey respondents*



The survey overwhelmingly reached civil society actors, with **97%** of respondents classified as **civil society** and **3%** as **non-civil society.**

Geographic representation

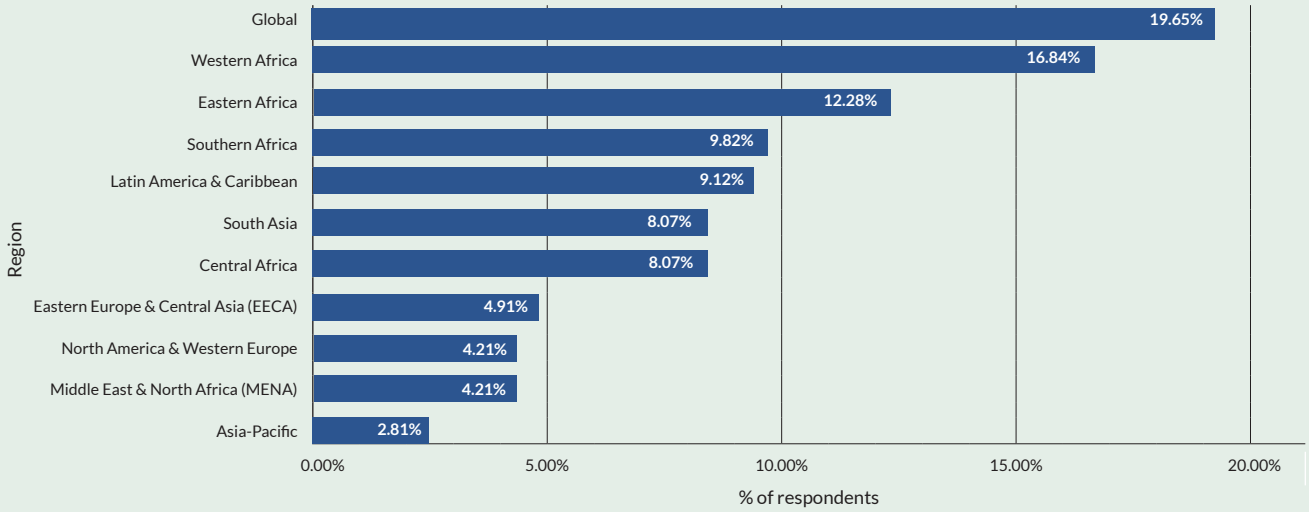
Respondents represented organisations working across more than 70 countries. The largest share identified their scope as global (20%), followed by Western Africa (17%), Eastern Africa (12%) and Southern Africa (10%). Latin America and the Caribbean, South Asia and Central Africa each accounted for around 8-9% of respondents.

For analysis, regional groupings were harmonised to ensure more consistent comparison across responses. Countries were mapped into consolidated regional categories, while organisations working across multiple regions were classified as "Global".

This geographic distribution indicates strong participation from regions where global health access and equity challenges remain particularly pronounced, while also capturing perspectives from transnational advocacy networks operating across multiple regions.



Figure 2. *Geographic distribution of survey respondents*



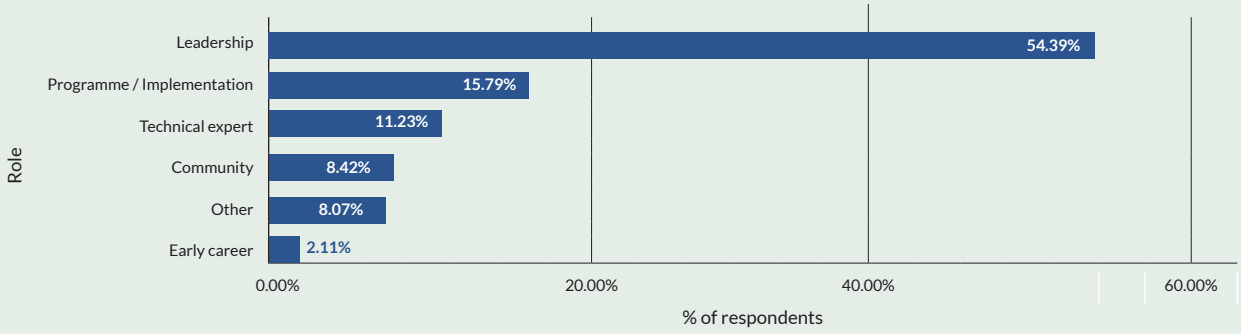
Respondents represented organisations working across multiple regions, with the largest shares identifying their scope as global, Western Africa, Eastern Africa and Southern Africa.

Professional roles

More than half of respondents reported holding senior leadership positions, such as executive directors, founders or organisational leads. Programme managers represented around one sixth of respondents. Technical specialists, researchers and community representatives were also represented.

This suggests that many respondents are involved in strategic decision-making, advocacy or programme oversight within their organisations. At the same time, the inclusion of community and peer-based roles indicates that some responses reflect perspectives closely connected to affected communities.

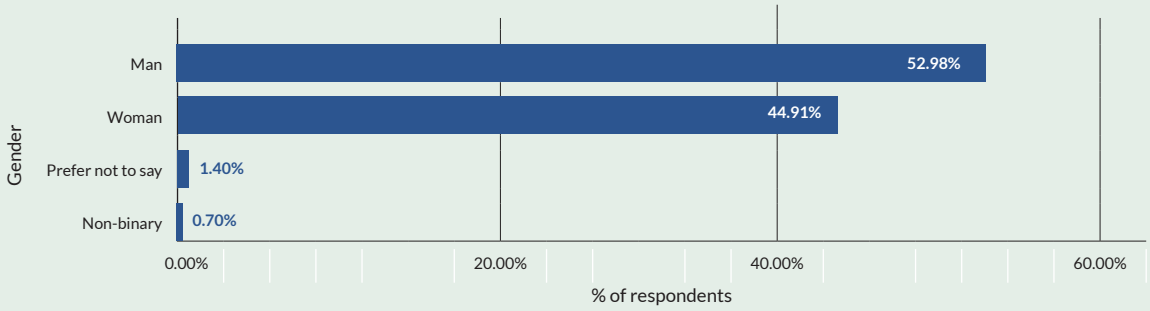
Figure 3. *Professional roles of survey respondents*



More than half of respondents occupied leadership roles, while programme, technical and community roles were also represented.

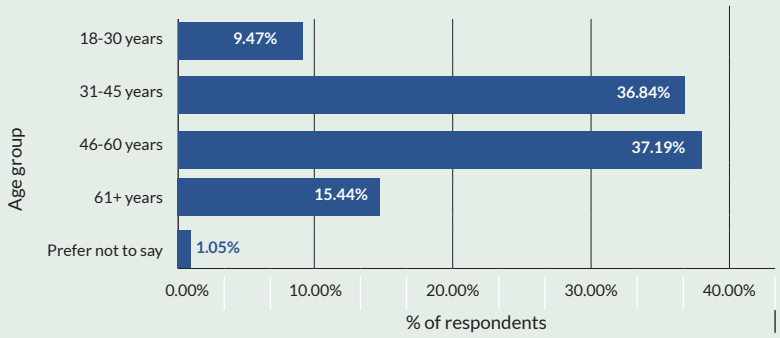
Demographic characteristics

Figure 4a. *Gender of survey respondents*



Gender representation among respondents was relatively balanced, with slightly more respondents identifying as men than women. A small number of respondents identified as non-binary or preferred not to disclose their gender.

