

Output Summary: HEAR CSO South Asia Consultation 27 October 2025

Background

The Health Architecture Reimagined Civil Society Organizations Consortium (HEAR CSO) launched in September 2025 with the goal of creating forums for civil society working across health topics and domains of global health architecture to discuss and explore visions for the futures of global health architecture. HEAR CSO is convened by diverse groups including the Civil Society Engagement Mechanism for UHC 2030, the Global Network of People living with HIV, International Treatment Preparedness Coalition, Noncommunicable Diseases Alliance, Stop AIDS UK and WACI Health. Through 10 regional consultations, global and national engagements, HEAR CSO is generating visions and priorities to support civil society engagement in multistakeholder processes. This summary was created for participants in the 27 October Consultation.

Approach

The outcomes summarized in this document are based on the “Causal Layered Analysis” (CLA) approach. HEAR CSO developed a toolkit and methodology based on CLA for its consultation because of CLA’s ability to help surface transformative solutions. Instead of simply reacting to the current state of the world, CLA invites teams to question existing narratives, reframe problems, and envision alternative futures. For example, while a Problem Tree Analysis might identify a lack of health facilities in rural areas as a *cause* of poor health outcomes for some populations, CLA would take this further by asking ‘*What institutional systems contribute to this lack of health facilities?*’, ‘*What societal beliefs about health or rural communities might limit equitable access?*’, ‘*What cultural narratives reinforce ideas around who deserves health care on demand*’. By using this approach, our consultations move towards “preferred futures” that address systemic barriers, change perceptions, and create realities that rely on social transformation.

Causal Layered Analysis involves exploring a challenge through four distinct layers. In the HEAR CSO methodology, these are called “stories” (the soundbites, headlines or concerns that keep you up at night), the “sources” (data, evidence, community points of view that support the stories), “worldviews” (the social structures in which this data or evidence is created—ie who decides on research agendas, indicators, metrics of human health), and finally “myths and metaphors” (the deep stories and images that underlie our sense of reality.) Each layer provides a different perspective, helping teams move from immediate symptoms to deeper, systemic causes and transformative solutions. The “pyramids” of causal layered analysis for the present and the preferred future are included in this document.

HEAR CSO approaches global health architecture in terms of four domains or areas: governance, coordination of access to public goods, financing and service delivery and implementation. These definitions are included at the end of the document.

Preferred Future Overview: Millions of Lamps Dispelling Darkness

This preferred future is supported by the image of many butter lamps pushing back the darkness in a temple. There is a brightness brought about by collective action, with strong government-civil society coordination and collaboration, and an investment in youth-led and -centered services. In this future, mental health and addiction are addressed as part of health care, which is freely available and based on a comprehensive universal health coverage approach. The future is reached through active pursuit of current milestones such as Sustainable Development Goals, UNAIDS global targets, realization of targets in various national documents such as the Adolescent Health Strategy. In other words, the near and mid-term work to reach this future does not require new documents or frameworks but rather a different approach to realizing goals in existing strategies and agendas. A mandated government contribution to health budgets (as a percentage of GDP) is viewed as essential, as is reform of the intellectual property environment, such that all countries have access to affordable, quality medical countermeasures whether through importation or regional and local manufacture, with TRIPS flexibilities including voluntary licensing and parallel importing utilized to address any inequities. Full, meaningful and decision-centered participation by impacted communities is a cornerstone of these futures, and the path to achieving this lies in institutional arrangements that facilitate co-creation of approaches, civil society accountability mechanisms, and service delivery. This integration of civil society into health systems and health architecture requires changes to governance and resourcing of CSOs and other sectors, as full participation requires resources.

Enabling Policies, frameworks, approaches and agencies include:

- Intentional investments to strengthen regional civil society networks
- Resourcing and strategy focused on attaining UNAIDS 2030 goals are to reduce new HIV infections by 90% and AIDS-related deaths by 90% from 2010 levels
- Attainment of goals in the Bangladesh Adolescent Health Strategy (2017-2030) recognizes SRHR, nutrition, and mental health as priorities
- Attainment of SDG 3.4 (Good Health and Well-being): This is the primary target that directly connects mental health and NCDs. It aims to reduce premature mortality from NCDs by one-third through prevention and treatment and promote mental health and well-being by 2030
- Attainment of SDG 3.5 (Good Health and Well-being): This target specifically addresses the prevention and treatment of substance abuse, which is closely linked to both NCDs and mental health issues
- Advocacy with Governments to support community-specific needs
- Advocacy with MoHFW and Ministries of Education, Women & Children Affairs to mainstream adolescent health and NCD prevention
- Youth perspectives are brought to the center of the programming

