

Defining, Not Receiving

**Perspectives on Health
Governance Reform in the
Middle East & North Africa**

July 2026

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LIST OF ACRONYMS

COVID 19	Coronavirus Disease 2019
CSOS	Civil Society Organization(s)
EMPHNET	Eastern Mediterranean Public Health Network
WHO EMRO	WHO Regional Office for the Eastern Mediterranean
GCC	Gulf Cooperation Council
GHA	Global Health Architecture
HEAR CSO	Health Architecture Reimagined Civil Society Organizations
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
IDP	Internally Displaced Person
ITPC	International Treatment Preparedness Coalition
MENA	Middle East and North Africa
NCD s	Non-Communicable Diseases
NGO	Non-Governmental Organization
PREP	Pre-Exposure Prophylaxis
UHC	Universal Health Coverage
UN	United Nations
UNRWA	The United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization
SDG s	Sustainable Developmental Goals
PHC	Primary Health Care

EXECUTIVE SUMMARY

The findings reveal broad consensus that governance challenges remain among the most significant barriers to health system strengthening in the MENA region. Participants consistently highlighted fragmented governance structures, weak coordination mechanisms, limited accountability, and insufficient alignment between stakeholders as major obstacles to effective health action. While numerous actors contribute to health governance across the region, interviewees emphasized the absence of a coherent regional platform capable of facilitating sustained collaboration, joint priority-setting, and collective action.

Financing emerged as another critical concern. Participants observed that health priorities are frequently shaped by funding availability, donor interests, and political visibility rather than population health needs. This dynamic contributes to persistent underinvestment in prevention, health promotion, primary health care, workforce development, and public health infrastructure. Several interviewees expressed concern that current financing arrangements may be insufficient to address the region's growing burden of non-communicable diseases and emerging health challenges.

Beyond technical governance challenges, participants emphasized the importance of political economy dynamics in shaping health priorities across the region. Interviewees highlighted the influence of financing arrangements, political incentives,

regional actors, and decision-making structures on resource allocation and reform efforts. The consultation also identified important areas of divergence, including the role of regional financing, the balance between humanitarian response and long-term system strengthening, and the extent of civil society participation in governance processes.

A particularly strong finding concerned the continued marginalization of prevention within health governance and financing systems. Although prevention is widely recognized as essential for improving population health and ensuring long-term sustainability, participants reported that health systems remain predominantly treatment-oriented. Interviewees called for stronger investment in prevention, greater emphasis on health promotion, and a shift toward governance approaches that address the underlying determinants of health.

INVESTING IN PREVENTION, PARTICIPATION,
AND COOPERATION TODAY IS
HOW THE REGION
BUILDS THE HEALTH SYSTEMS
IT WILL NEED
TOMORROW.

The consultation also highlighted growing support for "de-medicalizing prevention" and adopting multisectoral approaches to health governance. Participants emphasized that health outcomes are shaped not only by healthcare services but also by education, housing, food systems, employment, transportation, environmental conditions, and broader social determinants. As a result, respondents advocated for Health-in-All-Policies approaches and stronger collaboration across sectors.

Civil society organizations were widely recognized as essential contributors to health governance, particularly in community engagement, advocacy, service delivery, accountability, and humanitarian response. However, participants noted that civil society participation remains uneven and often limited to consultation rather than meaningful involvement in governance and decision-making processes. Many called for more formal and institutionalized mechanisms to support inclusive participation.

Conflict, displacement, and humanitarian crises were identified as defining features of the regional health landscape. Participants stressed that health governance reforms must account for the realities of protracted crises, refugee movements, and fragile settings while strengthening preparedness, resilience, and continuity of care. Climate change, migration, and demographic transitions were similarly identified as emerging challenges requiring greater attention within governance frameworks.

Finally, interviewees highlighted the need to strengthen connections between evidence generation, policymaking, and

implementation. While the region has significant research and technical capacity, participants observed that evidence is not consistently translated into policy and practice. Stronger mechanisms are needed to support evidence-informed governance and ensure that research contributes to tangible improvements in health outcomes.

Collectively, participants envisioned a future health governance architecture that is more coordinated, prevention-oriented, equitable, resilient, and inclusive. The consultation identified several priority areas for reform, including strengthening regional governance mechanisms, institutionalizing civil society participation, rebalancing financing toward prevention and primary health care, integrating climate and displacement considerations into health planning, and improving evidence-to-policy pathways.

