Health Architecture Reimagined

Civil Society Organizations

A collaborative global civil society initiative
focused on the future of global health

Participant Resource

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About the HEAR CSO Consortium

Climate change, funding shortages, and ongoing and emerging outbreaks and pandemics are challenging the current global health architecture. Discussions and decisions about the future of global health will not be complete, effective or bold without the input of civil society. It is critical that diverse civil society stakeholders are included from the beginning, so that new approaches are inclusive, equitable, and responsive to communities. This is particularly true for communities most likely to be marginalised or excluded from the processes that will determine the future of global health.

As new multi-stakeholder processes are launched to discuss the future of development, financial, and global health architectures, it is critical that all key groups are included from the beginning, particularly those that have historically been excluded or under-represented. Some global health institutions and processes, within global health, have a strong record of involving civil society and communities in governance and decision-making. But this is by no means automatic, and recent examples show that meaningful civil society and community involvement still needs to be advocated for and won.

Against this backdrop, the Health Architecture Reimagined Civil Society Organizations (HEAR CSO) Consortium was formed to support communities and civil society across sectors and regions. Through consultations, collection and sharing of information, and collaboration, HEAR CSO will amplify civil society views to shape the future global health architecture.

The HEAR CSO Consortium is led by CSEM, GFAN, GNP+, ITPC, NCD Alliance, STOPAIDS, and WACI Health. From September 2025 to May 2026, HEAR-CSO will work with global collaborators to collect and share diverse views on preferred futures of the global health architecture. Our work will include two global consultations (virtual), ten regional consultations (virtual), national consultations, a global survey, and an online information hub including resources on ongoing processes and reports from our convenings.

HEAR CSO does not aim to produce one single global consensus statement. Instead, we seek to support dialogues and share outputs that reflect diverse perspectives and priorities, including areas of overlap and divergence within and across civil society. Our goal is to ensure that civil society and communities at global, regional, and national levels can develop and share their own visions for the future of the global health architecture. We aim to make these reform processes more inclusive, equitable, and responsive to their needs.

About this document

This resource gives an overview of the definitions, trends and themes that the HEAR CSO Consortium steering committee has developed in the process of developing our approach. We welcome new ideas, insights, and perspectives as the consultations progress. This resource is designed to start and support dialogue, not to serve as a final analysis. It is designed to be used by participants in HEAR CSO consultations and our survey, and to support civil society engaging in other ongoing processes convened by governments, philanthropies and other stakeholders.

HEAR CSO is also developing a companion resource focused on the history of global health architecture and the role of civil society groups and communities in it. This companion resource is designed for civil society to advocate more effectively for inclusion in multi-stakeholder spaces.

Defining Key Terms

Global Health

The HEAR CSO Consortium defines global health as the field of study, research, and practice concerned with health equity everywhere.
We understand that, like any social concept, the meaning of global health keeps evolving. In developing our definition, we considered the widely cited 2009 framing, which defines global health as 'an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide.'[1] Work in this arena covers financing, socioeconomics, gender dynamics, and the social, political and legal elements needed to realise fundamental human rights.

We recognise that the geographic reach of global health is also political, and it can shift depending on the context. In some contexts, "global" refers mainly to low- and middle-income countries (LMICs), which can make the term difficult to use. For example, when someone from an LMIC works in their country's health system, is that global or public health? Or does "global health" only apply when someone from a high-income country (HIC) plays that role? Likewise, is addressing the high HIV prevalence within African American and Hispanic communities in the United States, or the health concerns of indigenous people in Canada or Australia considered global health?[2] HEAR CSO supports the definition suggested by Dr Abimbola, who writes, *"While international health focuses on helping LMICs, global health is about health equity everywhere, including within HICs, such that a paper addressing, for example, indigenous health equity in Australia is eligible for consideration in a global health journal."*

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1 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60332-9/fulltext

2 https://academic.oup.com/inthealth/article/10/2/63/4924746

While we affirm the global nature of the term, we also emphasise the need to address inequities so that everyone can access the health care they need, regardless of geography, race, class, sex, gender identity, caste, or another factor.

Global Health Architecture

The HEAR CSO Consortium defines global health architecture as the systems, structures, institutions, rules, and processes that collectively guide, coordinate, finance, and implement efforts to improve health on a global scale.