Figure 4b. *Age group of survey respondents*



Most respondents were mid-career or senior professionals aged between 31 and 60 years.

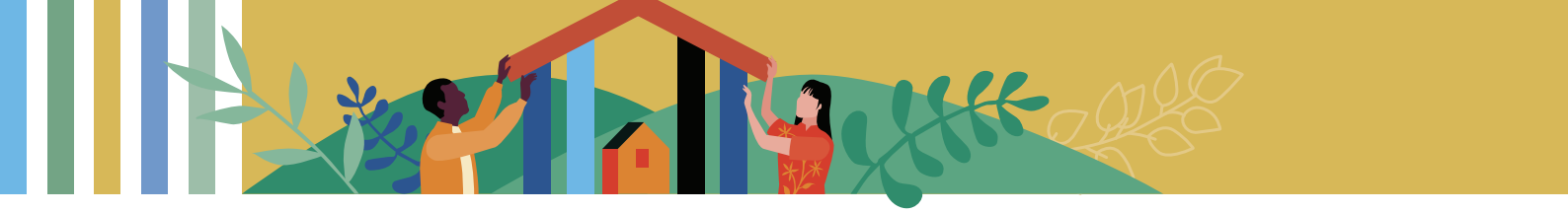
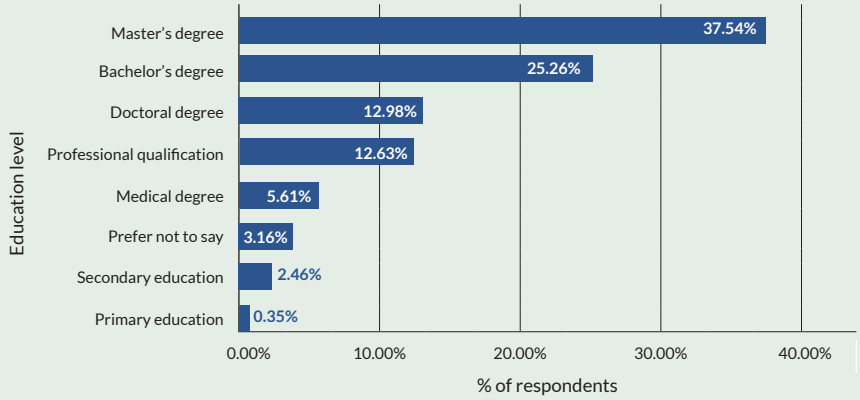


Figure 4c. Highest education level of survey respondents



Respondents were highly educated, with most reporting bachelor's, master's or doctoral degrees.

Respondents were relatively balanced in gender representation, with slightly more men than women participating. Most were aged between 31 and 60 years, indicating a predominantly mid-career and senior professional profile. Respondents were also highly educated, with the majority reporting bachelor's, master's or doctoral qualifications.

This profile suggests that many respondents operate within professional networks where advocacy, programme management and policy engagement are common.

> ***This profile suggests that many respondents operate within professional networks where advocacy, programme management and policy engagement are common.***



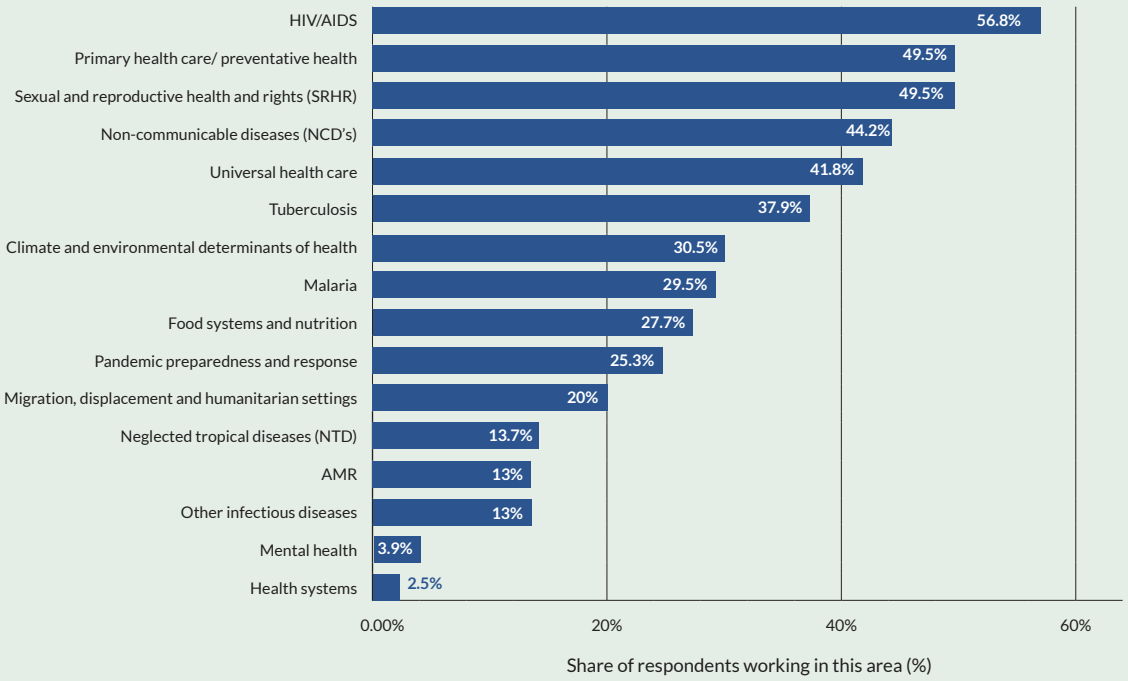
Health focus areas

Respondents reported working across a wide range of health areas. The most frequently represented areas were HIV/AIDS (57%), primary health care and preventive health (49%), sexual and reproductive health and rights (49%), non-communicable diseases (44%), and universal health care (42%).

Many respondents also reported working on cross-cutting issues such as climate and environmental determinants of health, food systems and nutrition, pandemic preparedness, migration and humanitarian settings.

Since respondents could select multiple thematic areas, these counts represent the number of respondents selecting each theme rather than mutually exclusive groups.

***Figure 5.** Health focus areas represented among survey respondents*



Respondents worked across a wide range of health issues, with strongest representation in HIV, primary health care, SRHR, NCDs and universal health care

Lived experience

Respondents were asked whether their perspectives on global health are shaped by lived experiences related to health inequities. Multiple responses were permitted.

