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# HEAR CSO 2025 Consultations Synthesis

## Background

This document presents a synthesis of the common and distinct content emerging from seven regional 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.

These consultations are part of the Health Architecture Reimagined: Civil Society Organizations (HEAR CSO) initiative, created to ensure that the perspectives, priorities, and innovations of community and civil society actors are central to ongoing discussions about the future of global health architecture. HEAR CSO is a partnership of UHC2030, GFAN, GNP+, ITPC, NCD Alliance, STOPAIDS and WACI Health.

This document updates the earlier summary of consultations held in October 2025 and reflects the entirety of the HEAR CSO regional consultations. In January 2026, HEAR CSO launched a global survey to expand the array of voices from impacted communities and civil society contributing to conversations and decisions about global health architecture reform. Visit [hearcso.org](http://hearcso.org) for reports from the Global Survey and other activities that reflect converging ideas, diverse regional framings, and evolving pathways toward a more equitable and inclusive global health architecture.

## Outreach

The regional consultations are 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.



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HEAR CSO worked 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 organized using HEAR CSO's four domains of global health architecture: guidance and governance, coordination of global public goods access, financing, and implementation and delivery.

## Results: Participation

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

- 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 & North America	37	8	31
<b>Totals</b>	<b>139</b>	<b>54</b>	<b>107</b>

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 experience a hurricane on the day of the consultation. HEAR CSO activities in 2026 aim to fill some of these gaps.



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## 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 characterization 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 deprioritized in favor of crisis-driven responses.

In Eastern Europe and Central Asia, participants emphasized 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 organizations. In Asia and the Pacific, participants highlighted widening inequities, politicized 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, securitized 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
- Strong **South-South collaboration**, complemented (not dominated) by North-South partnerships
- **Trust and transparency**, supported by open data and action against mis- and disinformation
- Health treated as a **public good**, and progress measured through wellbeing, equity, and shared prosperity

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 neutralizing mis and disinformation. Health is treated as a public good and global, national and regional indices reflect a prioritization 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 recognized 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.*

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.

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 institutionalize participation, transparency, and accountability.	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	Governance review and reform design.  Operationalized co-governance and transparency systems.

Strengthen legal and policy frameworks that recognize civil society as co-decision-makers.

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 prioritizes solidarity and long-term wellbeing over securitized, crisis-driven decision-making.

Asia Pacific: Community leadership and civil society oversight replace politicized decision-making and shrinking civic space

EECA: Governance reform prioritizes meaningful participation of communities in

		decision-making amid shrinking civic space, repression, and reduced presence of global institutions.	
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.	<p>Africa: Regional regulatory cooperation and open-data transparency.</p> <p>Latin America: South-South research and open-knowledge networks; regional regulatory and production capacity.</p> <p>South Asia: Digital health and adolescent information platforms.</p> <p>Western Europe/North America: Global R&amp;D and AI-governance frameworks; equitable-access agreements replacing TRIPS.</p> <p>MENA: Regional preparedness and interoperable health information systems are central to managing conflict, displacement, and cross-border health threats.</p> <p>Asia Pacific: Equitable governance of digital</p>	<p>Regional and South-South knowledge-sharing systems developed.</p> <p>Continued expansion and refinement of ethical digital health systems and solutions embedded in a decolonized governance structure. .</p>

	<p>health tools and AI addresses geographic, linguistic, and technological divides.</p> <p>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.</p>	
<p>Financing</p>	<p>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.</p>	<p>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.</p> <p>Latin America: Launch of a Latin American Regional Health Fund with CSO co-management.</p> <p>South Asia: 5% of GDP allocated to</p> <p>Fund(s) and capitalization 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.</p> <p>Expansion and iteration of global, regional and national financing systems.</p>

health; South Asian  
Mental Health Fund.

Western  
Europe/North  
America: Unity Fund  
for key and  
marginalized  
populations; advocacy  
for tax and debt-  
justice frameworks.

MENA: Financing  
mechanisms recognize  
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  
organizations,  
diversification of  
funding sources, and  
donor policies not  
limited by World Bank  
income classifications.

Implementation and Delivery	Strengthen human-resource capacity, leadership, and service-delivery models that reflect local priorities and community realities. Institutionalize youth leadership, gender equity, fair work, and the inclusion of lived experience as expertise.	<p>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.</p> <p>Latin America: Community analysts embedded in regional observatories and disease-surveillance systems.</p> <p>South Asia: Youth-led accountability and fair-work frameworks for health workers.</p> <p>Western Europe/North America: Partnerships linking cultural, scientific, and faith-based leadership in digital and ethical-health initiatives.</p> <p>MENA: Service delivery shifts from temporary</p>	<p>Inclusive delivery models that actualize objectives of “integration” (across diseases, mental and physical health, urban/rural and key population identities) are institutionalized, evaluated and implemented with community input.</p> <p>New indicators on wellbeing, health, equity and sovereignty developed to track and assess needs, gaps and achievements across systems.</p>
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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 institutionalized 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.

## Toward Principles for Global Health Architecture Reform Processes and Outcomes

Across the diverse array of voices, inputs and experiences shared as part of HEAR CSO consultations in 2025, it is possible to identify principles that could be used by civil society and impacted communities to assess and engage with global health architecture reform proposals. These principles were developed after the consultations, by the HEAR CSO steering committee and project team, and must be validated, discussed and refined in broader forums. We share a list here to serve as a starting point, and will be engaging with diverse community and civil society stakeholders to refine, update and disseminate in 2026. Visit [hearcsso.org](http://hearcsso.org) for updated information.

### Core Principles Global Health Architecture Reform Processes and Outcomes

- **Equity as the ultimate goal**  
Begin with a preferred future, not a reaction to the present context. Equity in access to health for all must be the objective.
- **Multisectoral representation, governance and scope**  
Health is more than the health sector. Climate, poverty, economics, and conflict impact health. Mental, physical, and planetary health are intertwined. Global health architecture must reflect this reality through a clearly defined scope, expansive inclusivity, and integrated plans and action.
- **Leadership and decision-making roles for communities heavily impacted by health inequities as part of broader civil society inclusion**  
Communities impacted by health inequities must be central, resourced partners with leadership roles and decision-making authority within global health architecture.
- **Transparent, joint decision-making**  
Everyone contributes, everyone decides, everyone benefits. Governance processes and outcomes must interrupt traditional donor–recipient and North–South dynamics, and uplift regional sovereignty and national leadership inclusive of communities impacted by inequities.
- **Financing and access arrangements aligned with equity and continuity**  
Global health architecture must include financing arrangements that are

predictable and aligned with need, supporting continuity of access to essential services and enabling the direct resourcing of community-based organizations. Financing rules and eligibility criteria must avoid transitions that undermine equity or disrupt participation and access.

### **Underlying Conditions for Effective and Equitable Reform**

- **Sustainability, resilience, and continuity during transition**  
Global health architecture reform is taking place in contexts of institutional change, funding volatility, and geopolitical instability. Continuity of access to affordable, accessible, acceptable and quality health care, and mechanisms for civil society and impacted community to hold duty bearers accountability during periods of transition are essential.
- **Protection of civic space and community actors**  
Meaningful participation, accountability, and service delivery depend on the protection of civic space and the safety and legitimacy of civil society and community actors, including those whose exclusion is structural rather than intentional.

### **Conclusion**

The HEAR CSO consultations created space for civil society organizations 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. Together, these consultations generated a working set of principles and priorities that reflect lived experience, regional diversity, and a shared commitment to more equitable, participatory, and resilient global health architecture.