We have adapted this overall definition from the Wellcome Trust's ongoing global and regional work on the future of global health architecture. Our framework combines ideas from several sources, and is designed to be flexible, reflects current thinking and capable of evolving as our consultations continue.[3]

Guidance and Governance	Coordination of Global Public Goods Access	Financing	Implementation and Delivery
Relates to how a health system is governed, and focus on issues such as policy authority, organisational authority, commercial authority, professional authority and about how stakeholders are involved in health systems decisions and on what terms. Approaches to management of cross-border externalities, including disease surveillance, reporting and outbreak and pandemic response are also addressed in this arena.	Development of new health products, international norms and standards, IP, knowledge generation and sharing, global surveillance, policy and implementation research, market shaping, risk shifting	Relates to how finances flow through health systems, and focus on how systems are financed, types of funding organisations, how to remunerate providers, how products and services are purchased and the incentive structures for consumers	Relates to how health services are delivered, accessed and catered to meet local priorities, and focus on factors that determine how care is designed to meet consumers' needs, by whom care is provided, where care is provided and with the supports used to those providing and receiving care

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3 Hoffman and Cole Globalization and Health (2018) 14:38 https://doi.org/10.1186/s12992-018-0340-2

Global Health Actors

HEAR CSO adapted the list developed by Frenk and Moon[4], which has guided many large-scale analyses of global health architecture. We have added more detail about the different types of civil society organizations.

National governments	Ministries of health, ministries of foreign affairs
Public research funders	US National Institutes of Health
Bilateral development cooperation agencies	US Department of State, UK Department for International Development, Norwegian Agency for Development Cooperation
UN System	World Health Organization, UN Children's Fund, UN Population Fund, Joint UN Programme on HIV/AIDS (UNAIDS)
Multilateral development banks	World Bank
Regional Development banks	
Multilateral Initiatives and Institutions	GFATM, Gavi, the vaccine alliance, UNITAID
Philanthropic Organizations	Gates Foundation, Wellcome Trust
Global civil society organizations and NGOS	Medecins Sans Frontieres (Doctors without Borders), OXFAM, Care International
Community-led organizations	Organisations led by people with lived experience of a particular health condition or health inequity. They can be involved in service delivery, research or advocacy. There are various approaches to defining the types of community-led organizations in order to leverage their expertise.[5]
Domestic NGOs	Non-governmental organisations that work in the country in which they are based.
Private industry	Pharmaceutical manufacturers
Professional associations	World Medical Association
Academic institutions	

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4 Frenk J, Moon S. Governance challenges in global health. N Engl J Med. 2013 Mar 7;368(10):936–42. doi: 10.1056/NEJMra1109339. PMID: 23465103.

5 https://www.dataetc.org/resources/docs/SCOPE%20Report.pdf

HEAR CSO Analysis – In Brief

Situational analysis: The recent past and present of global health architecture

In each HEAR CSO Consortium consultation, participants will share and reflect on a joint situational analysis of the current moment. Consortium members developed this summary to show you our own analytic framing and the urgency behind these dialogues.

Over the past 25 years, global health architecture has been dominated by multilateral, partnership-based approaches focused on results, often with disease- or topic-specific siloes. United Nations Member States recognized and supported a globally-functioning system for disease surveillance and information sharing helmed by the World Health Organization (WHO). There was widespread, hard-fought and constantly re-negotiated recognition of the value of civil society and impacted communities in designing and delivering effective responses.

Virtually every aspect of this system was gravely challenged by the COVID-19 pandemic. The global health system has been in flux ever since, with new initiatives and international agreements, such as the Pandemic Accord, emerging as responses. More recently, though, the state of change has become a state of threat, with severe and often abrupt funding cuts to multilateral entities, a retreat by the US—historically the largest funder of global health investments—from parts of the international community, and a wider funding crisis at the United Nations. These shifts could dramatically reshape the identities and scopes of work for UN agencies such as UNAIDS, UNFPA, and UNICEF, which have played key roles in health-related arenas over the past quarter century or more.

Summary of forces changing global health

The HEAR CSO Consortium identifies the following as the main forces shaping global health—the conditions that either worsen or reduce inequities in health worldwide.

People: Demographic & Social Transitions
• Rapid population growth in LMICs, while many HIC populations have a growing elderly population and reduced birth rates. • Urbanisation and the push towards "smart" sustainable cities concentrating health risks and increasing demand for services. • Shifts in disease burden toward non-communicable diseases (NCDs) and mental health challenges, while infectious diseases persist. • Rising inequalities in access to care, nutrition, and safe environments. • Rising migration and displacement driven by conflict, climate, and economic pressures.

Planet: Climate & Environmental Change

- Climate change reshaping disease patterns such as heat stress and vector-borne diseases.
- Extreme weather events that are causing drought, famine, fire, humanitarian disasters and health emergencies.
- Air pollution, food insecurity, and biodiversity loss are worsening global health outcomes.
- Growing focus on climate-resilient health systems and integration of climate and health financing.