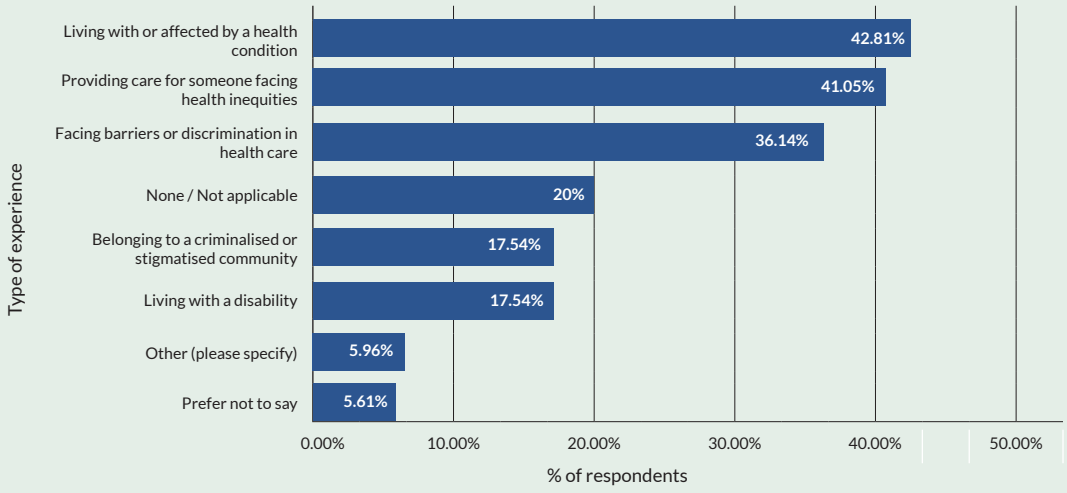
A large share of respondents reported experiences connected to health inequities. Eighty percent of respondents indicated at least one form of lived or relational experience, including living with a health condition, providing care for someone experiencing inequities, facing barriers or discrimination in health care, or belonging to marginalised communities.

The most frequently reported experiences were living with or being affected by a health condition (43%) and providing care for someone facing health inequities (41%). More than one-third of respondents reported experiencing barriers or discrimination in health care (36%).

Several respondents used the "Other" category to describe professional experiences working closely with affected communities rather than personal lived experience.

Several respondents used the "Other" response to describe professional experiences working closely with affected communities, rather than personal lived experience of health conditions.

Figure 6. *Lived or relational experiences shaping respondents' perspectives*



A large majority of respondents reported at least one form of lived or relational experience related to health inequities.

Current Context: Key Findings

This section explores how respondents assess the current global health architecture (GHA) across four core dimensions: governance, financing, access to global public goods, and implementation of services. Respondents were asked to indicate their level of agreement with a series of statements reflecting both achievements and systemic challenges within the current system.

The results provide insight into two key questions:

1. What elements of the current global health system are widely recognised as strengths?
2. Where do respondents see major structural failures or areas requiring reform?

Together, the responses highlight a global health system that has delivered important results but is widely perceived as struggling to adapt to shifting geopolitical, financial and social realities.

Overall patterns

Across the 39 statements assessed, respondents showed high levels of agreement on both strengths and systemic critiques. This suggests a relatively shared understanding among respondents of the current global health landscape: one in which important institutional achievements coexist with deep structural concerns.

Two broad patterns stand out:

- Strong recognition of past achievements, particularly those associated with multilateral cooperation, disease-specific initiatives, and global norms.
- Even stronger convergence around systemic weaknesses, including funding instability, governance imbalances and concerns about reduced support for community-led responses.

> ***Across the 39 statements assessed, respondents showed high levels of agreement on both strengths and systemic critiques.***

At the same time, several areas showed greater uncertainty or divided opinion, particularly around newer policy approaches such as integrated financing, market-shaping mechanisms and the future structure of service delivery systems.

Average agreement levels across governance, financing, access and implementation statements show broad recognition of institutional strengths alongside strong concerns about financing sustainability and the capacity of national and community-level systems to deliver effectively.

A Note on Interpretation

Percentages of agreement reported reflect responses from individuals who selected “agree” or “strongly agree.” In many cases, this provides a clear indication of overall sentiment.

However, agreement alone does not always capture how widely views are shared. For example, a statement may receive relatively high agreement (for example, around 70-80%) while still generating disagreement or uncertainty among other respondents.

To address this, we also calculated a consensus score, which reflects the difference between agreement and disagreement across all responses. This allows us to assess not only how many respondents agree with a statement, but also how evenly views are distributed.

A high consensus score indicates that responses are aligned, with little disagreement or uncertainty. A lower consensus score indicates more mixed views, even where overall agreement appears relatively high.

For example, some statements in this report show around 70% agreement but much lower consensus scores, indicating that these views are not strongly shared across respondents. In contrast, statements with both high agreement and high consensus scores reflect more widely held perspectives.

The consensus score is centred around zero: positive values indicate that agreement outweighs disagreement, while negative values indicate that disagreement outweighs agreement.

We use this measure selectively to highlight areas where views are more divided or where agreement alone may obscure important differences in perspective.



Governance

Quantitative findings

Respondents broadly recognised the institutional foundations of global health governance as important and effective in several areas.

There was particularly strong agreement that:

- Global agreements affirm key aspects of the right to health (94%).
- The World Health Organization plays a vital role in global health rules and standards (92%).
- Multilateral institutions such as Gavi and the Global Fund have delivered meaningful results (91%).

These responses suggest continued recognition of the legitimacy and value of multilateral cooperation.

However, respondents simultaneously expressed strong concern about how governance currently operates in practice.

High levels of agreement were recorded for statements highlighting structural challenges:

- Donors from the Global North determine priorities in the Global South (84%).
- Agreements promoting equity are often not enforced or financed (90%).
- Global health governance has not kept pace with changes in who pays, decides and implements (87%).

Together these responses suggest that while respondents value global institutions, they also feel that existing governance arrangements replicate or reinforce power differentials, rather than dismantling them.

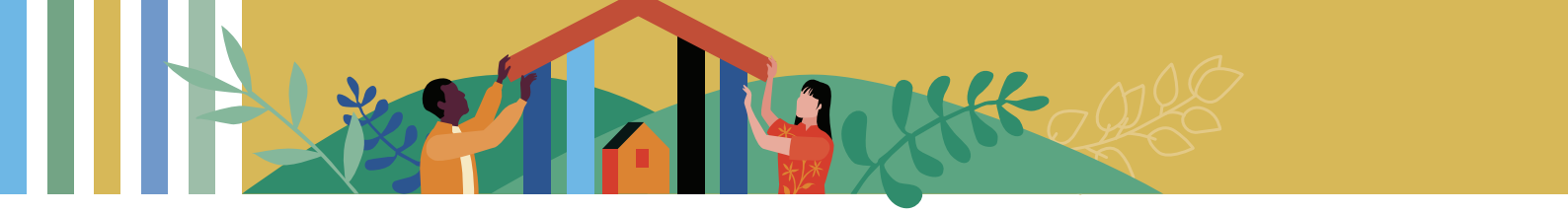
Qualitative insights

Open text responses strongly reinforced these quantitative findings.