BACKGROUND

This report is submitted at a decisive juncture for global health governance. Following the Global Health Architecture (GHA) reform process endorsed at the Seventy-Ninth World Health Assembly (WHA79, May 2026), a WHO-hosted joint Task Force has been charged with delivering an interim report to the WHO Executive Board by late 2026, ahead of final consideration at WHA80. In May 2026, after the Task Force released its governance proposal, HEAR CSO issued a statement – endorsed by 145 signatories – condemning the exclusion of civil society from the Task Force itself, and warning that the reform risks reproducing the very power asymmetries it is meant to correct.

This MENA consultation speaks directly to that contestation. Its central finding — that civil society participation across the region remains consultative rather than decision-making, formalized in appearance but not in substance — is not a regional peculiarity but the same structural pattern HEAR CSO has identified globally, documented here with regional, empirical specificity. It is offered as the MENA region's evidentiary contribution to the process, intended to inform the Task Force's interim report before it is finalized.

The context is a complex, evolving health landscape shaped by demographic transitions, a growing non-communicable disease burden, recurring humanitarian crises, climate threats, migration and displacement, and persistent health system weaknesses — while GHA reform opens an important opportunity to reassess how governance can better respond to regional realities.

Conducted on behalf of ITPC MENA and the HEAR CSO Consortium, the consultation explored health governance, coordination, financing, prevention, civil society participation, and reform priorities across the region. Semi-structured key informant interviews with representatives from academia, civil society, public health institutions, regional technical networks, and international organizations provided diverse perspectives on the challenges and opportunities ahead.

It sought to:

- Explore stakeholder perspectives on health governance in the MENA region
- Identify strengths and weaknesses in current governance arrangements
- Examine coordination, financing, prevention, and participation mechanisms
- Assess emerging challenges including climate change, migration, and displacement
- Generate recommendations to inform regional and global health architecture reform

METHODOLOGY

A total of eight semi-structured key informant interviews, comprising seven semi-structured key informant interviews and one written expert contribution, were conducted with senior experts representing academia, civil society organizations, international organizations, public health institutions, and regional technical networks across the MENA region. Participants represented perspectives from Jordan, Iraq, Egypt, Palestine, Yemen, and regional organizations operating across multiple countries in the region.

The consultation intentionally sought representation from diverse stakeholder groups involved in health governance, including UN agencies, academic institutions, public health networks, civil society organizations, health promotion

organizations, and WHO-linked leadership platforms. Interviews explored perceptions of health governance, coordination, financing, prevention, civil society participation, emerging challenges, and priorities for reform. Thematic analysis was used to identify recurring patterns, areas of consensus, and strategic recommendations emerging across interviews.

This round of interviews builds directly on the first-round HEAR CSO Middle East and North Africa consultation of 4 December 2025, which ITPC MENA co-convened and facilitated. That consultation used a Causal Layered Analysis to surface the narratives, worldviews, and preferred futures held by regional civil society. The present interviews were designed to complement it by adding the senior, system-level, and political-economy perspectives that a broad civil society consultation could not fully capture. Where the two rounds converge, this is noted below as cross-validation across distinct methods and participant groups.

FINDINGS

3.1 FRAGMENTED REGIONAL HEALTH GOVERNANCE AND WEAK COORDINATION

A consistent theme emerging across interviews was the perception that health governance in the MENA region remains fragmented, with limited coordination across countries, institutions, and stakeholder groups. Participants acknowledged the presence of numerous regional and international actors working on health-related issues, including ministries of health, UN agencies, civil society organizations, academic institutions,

technical networks, and donors. However, interviewees frequently noted the absence of a coherent regional platform capable of aligning priorities, facilitating collective action, and translating dialogue into sustained outcomes.

Several participants observed that while regional meetings, workshops, and technical forums are regularly convened, these mechanisms often generate discussion without producing tangible implementation outcomes. Coordination was frequently described as project-based, dependent on individual relationships, or driven by specific funding streams rather than institutionalized governance structures.