Impacts of these and other steps and actions:

- Health Economics Unit of the Ministry of Health and Family Welfare, news portals, and civil society platforms serve as sources of real time, transparent information that is used to show success and identify gaps
- Communities are at the center of programs. National Programs designed community sensitive/specific interventions for HIV/TB/Substance use

Access to Public Goods: Preferred Future: Services Responsive to Every Need

In this future, people with medical conditions (NCDs or other conditions) are able to access free or affordable medicines and or medical technology via primary healthcare. Friendly and responsible service provisions at the facilities. Marginalized communities including gender diverse, and persons with disabilities, people living in urban slums, climate vulnerable geographies are served with equity-based programmes and resources. Services responsive to needs of marginalized groups. No stockouts, communities get the required medicine at the government center. No patents on lifesaving new drugs.

Enabling Policies, frameworks, approaches and agencies include:

- Strengthen youth- and adolescent-led networks (school health clubs, youth councils, peer educators)
- Build digital platforms to share accurate health information with adolescents and young people
- Universalize adolescent nutrition programs: iron-folic acid for girls, healthy diet promotion for all, and fortified school meals
- Mainstream mental health services, including counseling in schools, universities, and digital platforms
- Enact and enforce stronger public health laws to curb tobacco use, regulate sugary drinks, and promote physical activity
- Build a resilient health supply chain ensuring uninterrupted access to essential medicines, contraceptives, vaccines, and diagnostics
- Innovation/development of public goods
- Publicly accessible mechanisms for addressing gaps and harms in access available in regional languages

Impacts of these and other steps and actions:

- Health care providers in LMICs are competent, offering greater hope of achieving UHC
- Bhutan achieves 80% coverage for substance use disorders and mental illness with decentralized services in all 20 dzonkhags
- All people living with HIV, TB and malaria can get their medications on time
- Health systems have become climate resilient
- Every health worker is trained to identify and support people facing common mental health issues

- Prevention works because we have addressed the root causes - inequality, trauma and disconnection
- Stigma has collapsed - seeking help for mental illness is as normal as treating diabetes

Financing - Preferred Future: Health as Investment, Not Charity

In this future, countries allocate at least 5% of GDP to health and also focus on prevention and PHC. The approach that health spending is an investment, not a drain/charity. Collaboration between the government and private sectors ensures domestic financing for CSOs' responses to achieve better health outcomes.

Enabling Policies, frameworks, approaches and agencies include:

- Regional South Asian Mental Health Fund provides sustained financing - Bhutan receives funds annually for community-led programs
- 5% of India's GDP invested in health sector with specific allocations for each department/ program
- No duplicate/similar health schemes
- To explore and utilise more CSR opportunities
- Best practices need to be reinvested, and also adequate resource support for evidence building (ex. more research/mapping related support) to advance community based interventions
- Budgetary allocations are in place for annual upskilling programs
- Digital mechanisms displaying use of funds

Impacts of these and other steps and actions:

- Funding shortage at the development sector, limiting to address the community specific needs
- Inadequate budget to implement the policies
- Addiction and mental health are finally funded like the health emergencies they are
- Governments and CSOs has to work together

Implementation and Delivery - Preferred Future: Communities Lead Their Own Healing

In this future, delivery models are co-created and lived experience is valued (not just tokenistic as it often is). The government recognizes CSOs as equal partners and includes and engages CSOs in the decision-making process, implementation, and monitoring and evaluation of the plan. Communities lead their own healing with resources, not just rhetoric. Social health protection needs to be incorporated in all health planning. Collaboration between health, environment, education and governance sectors. Locally appropriate solutions that are holistic and sustainable. Mental health and collective wellbeing are inseparable from every aspect of development, not optional add-ons.