Many respondents described governance as centralised, donor-driven and insufficiently accountable to communities.

Several comments emphasised the continued concentration of decision-making power in global institutions and major donor countries:

> ***"The global North has the financial muscle and this gives them the power to impose conditions on funding."***



Others highlighted the limited influence of communities and civil society in governance processes:

> ***"Discussions are in Geneva and New York, not in the communities they should serve."***

Some respondents also pointed to fragmentation within the institutional landscape:

> ***"Someone trying to develop policy is lost in the middle of the many recommendations and initiatives."***

Taken together, these comments suggest that respondents see governance challenges less as a lack of institutions and more as a lack of equity, coordination and accountability within the existing system.

Financing

Quantitative findings

Responses on financing reflected a similar pattern: recognition of historical achievements alongside strong concern about sustainability.

There was strong agreement with statements related to assessments that external financing has played an important role in global health progress:

- Overseas development assistance has enabled gains beyond domestic capacity (89%).
- Predictable funding has supported progress in some disease areas (90%).
- Pooled procurement mechanisms have expanded access to medicines and vaccines (83%).

At the same time, respondents expressed very strong concern about the current financial trajectory of global health systems.

The statement receiving the highest consensus in this section was:

- There is a funding crisis that is putting hard-won gains at risk (94%).

Respondents also expressed strong agreement that:

- Debt repayment limits countries' ability to invest in health (86%).
- Resources are lost to corruption and illicit financial flows (88%).
- Global tax and intellectual property structures favour wealthier actors (86%).

These responses suggest a shared perception that, while the current financing mechanisms of the past 20-25 years have supported some important gains, there is a present crisis, and an unsustainable future.

Qualitative insights

Open text responses reinforced the quantitative findings in this section. Many respondents highlighted the growing uncertainty surrounding development assistance, including reductions in donor funding and changing geopolitical priorities.

One respondent noted:

> ***"Most donors have closed their doors, and many organisations can no longer operate."***

Others emphasised the heavy reliance of many health systems on external funding:

> ***"Health investments have depended on donor contributions and wider aid trends, especially in Africa."***

Several comments also raised concerns about structural economic dynamics shaping global health financing, including intellectual property regimes and corporate influence:

> ***"Tax and intellectual property systems allow wealth to flow out of countries that need it most for health."***

These responses suggest that respondents view financing challenges not only as a short-term funding issue, but also as a reflection of broader global economic structures affecting health equity.



Access to global public goods

Quantitative findings

Responses relating to access to medicines, vaccines and other global public goods reflected a mixed picture.

Respondents broadly agreed with statements that global mechanisms have contributed to improved access in some areas:

- WHO guidance and essential medicines lists support access to safe commodities (89%).
- Regionally coordinated procurement can expand access and reduce prices (85%).
- Advocacy and activism have helped improve access to medicines (81%).

However, confidence in the system's ability to guarantee universal access was significantly lower.

For example:

- While 70% agreed that current coordination mechanisms can deliver access to priority medicines and vaccines for all, the relatively low consensus score (51%) indicates that this view is not widely shared across respondents. In practice, this means that a substantial proportion of respondents either disagreed or expressed uncertainty, pointing to more mixed or divided views than the agreement percentage alone suggests.
- Only 52% agreed that the current system is set up to provide access for all during a global pandemic.

This latter statement had one of the lowest consensus scores across the entire survey.

Qualitative insights

Respondents frequently referred to the COVID-19 pandemic when explaining their responses. Many described the pandemic as evidence of systemic inequities in global access.

One respondent commented:

> ***"COVID-19 showed that the system is not ready to provide access for all during a global crisis."***

Others highlighted structural factors such as intellectual property rules and manufacturing capacity:

> ***"Intellectual property barriers and production capacity allow high-income countries to control access."***

Some respondents also emphasised the importance of stronger regional manufacturing and technology transfer to address these inequities. Together, these comments suggest that respondents see access challenges as rooted in structural power imbalances within global supply chains and innovation systems.

Implementation and service delivery

Quantitative findings

Responses relating to implementation highlighted both major achievements and significant operational challenges.

Respondents widely agreed with a statement on the impact of disease-specific initiatives:

- Major progress has been achieved through vaccination programmes and investments in HIV, TB and malaria (91%).

However, respondents expressed strong concern about the capacity of health systems to deliver services sustainably.

Statements with very high agreement included:

- The health workforce is burnt out, underpaid and under-resourced (93%).
- Community-based services are losing resources they previously had (89%).
- Stigma and criminalisation prevent some communities from accessing care (87%).

One of the strongest areas of disagreement concerned pandemic preparedness:

- A majority of respondents disagreed that the world is sufficiently prepared for the next pandemic.

This was the only statement in the survey with a negative consensus score, indicating that more respondents disagreed than agreed. This makes it the clearest and strongest signal of concern across all findings.



Qualitative insights

Many respondents highlighted the role of community health workers and civil society organisations in delivering services. However, they also emphasised the limited support these actors receive.

One respondent wrote:

> ***"Community health workers are essential to service delivery, but they are nowhere near sufficiently resourced."***

Others highlighted the exclusion of certain groups from health systems, including young people, persons with disabilities and marginalised populations. Several responses also emphasised the need for stronger integration between different areas of health and social policy. These comments suggest that respondents view implementation challenges as closely linked to governance and financing structures, rather than purely operational issues.

Cross-cutting insights

Across governance, financing, access and implementation, a number of cross-cutting themes emerged.

These included a perception of the present context as being defined by:

- Persistent power imbalances in global decision-making.
- Financial instability.
- Continued fragmentation of global health institutions, with responses to open-ended questions noting duplication of mandates, siloed disease-specific approaches, and weak coordination across actors.
- Insufficient community participation in governance and delivery.

One respondent summarised these concerns succinctly:

> ***"Agreements exist but lack enforcement. Financing flows but remains unstable. Coordination mechanisms function but fail to guarantee access. And service delivery is undermined by stigma, discrimination and workforce burnout."***

Taken together, the results suggest that many respondents see the current global health architecture as both successful in some areas and under significant strain in others.

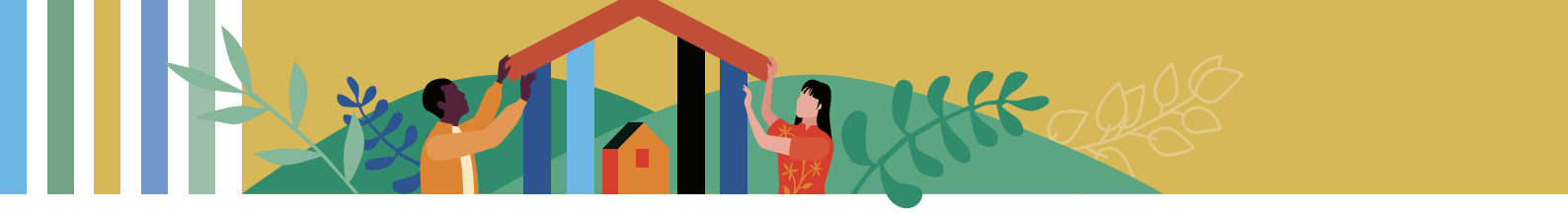
Reform Pathways: Key Findings

In this section, respondents were asked to rank five or six proposals for reform pathways in each of the four global health architecture domains (governance, financing, access to global public goods, and implementation). For the purposes of analysis, options ranked first or second were considered 'top tier.' A ranking in third through fifth positions does not mean that the option is not important or a priority. Rather, inputs ranked third or lower are interpreted as being deprioritised relative to the other options.