Participants highlighted that existing regional coordination mechanisms remain dispersed across different organizations and mandates. While structures such as the WHO Regional Committee, regional UN offices, technical networks, and thematic alliances play important roles, no single platform currently provides comprehensive coordination across the health governance landscape. As a result, opportunities for collective agenda-setting, shared learning, pooled action, and joint accountability remain underutilized.

Interviewees nevertheless identified examples of successful regional collaboration. The Gulf Cooperation Council (GCC) was repeatedly cited as a model for cooperation, particularly in areas such as disease surveillance, information sharing, procurement, and technical exchange. Participants suggested that elements of these experiences could be adapted and expanded to strengthen collaboration across the wider MENA region.

At the national level, respondents noted that coordination often functions more effectively, particularly during emergencies. Examples included health clusters and country-level coordination mechanisms that bring together governments, UN agencies, NGOs, and other partners around operational priorities. However, participants stressed that these successes have not yet translated into a broader regional governance architecture capable of addressing shared health challenges.

Several interviewees argued that stronger regional leadership is needed to facilitate dialogue, identify common priorities, and promote collective solutions. Participants emphasized that future governance arrangements should move beyond replicating global models and instead be grounded in regional realities, including conflict, displacement, demographic transitions, and the growing burden of non-communicable diseases.

3.2 FINANCING SHAPES PRIORITIES MORE THAN POPULATION HEALTH NEEDS

“We had at that time more than 25 preventive programs. Believe me, less than 1% of the Ministry of Health budget is directed for those programs.”

— PUBLIC HEALTH SYSTEMS EXPERT

Across interviews, participants consistently highlighted financing as one of the most influential determinants of health priorities in the MENA region. Respondents described a persistent disconnect between population health needs and the allocation of financial resources, with priorities often shaped by funding availability, donor interests, political visibility, and short-term pressures rather than long-term public health goals.

Several interviewees observed that health systems frequently prioritize curative and hospital-based services at the expense of prevention, health promotion, and primary health care. Participants noted that investments tend to favor highly visible services, infrastructure projects, and treatment programs that generate immediate political or public recognition, while preventive interventions often remain underfunded despite their proven health and economic benefits.

This imbalance was particularly evident in discussions on public health and prevention. One participant described how preventive and promotive health programs received only a very small proportion of national health budgets despite the existence of numerous prevention initiatives. Others noted that health financing structures continue to reward treatment rather than prevention, contributing to rising costs associated with non-communicable diseases and other preventable conditions.

Participants also expressed concerns about the sustainability of current financing models. Several respondents highlighted the growing dependence of many countries and programs on external funding sources, particularly in fragile and conflict-affected settings. Recent reductions in international assistance and global health financing were identified as a significant risk, particularly for disease control programs, humanitarian health responses, and vulnerable populations.

These observations echo the first-round HEAR CSO consultation, in which participants described a global health system that behaves like an emergency room rather than a wellness centre, with financing following perceived security and economic threats rather than population health needs.

Interviewees further noted that financing decisions are often influenced by political and institutional incentives rather than evidence-based assessments of health needs. In some cases, participants argued that governments and donors prioritize interventions that are highly visible or politically attractive, while less visible but high-impact investments—such as prevention, health promotion, workforce development, and public health infrastructure—receive comparatively limited attention.

The interviews also revealed concerns regarding inefficiencies in resource allocation, weak accountability mechanisms, and the effects of corruption on health financing. Several participants stressed that improving health outcomes in the region will require not only increased investment, but also more transparent governance, stronger accountability systems, and better alignment between financing decisions and population health priorities.

Overall, respondents emphasized that sustainable progress toward universal health coverage, stronger health systems, and improved health outcomes will depend on financing arrangements that prioritize equity, prevention, resilience, and long-term public health value rather than short-term political considerations or externally driven funding agendas.

3.3. POLITICAL ECONOMY AND POWER DYNAMICS SHAPING HEALTH GOVERNANCE IN THE MENA REGION

The consultation findings suggest that many of the governance challenges facing health systems in the MENA region are rooted in the distribution of power, resources, and influence across actors operating within and beyond the health sector. Across interviews, a consistent pattern emerged: health priorities and governance outcomes are shaped as much by political and financial structures as by technical evidence or population health needs.

Who Really Sets Health Priorities?