Power: Globalization, Geopolitics & Governance

- Multipolar world order (China, BRICS members, and Gulf states) shifting global health diplomacy and financing.
- Growing tension between national security/self-interest and global solidarity, seen in issues such as vaccine nationalism.
- Declining trust in science and public health institution
- Increasing pressure to decolonise global health and give LMICs a stronger voice in decision-making and governance.

Technology: Digital, Data & Biotech Revolution

- Digital health (telemedicine, AI diagnostics, and big data) transforming surveillance and service delivery.
- Mobile money and Fintech enabling new and innovative health financing models.
- Biotech breakthroughs, such as (mRNA vaccines, genomics, and personalised medicine).
- Risks: digital divides, data privacy, and inequitable access.

Finance: Economic Pressures & New Models

- Debt distress and austerity are limiting fiscal space for health in many LMICs.
- Major retreats in government foreign aid for health including abrupt transitions in US government approach, retreats by other government funders while promoting a shift from donor aid dependence towards domestic resource mobilisation and "self-reliance."
- Increasing attention to innovative financing, including blended finance, impact investing, and outcome-based funding.
- Rising role of multilateral development banks and emphasis on climate-health finance integration.

Health Security: Emerging & Persistent Threats

- COVID-19 revealed systemic gaps in preparedness and equity and triggered attempts at various pandemic preparedness actions including reform of the International Health Regulations and the Pandemic Accord.
- Ongoing outbreaks, such as including mpox, influenza viruses, and COVID-19, highlight the need for global disease surveillance, data sharing, and pathogen access, even as the US government retreats from collaboration.
- Growing threat of antimicrobial resistance (AMR) undermining modern medicine.
- Major gaps in financing for global public goods for pandemic preparedness,

Summary of potential outcomes of a re-imagined global health architecture

Digital Health & Data Systems that Support Health Equity

- Wider use of AI, big data, and predictive analytics for disease surveillance and outbreak forecasting.
- Expansion of electronic health records (EHRs) and telemedicine, especially in low-resource settings.
- Development of global health data-sharing platforms.

Stronger Pandemic Preparedness

- Development of stronger global early-warning systems.
- Expansion of vaccine manufacturing hubs in Africa, Asia, and Latin America.
- Investment in stockpiles of essential medical supplies and systems for rapid deployment.

Localisation & Decentralisation

- Moving towards regional health hubs, such as Africa CDC, ASEAN health networks.
- Training and supporting community health workers to reach rural and underserved areas.

Climate Resilience

- Recognising prevention and treatment of health threats as a crucial component of effective strategies for addressing climate change. .
- Building climate-resilient hospitals and health facilities.
- Integrating environmental monitoring into health systems.

Global Health Equity & Access

- Greater focus on decolonising global health by shifting decision-making power.
- Programmes that ensure equitable access to vaccines, diagnostics, and treatments.
- More emphasis on gender equity in the health workforce and leadership.

Effective Public-Private Partnerships (PPPs)

- Pharmaceutical companies, NGOs, and governments working together more closely.
- Private sector innovation, especially health-tech, is being integrated into public health systems.

Integrated "One Health" Approach

- Linking human, animal, and environmental health to tackle zoonotic diseases.
- Strengthening collaboration across sectors, such as agriculture, veterinary science, and public health.

Expanded & Innovative Funding

- Shifts toward sustainable domestic financing, rather than reliance on foreign aid.
- Use of pandemic bonds and innovative insurance mechanisms to fund rapid responses.

Summary of Relevant Movements

Many of the HEAR CSO Consortium members have explored and worked on the following movements and approaches, which may inform and strengthen the collective effort to re-imagine global health architecture. We summarise these approaches to acknowledge existing work, identify others to share relevant efforts to re-balance power between the Global North and Global South.

Debt Justice: The debt crisis began when conditional loans from the World Bank and IMF forced many low- and middle-income countries to liberalise trade and decrease social spending. Debt justice seeks to end exploitative lending practices and cancel unjust debts. Today, at least 23 low-income African countries face a debt crisis, together owing more than $68.9 billion in external debt payments. This crisis directly affects global health because it diverts public resources away

from health and social spending. Christian Aid reports that more than 60% of African countries spend more on external debt payments than on health and education.

Reparations and reparative justice: Reparations began by acknowledging historic wrongs and taking responsibility for them. Global reparations have gained increased international attention in recent years, though related campaigns have existed for centuries. Recent movements link reparations not only to the legacies of slavery and colonialism, but also to issues like climate change, debt, and ongoing financial transfers from the Global South to the Global North.