Governance reform: Polarised priorities, emerging directions

There was no single dominant reform priority in this domain, and mixed and/or polarised responses for three out of five options. Responses in this section affirm that civil society and impacted communities have diverse views, and suggest that an emerging distinction between reforms that focus on redistributing power within global health governance, which tend to produce more polarised responses, and those aimed at improving coordination between global institutions and national systems, which tend to generate broader but less intense support. These findings suggest that additional national, regional and global dialogue could be beneficial for surfacing underlying beliefs and assumptions, with the potential for identifying areas of clear consensus or divergence.

- A slim majority (53%) of respondents ranked **"collective bargaining model whereby regional entities or blocs aggregate country positions and negotiate with global institutions and funders"** strengthening collective negotiating power at the regional level as a top tier priority.
- The reform proposal to **"align all global support to costed national or regional health plans"** received moderate but broadly consistent support. While fewer respondents placed this proposal in their top tier (36%), it had the lowest level of opposition among governance options, with only 21% ranking it in the lower tier. This suggests that alignment with national planning processes is widely viewed as necessary, even if it is not seen as the most transformative reform.
- The proposal **"consolidate financing mechanisms like Global Fund and Gavi into one entity with shared governance and secretariat"** was highly polarising, with 49 percent ranking it among their top two priorities. However, this proposal was also highly polarising, with 42 percent of respondents placing it in the lower tier of priorities. Descriptively, support for consolidation appeared somewhat higher among respondents selecting disease-specific health areas such as tuberculosis (60%) and malaria (63%), compared with those selecting broader system-oriented areas such as universal health coverage (45%) and primary health care (47%). Since respondents could select multiple health focus areas, these patterns should be interpreted cautiously. This split may suggest differing views on whether institutional consolidation would strengthen coordination or risk undermining specialised mandates.



- The proposal to "**establish or strengthen civil society decision-making roles at global and regional level and with an emphasis on highly-impacted, marginalised groups"** also produced mixed responses. While 38% of respondents ranked it among their top priorities, 45% placed it in the lower tier. Importantly, respondents strongly prioritised community-based and -led services (see page 40). Together, these findings suggest consensus on an architecture that centers communities as the cornerstone of health equity, and less agreement, in the context of a ranked choice exercise, as to whether changes in decision-making roles is the top priority for achieving this outcome.

Options for governance reform pathways:

Shift to collective bargaining model whereby regional entities or blocs aggregate country positions and negotiate with global institutions and funders.

Consolidate financing mechanisms like Global Fund and Gavi into one entity with shared governance and secretariat.

Align all global support to costed national or regional health plans.

Integrate climate and health in national, regional and global planning and budgeting activities.

Establish or strengthen civil society decision-making roles at global and regional level and with an emphasis on highly-impacted, marginalised groups.



Financing reform: Strong support for increased domestic resourcing for health, diverse views on how this goal should be attained

A clear majority of respondents identified increasing domestic financing for health at the national level as a top tier priority. However neither of the two reform pathways for increasing this revenue (debt relief and reform of tax and tariff structures) were a top tier priority. Financing pathways designed to support equity (solidarity funds for key and vulnerable groups, investments centered on primary healthcare) were more frequently ranked in the lower tier. As participants noted in their open-ended responses, this question offered a heterogeneous set of inputs (i.e. the outcome of increased domestic financing), as well as pathways to attain this and, potentially, other outcomes (available financing, equity and holistic health provision). The responses clearly affirm that resource sufficiency at a national level is the top priority among the choices presented, and suggest that both the means of attaining this sufficiency, and the approaches to attaining equity in the context of this sufficiency should be explored independently.



- Across the sample, the strongest priority was **"increase domestic financing for health at national level".** Nearly seven in ten respondents (69%) ranked this proposal among their top two priorities, while only 16% placed it in the lower tier.
- The proposal to **"find or scale financing approaches that work in middle-income contexts and mixed-income regions"** was the second most prioritised reform, with 55% of respondents placing it in their top tier. Support for this proposal varied across regions. For example, around 70% of respondents in South Asia ranked it among their top priorities, compared with 54% in Latin America and the Caribbean and 57% in Eastern Europe and Central Asia, while support was lower among respondents identifying their scope as global (38%) and in the Middle East and North Africa (33%).
- Approximately one quarter of respondents placed **"remove or restructure debt burden"** among their top priorities, while a larger share ranked it in the middle or lower tiers. Several respondents acknowledged the importance of debt relief but suggested that such reforms fall largely outside the direct mandate of global health institutions.
- **Create "solidarity" funds for health administered by and for marginalised and criminalised groups** received the lowest level of top-tier support (11%), with nearly 80% of respondents placing it in the lower tier. In open-ended responses, several respondents described targeted mechanisms such as solidarity funds as important but dependent on wider financing reforms, while others raised concerns about feasibility, governance and sustainability.
- Proposals to shift funding away from fragmented vertical programmes toward system-wide and primary health care investments and to reform tax and tariff structures to increase revenue from large corporations were more frequently ranked in the lower tier, with 71% and 62% of respondents respectively placing these proposals in the lower tier of priorities. However, these results appear to reflect different underlying dynamics. For tax and tariff reform, a large proportion of respondents who ranked the proposal in the lower tier also reported limited familiarity, and qualitative responses suggest it was often perceived as complex, indirect, or politically difficult to implement. In contrast, qualitative responses on system-wide and primary health care investment suggest that lower rankings were less about unfamiliarity and more about concerns regarding implementation, scope, and trade-offs with other priorities, including the risk of underinvesting in specialised services or misinterpreting primary health care as a narrow delivery model. These findings suggest that lower-tier rankings reflect a combination of limited familiarity, perceived feasibility, and differing views on how these reforms would operate in practice.

Options for financing reform pathways from the survey:

Find or scale financing approaches that work in middle-income contexts and mixed-income regions.
Increase domestic financing for health at national level.
Remove or restructure debt burdens.
Create "solidarity" funds for health administered by and for marginalised and criminalised groups.
Shift funding away from fragmented vertical programs toward system-wide and primary health care-based investments.
Reform national and global tax and tariff structures to increase revenue from the wealthiest corporations to support health for all.