While Ministries of Health are formally mandated to lead health policy and planning, interview data suggest that decision-making authority frequently extends beyond the health sector itself. In many countries, major health investments depend on approval from ministries of finance, central government authorities, senior political leadership, and, in some settings, external financing partners. As a result, ministries of health often possess technical responsibility without equivalent fiscal or political authority.

Participants repeatedly emphasized that identifying health needs was rarely the primary challenge. Rather, the challenge lies in securing political commitment, mobilizing resources, and maintaining attention to health priorities within broader political and economic agendas. In contexts affected by conflict, fiscal pressures, or political instability, health priorities often compete with security, economic, and governance concerns, limiting the ability of health actors to independently shape reform agendas.

The consultation therefore suggests that formal institutional mandates provide only a partial picture of how health priorities are determined in the MENA region. Power over resource allocation frequently sits outside the health sector itself, influencing which reforms advance and which priorities remain underfunded.

Financing as a Source of Power

Across interviews, financing emerged as one of the primary mechanisms through which influence is exercised within health systems. Participants consistently highlighted that funding availability often shapes priorities more strongly than epidemiological need. This dynamic is particularly visible in conflict-affected and resource-constrained settings, where external financing remains essential for maintaining

health services. Several respondents described financing as unpredictable, fragmented, and frequently driven by donor priorities rather than long-term national strategies.

The MENA financing landscape is shaped by both multilateral actors and influential regional actors. Several participants pointed to Gulf countries, particularly Saudi Arabia, the United Arab Emirates, Qatar, and Kuwait, as increasingly important sources of humanitarian, development, and health-sector financing. At the same time, interviewees emphasized that regional financing mechanisms remain fragmented and have yet to evolve into a coherent regional health governance architecture.

The consultation suggests that financial influence is often exercised through specific mechanisms, including earmarked funding streams, project-based investments, reporting requirements, and parallel implementation arrangements. These mechanisms shape which health issues receive attention, which programs expand, and which actors gain influence within governance processes. In practice, actors controlling financial resources frequently gain greater agenda-setting power than actors responsible for implementation or service delivery.

Interviewees also highlighted concerns regarding fragmented financing arrangements, growing privatization in some contexts, and insufficient investment in public health functions. Collectively, these dynamics contribute to a system in which financing structures do not always align with long-term health system needs or equity objectives.

These same dynamics underpin two of the consultation's most contested questions: the persistent underfunding of prevention, examined in Section 3.3, and the future of regional financing and the humanitarian–development relationship, examined as areas of divergence in Section 4. In each case the underlying issue is less a matter of technical disagreement than of competing incentives and the distribution of decision-making power.

Accountability, Participation, and Decision-Making Power

The consultation further suggests that participation is fundamentally linked to decision-making power. Civil society organizations were widely recognized as important actors in service delivery, advocacy, prevention, and community engagement. However, participants differed in how they conceptualized the role of civil society within governance processes.

Some interviewees emphasized civil society as an implementation partner and community representative, while others argued for a more substantive role in agenda-setting, monitoring, accountability, and policy oversight.

Several participants observed that civil society organizations are frequently consulted but less frequently involved in decisions regarding resource allocation, governance arrangements, or strategic priorities. These findings suggest that participation remains uneven across contexts and that inclusion in consultation processes does not necessarily translate into influence over decision-making. Strengthening accountability will therefore require greater transparency alongside more equitable participation in decision-making processes.

Key Political Economy Insight

Taken together, the consultation findings suggest that health governance challenges in the MENA region are shaped by the interaction of political authority, financing structures, regional and international influence, humanitarian realities, and competing interests operating within and beyond the health sector. These dynamics influence whose priorities receive attention, how resources are allocated, and which reforms gain traction. Understanding these relationships is essential for designing governance reforms that are technically robust, politically feasible, and responsive to the realities of the region.

3.4 PREVENTION REMAINS MARGINAL DESPITE UNIVERSAL RECOGNITION OF ITS IMPORTANCE

One of the strongest areas of consensus across interviews was the recognition that prevention and health promotion remain insufficiently prioritized within current health governance and financing structures. While participants universally acknowledged the importance of prevention as a cornerstone of population health and health system sustainability, many argued that this recognition has not translated into adequate investment, policy attention, or institutional commitment.