Enabling Policies, frameworks, approaches and agencies include:

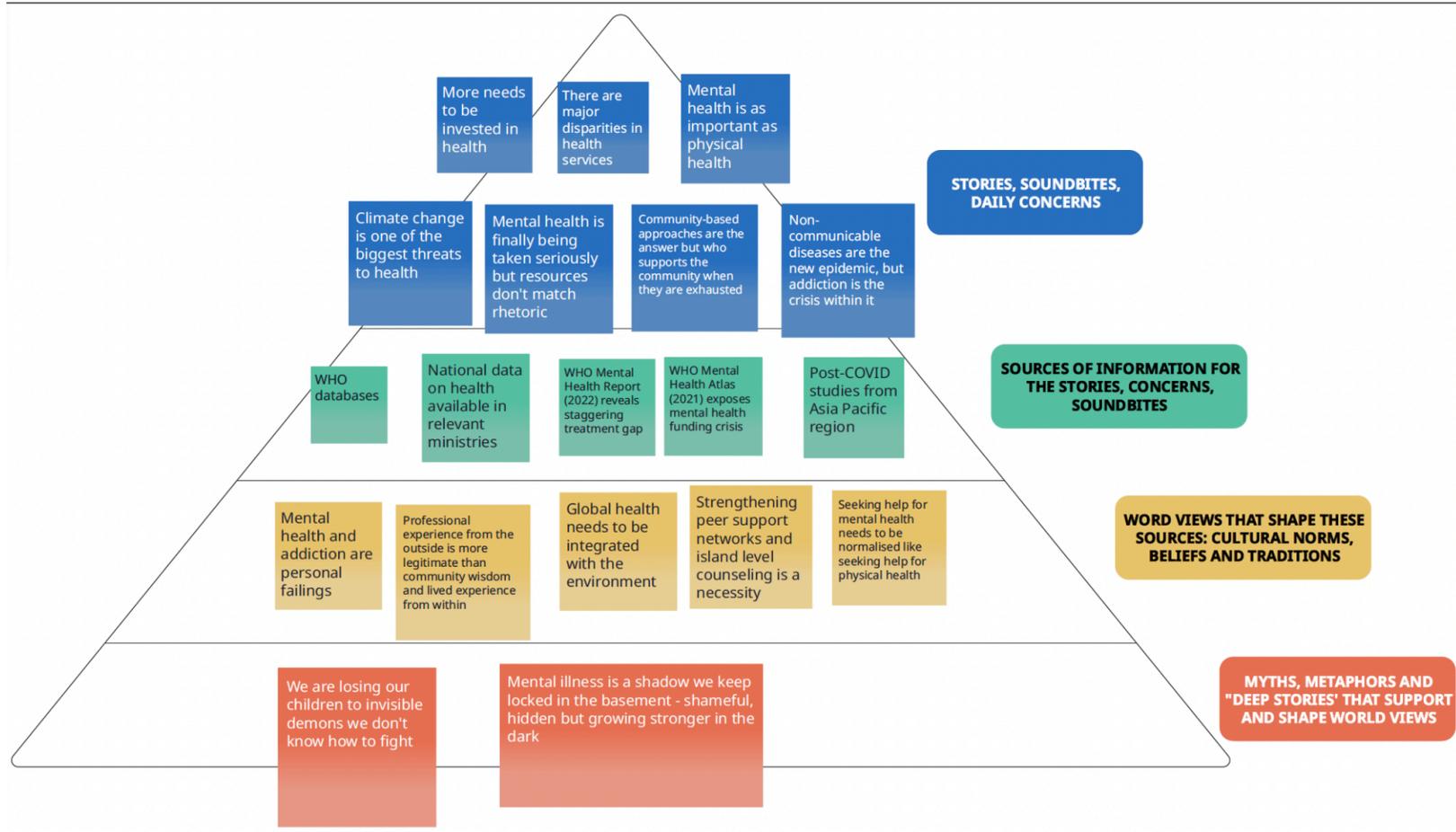
- Robust monitoring with community sensitive/friendly CLM
- Social Determinant based model of service delivery
- Real time national CLM reporting. National portals showing real time data
- Capacity building of the CSOs, community led organisations
- Adopt HRH retention strategies, such as Governments and international donors should focus on allocation of sufficient budget for HRH as a core economic development investment
- Decent Work- guaranteeing fair pay, safe environments, and professional protection for all health workers
- Targeted retention incentives for LMIC-based health workers
- Ethical recruitment of health workers; WHO Global Code of Practice on the International Recruitment of Health Personnel
- Recognise families as an important stakeholder

Impacts of these and other steps and actions:

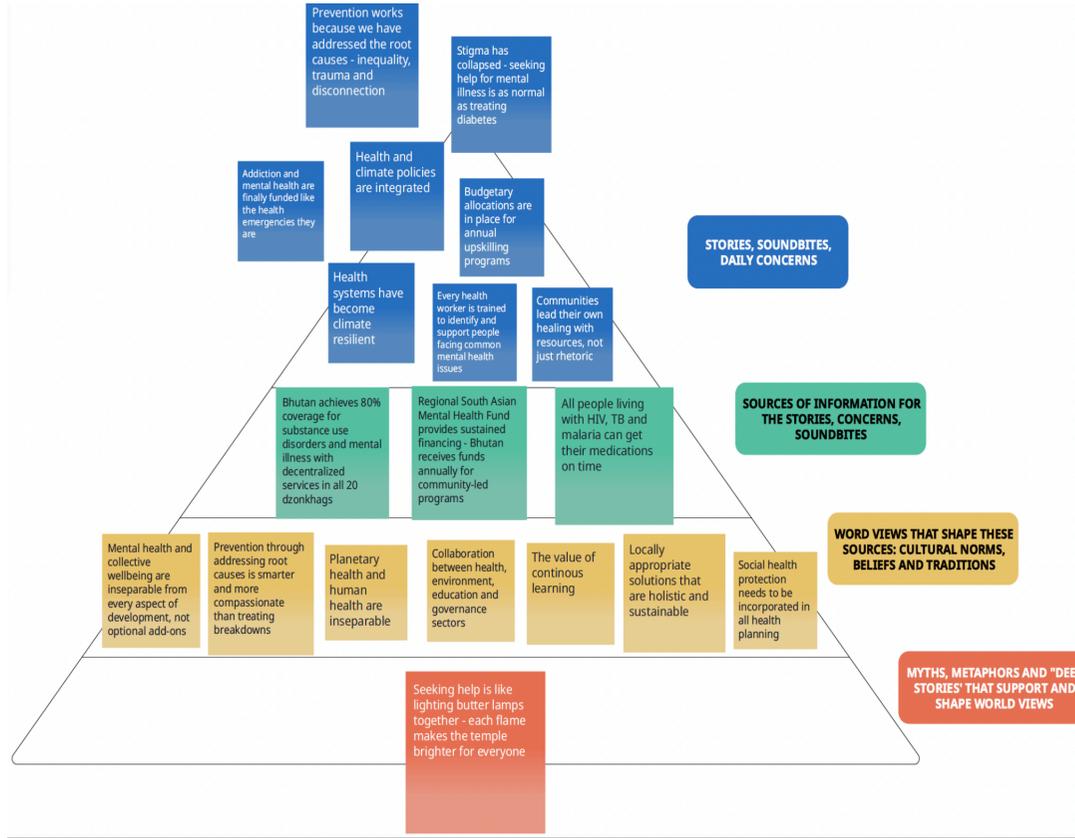
- Stigma and discrimination reduced against the marginalised groups
- Amplify community Led Monitoring and community mobilization activities
- Healthcare services will be more inclusive
- Punitive laws will be addressed and will be revised

Key stakeholders across all areas include:

- Community/CSOs/networks (including PWID community, CYOB, Youth Health Action Networks)
- Governments (Ministry of Health & Family Welfare - DGHS, DGFP, NCDC; Ministry of Education, Ministry of Women & Children Affairs, Local Government)
- Bilateral agencies (UN groups, WHO, ILO, UNAIDS, UNICEF, UNFPA, Global Fund, World Bank, UNODC)
- Traditional and non traditional funding agencies
- Private sector (CSR programs, pharma, ICT companies, telecom, food industry, pharmaceutical companies)
- Development partners, regional networks (APN+, Youth LEAD, WHO SEARO Youth Council)
- City corporations and municipalities (urban youth health services)
- School and university administrations



CAUSAL LAYERED ANALYSIS: CURRENT CONTEXT



PREFERRED FUTURE CAUSAL LAYERED ANALYSIS

Our working definition

By global health architecture, we mean the systems, structures, institutions, rules and processes that collectively **guide**, **coordinate**, **finance** and **implement** efforts to improve health on a global scale.

Guidance and Governance

Relates to how a health system is governed, and focus on issues such as policy authority, organizational authority, commercial authority, professional authority and about how stakeholders are involved in health systems decisions and on what terms. Also informs approaches to cross-border externalities such as disease surveillance and information sharing

Coordination of Global Public Goods Access

Development of new health products, international norms and standards, IP, knowledge generation and sharing, global surveillance, policy and implementation research, market shaping, risk shifting

Financing

Relates to how finances flow through health systems, and focus on how systems are financed, types of funding organizations, how to remunerate providers, how products and services are purchased and the incentive structures for consumers

Implementation and Delivery

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