Coordination of Access to Global Public Goods: Strong support for regional platforms and a broadly scoped definition of global public goods

Nearly three quarters of respondents (72%) ranked the proposal to agree on a common definition of global public goods as a top tier priority, making it the most widely supported access reform in the survey. As shown below, this option included a list of elements that might be included in this definition. Many of the items are, in HEAR CSO's interpretation, an expansion of prevailing definitions that often center on medical countermeasures such as tests, vaccines or treatments. In the conceptualisation offered, data and surveillance systems, pooled procurement mechanisms and research and development all belong to, and must be jointly owned by, all global stakeholders, with a fair-share contribution approach. In the present, these elements are explicitly and/or implicitly controlled or shaped by national and/or funder and/or private sector interests. As with the financing domain, this question offered an outcome (an holistic, expansive definition of global public goods), along with actions that would improve access, primarily to biomedical interventions. However in this domain, regional coordination emerged as a clear "how," in relation to the "what" of global endorsement of a comprehensive definition of global public goods. Free-text responses provide additional context for these results. Many respondents emphasised that agreeing on a definition of global public goods is an essential first step for coordinated action. As one participant noted, "Without a good definition then you can't even start."

At the same time, several respondents stressed that practical supply challenges remain critical.

Comments highlighted the importance of technology transfer, regional manufacturing capacity and coordinated regulatory processes to ensure that licences translate into actual product availability.

- Support for the reform action of securing global agreement on an expanded definition of global public goods was high across respondents with different levels of familiarity with this domain of global health architecture. Among those who described themselves as very familiar with the reform pathway proposals, approximately 83% ranked the definition of global public goods among their top priorities. Similarly high levels of support were observed among respondents who were new to the topic or had heard of these debates but not in detail. This suggests that clarifying the concept of global public goods is widely viewed as a foundational step in reforming global health architecture.
- The second highest-ranked proposal focused on using regional platforms to coordinate licensing, regulatory approval and procurement, with 62% of respondents placing it in their top tier.
- Other proposals related to intellectual property and licensing mechanisms received more mixed responses. For example, around one fifth of respondents ranked the proposal to apply existing intellectual property flexibilities more consistently and collectively among their top priorities, while a larger share placed it in the middle tier.
- Proposals to coordinate licensing with regulatory approval and procurement and to grant licences to manufacturers capable of producing in the region received relatively lower levels of top-tier support and higher levels of lower-tier rankings.

Options for coordination of access reform pathways from the survey:

Agree on a common definition of global public goods—data and surveillance, norms and standards, R&D, pooled procurement, and mechanisms for equitable access—through fair-share contributions by countries, private sector and philanthropy.
Use regional platforms to coordinate licensing, regulatory approval, and procurement.
Apply existing intellectual property flexibilities more consistently and collectively.
Coordinate licensing with regulatory approval and procurement so products can be made, approved, and bought without long delays or gaps.
Grant licences to manufacturers that can actually produce in the region (rather than licences that exist on paper but don't lead to supply).



Implementation and Service Delivery: Strong support for community-led services embedded in national systems

Respondents were asked to rank five proposals related to strengthening implementation and service delivery within the global health architecture. In this domain, sixty percent respondents selected community-led and -designed services, including for marginalised groups, as a top-tier priority, with additional prioritisation of national delivery platforms for all investments. This preference for nationally-owned, community-led services strongly aligns with the HEAR CSO regional consultations. More specific reform pathways, such as law and policy reform, shifts in approaches to workforce support, and a primary health care platform were comparatively less prioritised, however in open-ended questions, respondents emphasised the importance of these longer-term structural reforms.

- Support for community-led services was consistent across respondents with different levels of familiarity with proposals for reform of service delivery and implementation debates. Approximately 64% of respondents who described themselves as very familiar with the proposals ranked community-led services among their top priorities, alongside similarly high levels of support among those who were somewhat familiar or less familiar with the proposals. This suggests that community-led service delivery is widely viewed as a central component of effective health system implementation.
- The proposal to use national delivery platforms, data systems and workforces for all health investments also received strong support, with 55% of respondents placing it in the top tier. Several qualitative responses emphasised the importance of avoiding parallel systems created by donor programmes and instead strengthening national service delivery platforms.
- The proposal to strengthen primary health care as the delivery backbone received moderate support, with 44% of respondents ranking it among their top priorities. Respondents frequently emphasised the importance of primary care as a foundation for integrated health services, although some noted that strengthening primary care must also be accompanied by investments in broader system capacity.
- Two proposals received comparatively lower levels of top-tier support: reforming stigmatising and criminalising laws that prevent people from accessing health care, and funding long-term workforce and management capacity rather than short-term technical assistance.
- The proposal related to legal reform was frequently placed in the middle tier (42%), suggesting that respondents recognise its importance. Qualitative responses consistently emphasised that legal and policy reform is essential for enabling equitable access, particularly for marginalised and criminalised groups. However, respondents often positioned it as a longer-term or upstream action, which may explain why it was less frequently prioritised above more immediate service delivery reforms.

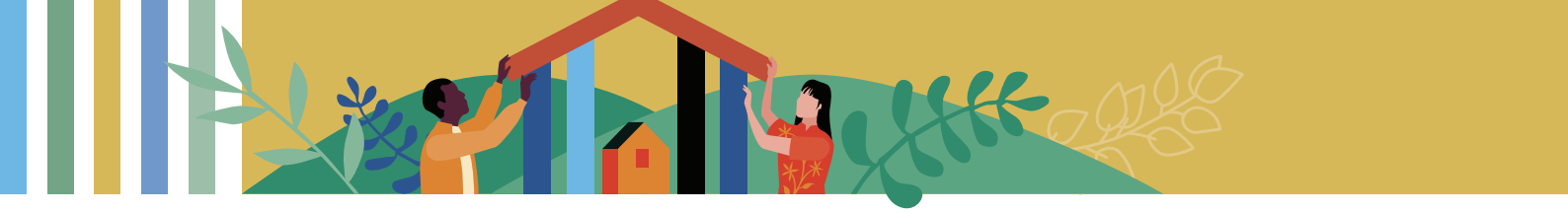
- In contrast, the proposal to fund long-term workforce and management capacity was more often placed in the lower tier (67%). Qualitative responses suggest that while respondents acknowledge its importance, they tend to prioritise more immediate investments in service delivery and community-led programmes, particularly in contexts where systems face acute delivery gaps. This could suggest that lower rankings reflect differences in perceived immediacy and implementation pathways, rather than disagreement with the underlying importance of these reforms.

Taken together, the results suggest that respondents prioritise implementation reforms that strengthen community leadership, service delivery capacity and integration with national systems, while recognising that broader structural reforms related to legal frameworks and workforce development remain essential for long-term system resilience.

Options for implementation and service delivery from the survey:

Use national delivery platforms, data systems and workforces for all health investments.
Ensure sufficient funding for community-led and -designed services including community health workers and/or for programs led by and for marginalised, stigmatised or criminalised groups.
Reform stigmatising and criminalising laws, policies and practices that prevent people from accessing health care with dignity.
Strengthen primary health care as delivery backbone.
Fund long-term workforce and management capacity, not short-term technical assistance.