Reparations and reparative justice take many forms. The Asian People's Movement on Debt and Development calls for the immediate cancellation of illegitimate debts. Economist Ndongo notes that reparations also include economic sovereignty, allowing formerly colonised countries to trade in their own currencies. The CARICOM (Carribbean Community) Reparations Commission has a 10-point action plan, currently being updated, aimed at European Governments responsible for exploitation during the slave trade and colonial era. The plan includes: a full formal apology; support for addressing public health crises; stronger historical and cultural exchanges; psychological healing for intergenerational trauma; the right to development through access to technology; and debt cancellation and monetary compensation.

Reparations are also discussed at national levels. For example, see the information NAACP's work on reparations for African Americans in the United States

Tax Justice: Tax justice promotes equality and social fairness through fair taxation of wealthy individuals and multinational corporations. It focuses on reducing tax evasion, closing tax havens, and limiting corruption and abuse by multinational corporations and the super-rich.

For example, South Africa's mining industry has lost $329 billion to capital flight over the last five decades. Practices such as mis-invoicing, embezzlement and tax evasion allow some corporations and wealthy individuals to increase their wealth at the expense of governments, communities, and local businesses.

GPI: Global Public Investment, or GPI, is a new approach to international public finance for sustainable development that benefits everyone. GPI is based on three key principles: all contribute, all decide, all benefit — known as the three 'C's:

- Universal Contributions. GPI moves beyond the broken promises and patronising language of the current international order, where "donor" countries give to "recipient" countries. In its place, it introduces an all-contributor approach to international public finance.
- Ongoing Commitments. GPI ends from the flawed insistence that countries "graduate" after achieving a relatively low level of income per capita. We need to dramatically expand our time-scales and begin thinking longer-term.
- Representative Control. To ensure (1) and (2), GPI questions the entrenched power relations associated with ODA. It means a more democratic and accountable approach to the way international public finance is governed.

Solidarity Levies: These involve taxes on goods and activities that drive climate change or exploitation, such as fossil fuels, air travel, plastics, and financial transactions. The Global Solidarity Levies Task Force (For People and the Planet) launched at COP28 in November 2023, co-chaired by Barbados, Kenya and France, to advance ideas on international levies. The aim is to raise much new revenue to fight climate change, support sustainable development and conservation, and help meet its Paris Agreement commitments.

UN reform: Since its creation after the Second World War, the United Nation system has faced regular criticism and introduced reforms to stay relevant and effective. The latest reform process was initiated by UN Secretary-General António Guterres, who has promoted change since the beginning of his term in 2017.

In development, this means new country teams led by resident coordinators. Management reforms aim to empower staff, simplify processes, increase transparency, and improve delivery of UN mandates. In peace and security, reforms aim to make peacekeeping and political missions more effective and to align them more closely with development and human rights.

Africa has called for reform of the United Nations Security Council (UNSC) to include one or more African permanent members. This is part of a wider push to decolonise the Council's composition. On 13 August 2024, UN Secretary-General António Guterres called for Africa to have one permanent seat. The US later supported two permanent seats (without veto power). The timeline for these changes remains unclear.

About the Consultation Methodology: Causal Layered Analysis

The HEAR CSO Consortium is using a futures-thinking approach called Causal Layered Analysis (CLA), created by Professor Sohail Inayatullah. This approach has been, and is, used around the world to engage stakeholders from many sectors and support better decision-making. We selected this methodology because it's flexible and inclusive. CLA recognises that there is not one single future, there are many possible futures shaped by the actions and decisions we take today.

The CLA method looks at four interconnected layers of understanding:

Term	Simple definition	Example
Soundbite / Story	A short statement that you think is pervasive or repeated about global health.	"We are not prepared for the next pandemic."

Source / Explanation	Evidence or information that is used to support this story (news, data, report, observation).	"The Global Fund budget was cut last year."
Worldview / Reason	The broad systems of culture, beliefs and distributions of power, resources and knowledge that make shape the information you've offered as an explanation.	"Funding decisions are controlled by donors."
Metaphor / Deeper story	A belief, image, or symbol that underpins this worldview—that might not be conscious or articulated, but which underpins it nonetheless.	"Global health financing is a pie that cannot feed everyone."

Participants will be asked to share their reflections for the current context before each consultation. Each consultation will begin with a collective review of the group's situational analysis. We will then move into a future-focused session to imagine preferred outcomes, with time to explore specific areas of global health architecture defined earlier in the document. Finally, participants will come back together to discuss the pathways to make these futures a reality. The outputs from each consultation will be shared with participants for feedback and validation, and published — anonymised and de-identified— on the HEAR CSO website: hearcso.org