Interviewees consistently described health systems across the MENA region as predominantly treatment-oriented. Resources, political attention, and public expectations continue to focus on hospitals, specialized care, and curative services, while preventive interventions are frequently underfunded and undervalued. Several participants noted that prevention often receives rhetorical support within national strategies and policy documents but remains marginalized during budgeting and implementation processes.

Participants emphasized that this imbalance is particularly concerning given the region's growing burden of non-communicable diseases (NCDs), including cardiovascular diseases, diabetes, obesity, and cancer. Many argued that current health systems are investing heavily in managing the consequences of these conditions while dedicating comparatively limited resources to addressing their underlying determinants. This pattern was viewed as both economically inefficient and unsustainable in the long term.

“Prevention is still not taking quite reasonable budget-wise and commitment-wise as other parts of healthcare”

— SENIOR REGIONAL NCD EXPERT

Several respondents highlighted structural barriers that hinder prevention efforts. These included short political cycles that favor visible and immediate results, limited public understanding of prevention's value, weak intersectoral collaboration, and financing mechanisms that prioritize service delivery over health promotion. Participants noted that preventive interventions often require longer time horizons before measurable impacts become visible, making them less attractive to policymakers seeking immediate outcomes.

The first-round HEAR CSO consultation reached the same conclusion from a different angle, identifying non-communicable diseases, primary care, and the long-term needs of displaced populations as the sustained priorities most consistently crowded out by crisis-driven attention.

Health promotion was also identified as an area requiring substantial strengthening. Interviewees argued that many prevention initiatives remain focused on awareness campaigns rather than comprehensive strategies capable of influencing behaviors, environments, and social determinants of health. Participants stressed that meaningful prevention requires sustained engagement with communities, schools, workplaces, local authorities, and other sectors beyond the health system.

Several experts further emphasized the need to elevate the status of public health and preventive medicine within health systems. Concerns were raised about insufficient investment in preventive health programs, limited recognition of public health professionals, and inadequate institutional support for prevention-oriented approaches. Participants argued that strengthening public health institutions and workforce capacity would be essential for shifting systems toward a more prevention-focused model.

Overall, interviewees viewed prevention not as a technical issue but as a governance and political priority. The findings suggest that meaningful progress will require rebalancing health investments, strengthening public health institutions, and embedding prevention more systematically within policy, financing, and accountability frameworks. Participants consistently argued that without a stronger prevention agenda, health systems across the region will struggle to achieve sustainable improvements in population health and universal health coverage.

3.5 DE-MEDICALIZING PREVENTION AND ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

A prominent and recurring theme across interviews was the recognition that improving population health requires moving beyond a narrow healthcare-centered approach and addressing the broader social, economic, environmental, and political determinants of health. Participants repeatedly emphasized that many of the region's most pressing health challenges cannot be effectively addressed through healthcare services alone, regardless of how well health systems are funded or organized.

Several interviewees highlighted the need to "de-medicalize prevention" by expanding responsibility for health beyond ministries of health and healthcare providers. Participants argued that prevention should be viewed as a whole-of-government and whole-of-society responsibility involving education systems, municipalities, urban planners, agricultural sectors, labor institutions, environmental authorities, media organizations, and community structures. According to respondents, health outcomes are often shaped by factors that lie outside the direct control of healthcare systems, including housing conditions, food environments, education, employment, transportation, social cohesion, and environmental exposures.

Participants noted that many current prevention efforts remain overly focused on awareness raising and individual behavior change, while insufficient attention is paid to the structural factors that influence health. Several respondents argued that campaigns encouraging healthy lifestyles are unlikely to achieve meaningful impact if communities continue to face unhealthy food environments, limited opportunities for physical activity, inadequate urban infrastructure, poverty, or restricted access to healthy choices.

The concept of "Health in All Policies" emerged repeatedly throughout the interviews. Participants emphasized the importance of integrating health considerations into decision-making processes across government sectors and ensuring that health impacts are considered in policies related to education, transportation, urban development, climate adaptation, food systems, and economic planning. Interviewees argued that such approaches are particularly important given the increasing burden of non-communicable diseases and the growing influence of social and commercial determinants of health.