Discussion

Key Findings

HEAR CSO's survey and consultations gathered a diverse, vibrant and vital array of inputs from civil society and members of communities impacted by health inequities. There is strong consensus across the platforms for engagement that the current global health architecture has delivered meaningful results and, at the same time, that the present moment places these gains at risk, with massive funding losses, rising instability due to climate, conflict, authoritarianism all named as contributing factors.

In looking toward the future, participants were strongly aligned on the need for transformative actions, with varied views on the proximate steps to take to achieve this transformation. The clearest priority across platforms for input was a call to expansively redefine and reframe the concept of global health architecture, with the virtual consultations offering ambitious visions, and the survey respondents focusing on a capacious conceptualisation of public goods for health that includes data sharing, surveillance and procurement systems, along with biomedical tools and countermeasures.

Significantly, this conceptual shift could, in theory, be attained by existing global health institutions and stakeholders. It is a change in framing that would lead to new funding flows and action agenda. At this moment in time, the individuals who engaged in HEAR CSO's consultative platforms prioritised redefinition of the purpose over renovation of the global health architecture. There is a need to continue and extend dialogues and conversations about specific aspects of GHA reform to bring civil society and impacted communities' views to bear on particular proposals. However these findings affirm that the proposals and processes should "begin with the end in mind" and undertake systemic shifts in order to attain a truly transformed, equitable future.

> ***At this moment in time, the individuals who engaged in HEAR CSO's consultative platforms prioritised redefinition of the purpose over renovation of the global health architecture.***

Much work needs to be done to ensure that civil society and impacted communities are included in these proposals and processes. The HEAR CSO engagements also find that the overwhelming majority of participants have not been part of processes and consultations, other than those convened by HEAR CSO, that directly engage with reform proposals. This is a significant, striking gap that should be closed with every global, regional and national process going forward.

HEAR CSO identifies the following findings as core outcomes of our work to date:

- Strong support for three pillars of a transformed global health architecture reform.
  - An expansive definition of "global public goods" for global health encompassing data collection and surveillance systems, research and development, procurement mechanisms and much more.
  - Robust regional platforms for agenda-setting, negotiation and procurement, enabling countries and regions to exercise greater collective bargaining power in global health governance.
  - Health systems supported by increased domestic resources and centered on community-designed and -led services that leave no one behind.
- Alignment on ambitious, holistic transformation; diverse views on short-term, institutional reforms.
  - Specific reform pathways such as institutional mergers to reduce fragmentation or broader application of existing intellectual property flexibilities were lower priorities than overarching shifts in resourcing, conceptualisation and service delivery approaches.
  - Some reform pathways were polarising–with significant proportions of respondents ranking the same option as a high or low priority.
- A significant gap between civil society and impacted communities' interest and readiness to engage in global health architecture reform and access to reform processes.
  - HEAR CSO found high levels of enthusiasm for and interest in engagement in global health architecture reform.
  - Consultation participants consistently affirmed the relevance and timeliness of the conversation, with regionally varied feedback about how to frame or approach the topic.
  - A readiness index constructed from respondents' familiarity with global health architecture concepts, institutions and reform processes suggests that 73% of respondents fall into moderate or high readiness categories, while 34% fall into the highest readiness category.
  - Only 8.5% of respondents reported clear participation in processes explicitly framed as global health architecture reform, although 15% reported engagement in related governance or policy processes.



Lessons Learned, Gaps and Limitations

Demographics

In HEAR CSO's engagements to date, youth, frontline workers and professionals in early stages of career development are under-represented. In geographical reach, HEAR CSO has engaged fewer participants from Latin America and the Caribbean, and the Middle East and North Africa.

Methodologies

The Causal Layered Analysis methodology used in regional consultations did not pre-specify particular pathways to achieving change, and encouraged participants to imagine a preferred future ten years from the date of the convening. This led to rich, deep and, according to some participants, satisfying explorations of future states at a remove from the crisis-laden present. For other participants, the request to project a decade ahead felt mis-aligned with the daily struggles to maintain resources for continued advocacy and engagement. There was also variability in participants' ability to complete the full 2.5 hour consultation, and in groups' interest in using the tools developed to capture inputs, versus engaging in open conversation. The Project Team leading the consultations adapted the methodology after the first consultation and continued to work with regional partners to identify fruitful approaches. This led to a heterogeneity reflective of priorities and interests, rather than complete fidelity to the same approach in every instance.

In order to make the Survey both meaningful and analyseable, the Project Team opted not to recreate the CLA-based approach but instead to develop a set of statements and proposals reflecting both consultations and widely-circulating reform proposals. In selecting inputs, the Project Team intentionally opted for statements that operated at multiple levels—global, regional and community-based, and at different scales—holistic change versus incremental shifts. In open-ended responses, survey respondents noted that the heterogeneity of options within a given category made prioritisation, in particular, more challenging.



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Principles for Global Health Architecture Reform Processes and Outcomes

The HEAR CSO Steering Committee has analysed the consultation and survey inputs and used them as the basis for a set of core principles for all global health architecture reform processes and outcomes.



1. Equity as the ultimate goal

Begin with a preferred equitable future, not just a reaction to the present inequitable context. Equity in access to health for all must be the objective.



2. Transparent, inclusive, joint decision-making

Everyone contributes, everyone decides, everyone benefits. All stakeholder groups must have an equal say in governance design, process and outcomes. Institutions and processes must not repeat or reinforce traditional power imbalances between donors and implementers in the global North and global South. Funder-driven agendas must be replaced by agendas shaped through national and regional processes and platforms that support geographic self-determination and sovereignty through structures that meaningfully include civil society and communities impacted by inequities.



3. Multisectoral representation, governance and scope

Effective health responses must engage stakeholders beyond the health sector. An effective global health architecture must reflect and engage with the environmental, social, legal, economic and commercial determinants of health, and the reality that mental, physical, animal, and planetary health are intertwined. The future global health architecture must reflect this reality through a clearly defined scope, expansive inclusivity, cross-sectoral collaboration, and integrated plans and action.



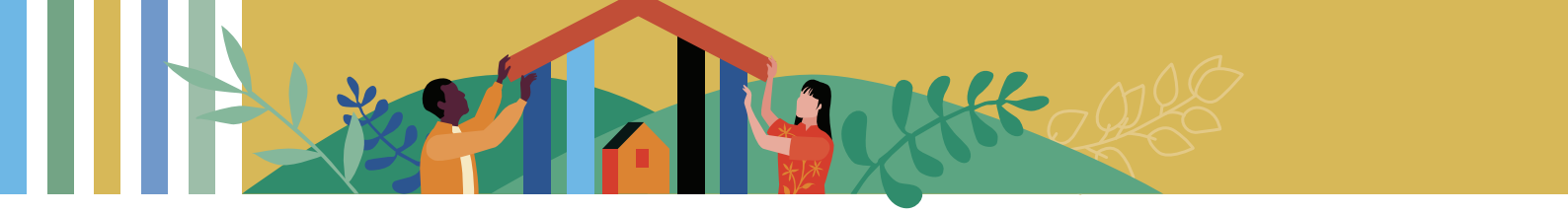
4. Leadership and decision-making roles for communities heavily impacted by health inequities

Communities and people impacted by health inequities must be recognised as a distinct expert stakeholder group alongside civil society organisations and should be central, resourced partners with leadership roles and decision-making authority within global health architecture.



5. Financing and access arrangements aligned with equity and continuity

Global health architecture must include financing arrangements that are: aligned with nationally led plans and priorities; flexible; catalytic; supporting continuity and expansion of access to essential services, particularly for the most marginalised and vulnerable populations; and enabling the direct and predictable resourcing of community-based organisations.



Reform processes following these core principles also require the following underlying and enabling conditions:

- **Sustainability, resilience, and continuity during transition.**
  Global health architecture reform is taking place in the context of institutional change, funding contractions, and geopolitical instability. Continuity and expansion of access to affordable, accessible, acceptable and quality health care, and mechanisms for civil society and impacted community to hold duty bearers accountable during periods of transition are essential. Financing rules and eligibility criteria must avoid transitions that undermine equity or disrupt and prevent participation and access.
- **Protection of civic space and community actors.**
  Meaningful participation, accountability, and service delivery depend on the protection of civic space and voices and the safety and legitimacy of all civil society and community actors.

The HEAR CSO steering committee has also developed specific recommendations for the WHO-led joint process on global health architecture reform. For these recommendations, HEAR CSO relied on both the findings to date and on organisational experiences with WHO-led processes such as the ACT-A platform and other governance structures for global health institutions.





Key considerations for the WHO-led joint process on global health architecture reform:

The process design phase leading up to WHA 2026 must:

- Ensure inclusive, transparent, accountable and joint decision making. HEAR CSO endorses the principles WHO has shared as guides for the process development phase from March-May 2026, including that it should be 'a joint process', based on 'inclusivity', 'transparency', and 'equity and solidarity'.
- Engage people and communities impacted by health inequities to directly inform and endorse the process. Civil society engagement in global health architecture reform processes to date has often centered on professional associations, NGOs, academics and research groups, all of which contribute invaluable expertise. Of the 285 individuals who completed HEAR CSO's Global Survey on the Future of Global Health Architecture, 73 percent were at moderate to high levels of readiness to participate in these processes, yet only 8.5 percent reported participating in spaces specifically focused on global health architecture reform. Individuals from these civil society groups may or may not have direct, lived experience with health inequities, and meaningful engagement of members of these communities is essential. The process should allow for the involvement of the full diversity of civil society and communities around the world across the full range of health issues and deliberately create spaces for members of marginalised, criminalised and stigmatised groups to safely and confidentially share experiences and insights that might incur risk for the individual if brought forward to the government of the country in which they live or hold citizenship.
- In line with the commitment that this should be a fully inclusive process, consultations must not be limited to WHO structures and WHO-validated organisations. In the context of civil society and communities this means that consultations must go beyond the WHO Civil Society Commission and those civil society organisations that have designation as non-state actor in official relations. Consultations should be co-led by and for civil society and impacted communities engaged across the whole global health architecture.
- Establish clear, transparent communications channels between WHO leadership for this process and CSOs and impacted communities. These channels should ensure that civil society and communities impacted by health inequities have timely access to updates, opportunities to lead and engage in dialogues, review and finalisation discussions.
- Include clear conflict of interest safeguards for health-harming industries such as tobacco, alcohol, fossil fuels, unhealthy foods. Conflict of interests for health industries including pharmaceutical and private health insurers, that may be driven by profit above impact in certain cases, should also be declared. Broad and inclusive non-state actor engagement in this process is essential, as many representatives of civil society and communities impacted by health inequities do not have access to WHO deliberations through formal channels. As participation expands to non-state actors outside WHO structures, building on the Framework of Engagement with Non-State Actors (FENSA), it is imperative to explicitly exclude entities linked to health-harming industries.



- Establish an inclusive, impartial, transparent decision-making structure and accountability framework. This must ensure the meaningful inclusion of low- and middle- income countries, and specifically civil society and impacted communities. Decision-making involvement should be documented and shared back with transparency, so that there is clarity about who has been involved, how, with what suggestions or recommendations and which action.

The formal joint process initiated after WHA 2026 must:

- Reflect real ambition and be designed to generate ideas for, and support implementation of, holistic transformation.
- Prioritise process over speed. Lessons from ACT-A clearly show that when WHO-initiated ad-hoc processes and structures are established at speed, there is a danger that this can work against inclusion, transparency and accountability.[4] The stated objective of completing the process between World Health Assembly 2026 and the 2027 gathering can be used to structure planning, but this ideal timeframe should not be used as a rationale for abbreviated, non-inclusive processes and structures.
- Maintain and expand the inclusivity and accountability approaches undertaken in the process design phase. Specifically:
  - Prioritise the participation and leadership of low- and middle-income country stakeholders, including impacted communities and civil society, ensuring, at minimum, their equal voice to representatives from high-income countries.
  - Ensure broad diversity across all stakeholder groups. WHO is led by Member States whereas this is being presented as a jointly driven inclusive multi-stakeholder process. Government representation is necessary but not sufficient. Moreover, sovereignty agendas articulating the need for national and regional health governance must consistently and clearly recognise the role for civil society and communities impacted by health inequities as leaders, experts and crucial constituencies whose experiences overlap with and are distinct from governments.

> ***Prioritise the participation and leadership of low- and middle-income country stakeholders, including impacted communities and civil society, ensuring, at minimum, their equal voice to representatives from high-income countries.***

4 https://covid19advocacy.org/acta-key-lessons/



Conclusion

The HEAR CSO consultations created space for civil society organisations and communities impacted by health inequities in seven regions to collectively examine the current global health context and articulate preferred futures for global health architecture. Through shared reflection and regional dialogue, participants surfaced common challenges, distinct regional realities, and underlying assumptions shaping governance, financing, coordination, and service delivery. While this is the conclusion of this document, it is the beginning of a process. The inputs shared here reflect diverse views, unanswered questions, regional variation and differing levels of familiarity with reform pathways currently under discussion. It is imperative that these findings be used as a starting point for expanded, deeper work by civil society and impacted communities to discuss, debate and develop analyses that drive development of a more equitable, participatory, and resilient global health architecture.



About HEAR CSO

HEAR CSO is steered by a diverse consortium of civil society and community networks and organisations comprising of Civil Society Engagement Mechanism (CSEM) for UHC2030, Global Fund Advocates Network (GFAN), Global Network of People Living with HIV (GNP+), International Treatment Preparedness Coalition (ITPC), STOPAIDS, Noncommunicable Disease (NCD) Alliance, and WACI Health. Collectively, we operate at global, regional and national levels across a very broad range of health issues and will use our extensive networks and partnerships to ensure as diverse a representation as possible in the consultations.

HEAR CSO is committed to working collaboratively, transparently and equitably with the diverse members of civil society and communities impacted by health inequities all around the world to develop and advance a shared agenda for meaningful change.

To learn more please visit: www.hearcso.org.
To share feedback, ongoing work or get involved, reach out: info@hearcso.org

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