Several participants also stressed the importance of community engagement and local action. Schools, workplaces, municipalities, youth organizations, faith-based institutions, and community groups were identified as critical platforms for promoting health and preventing disease. Respondents emphasized that sustainable prevention requires meaningful engagement with communities rather than relying solely on health professionals or healthcare facilities.

Climate change, environmental degradation, and migration further reinforced the need for multisectoral approaches. Interviewees noted that emerging health challenges increasingly transcend traditional sectoral boundaries and require coordinated responses involving actors beyond the health sector. This was viewed as particularly relevant for the MENA region, where climate vulnerability, displacement, urbanization, and demographic transitions are expected to shape future health outcomes.

Overall, participants argued that achieving healthier populations will require a fundamental shift from treating disease to creating healthy environments. The findings suggest that health governance reforms should prioritize multisectoral action, community participation, and stronger integration of health considerations across public policy domains. Such approaches were viewed as essential for addressing the root causes of poor health and building more resilient and equitable societies.

AN ITPC MENA PERSPECTIVE: FROM THE HIV RESPONSE TO A BROADER PREVENTION AGENDA

The consultation's call to "de-medicalise prevention" echoes a shift that the HIV response in this region has already lived through, and ITPC MENA reads these findings through that experience. Over two decades, HIV prevention and treatment moved out of the exclusive control of clinicians and hospitals and into the hands of communities. Peer educators, community health workers, people living with HIV, and organisations led by the populations most affected became the people who delivered testing, adherence support, prevention information, and referral. The tools followed the same path: HIV self-testing, oral (and now, in Morocco long-acting injectable) PrEP, differentiated service delivery, and community-led monitoring all moved prevention closer to where people actually live. De-medicalisation, in this sense, is not only about acting on the social determinants of health; it is also about who holds the tools and the authority to act.

This model was not a matter of convenience. It was a response to the same conditions the consultation describes: overstretched clinical systems, stigma that keeps people away from formal facilities, and populations that move across borders and fall between services. Those conditions are not unique to HIV. They will shape how the region confronts its growing burden of non-communicable diseases, its unmet sexual and reproductive health needs, and the long-term needs of an ageing population, including the first generation now growing older while living with HIV.

The community-led, de-medicalised approaches developed for HIV have direct analogues. For non-communicable diseases, community-based screening, peer support for hypertension and diabetes, and task-shifting to lay health workers can extend chronic-disease care beyond the clinic. For sexual and reproductive health, self-care interventions such as self-administered injectable contraception, HPV self-sampling, and self-managed components of care place agency with the individual, particularly where clinical access is limited or stigmatised. For ageing and chronic conditions, the differentiated, community-anchored care models built to sustain lifelong HIV treatment offer a ready template. In fragile and displacement settings, where the consultation found clinical systems least able to cope, these community-rooted approaches are often the only realistic route to continuity of care.

Positioning prevention this way reframes it as a governance and financing choice rather than a purely clinical one. It requires recognising community health workers and peer providers within the system, financing community-led delivery, and writing self-care and task-shifting into national policy. De-medicalisation is not deprofessionalisation: it depends on quality standards, clear links back to clinical care, and protective legal environments. But the central lesson of the region's HIV response is that prevention scales when it is owned by communities, not when it is confined to the clinic.

3.6 CIVIL SOCIETY

PARTICIPATION REMAINS VALUABLE BUT INSUFFICIENTLY INSTITUTIONALIZED

A recurring theme across interviews was the recognition of civil society organizations (CSOs) as essential actors within health governance systems. Participants consistently acknowledged the important roles that civil society plays in service delivery, community engagement, advocacy, accountability, health promotion, humanitarian response, and reaching marginalized populations. However, respondents also emphasized that civil society participation remains uneven, inconsistent, and insufficiently institutionalized across much of the MENA region.

Several interviewees noted that CSOs often possess unique access to communities and populations that may be underserved by formal health systems, particularly in fragile, conflict-affected, and humanitarian settings. Participants highlighted the ability of civil society organizations to identify emerging needs, generate community trust, mobilize local action, and provide valuable insights into the lived realities of affected populations. In many contexts, civil society was described as serving as a bridge between communities and policymakers.

Despite this recognized value, participants frequently observed that civil society engagement remains largely consultative rather than participatory. While CSOs are often invited to attend meetings, workshops, and consultations, interviewees noted that they are not always meaningfully involved in decision-making processes, priority-setting discussions, or governance structures. Several respondents described participation mechanisms as dependent on individual relationships, donor requirements, or institutional goodwill rather than formalized governance arrangements.

“There should be direct contact with CSOs... If it is possible that CSOs should also have a seat, even as an observer, I think this will help.”

— CIVIL SOCIETY LEADER

Interviewees further highlighted disparities in civil society engagement across countries and contexts. In some settings, strong partnerships between governments, civil society, and international organizations have facilitated collaborative approaches to health challenges. In other contexts, civil society organizations continue to face barriers related to political environments, limited resources, regulatory restrictions, or insufficient recognition of their contributions. Participants stressed that these challenges are often magnified in conflict-affected settings, where local organizations may play critical operational roles while remaining excluded from strategic decision-making processes.

Several respondents argued that civil society participation should not be viewed solely as a mechanism for project implementation. Instead, participants emphasized the importance of recognizing civil society as a governance actor with legitimate roles in accountability, monitoring, policy dialogue, and health system reform. Interviewees suggested that stronger governance outcomes are often achieved when civil society is engaged throughout the policy cycle, from agenda-setting and design to implementation and evaluation.

The interviews also underscored the importance of including a broader range of voices within governance processes. Participants highlighted the need to

strengthen representation from youth-led organizations, women's groups, patient associations, community-based organizations, humanitarian actors, and organizations representing displaced and marginalized populations. Expanding participation was viewed as essential for ensuring that governance arrangements reflect diverse experiences and priorities across the region.

Overall, participants viewed civil society as an indispensable component of effective health governance. However, the findings suggest that meaningful progress will require moving beyond ad hoc consultation toward institutionalized mechanisms that enable sustained, transparent, and inclusive participation in health policy and governance processes. Strengthening these mechanisms was widely regarded as critical for improving accountability, responsiveness, equity, and public trust in health systems.

3.7 CONFLICT, DISPLACEMENT, AND HUMANITARIAN CRISES CONTINUE TO RESHAPE HEALTH GOVERNANCE IN THE MENA REGION

A defining characteristic of the MENA region's health governance landscape is the persistent influence of conflict, displacement, and humanitarian crises on health systems and governance arrangements. Across interviews, participants repeatedly emphasized that health governance in the region cannot be understood without considering the realities of protracted conflicts, forced displacement, political instability, and recurring humanitarian emergencies.

Interviewees noted that several countries in the region continue to experience complex

“Health governance in our region must account for displacement, refugees, and conflict-affected populations. These realities cannot be treated as exceptional circumstances.”

— HUMANITARIAN HEALTH EXPERT

and overlapping crises, including armed conflict, economic instability, large-scale displacement, and weakened public institutions. These conditions place extraordinary pressure on health systems and often shift priorities away from long-term health system development toward immediate humanitarian response. Participants highlighted that while emergency interventions are essential, prolonged reliance on crisis-oriented approaches can undermine investments in prevention, primary health care, workforce development, and system resilience.

Several respondents emphasized the significant challenges associated with ensuring continuity of care for refugees, internally displaced persons (IDPs), migrants, and conflict-affected populations. Participants described how displacement disrupts access to essential health services, interrupts treatment for chronic diseases, increases vulnerability to communicable diseases, and creates additional burdens on host communities and health systems. Maintaining equitable access to healthcare under these circumstances was identified as one of the region's most pressing governance challenges.

Interviewees also highlighted the growing fragmentation that can emerge when multiple humanitarian and development

actors operate simultaneously within crisis settings. While humanitarian partnerships often facilitate life-saving interventions, respondents noted that parallel systems, fragmented funding streams, and differing institutional mandates can create coordination challenges and weaken long-term system strengthening efforts. Several participants stressed the importance of strengthening the humanitarian-development nexus to ensure that emergency responses contribute to sustainable health system recovery and resilience.

First-round participants gave this dynamic a concrete face in Jordan, where public health infrastructure must serve both citizens and large refugee populations on limited and unpredictable support – illustrating how protracted displacement becomes a structural feature of the regional health system rather than a temporary emergency.

Preparedness and resilience emerged as particularly important themes. Participants reflected on lessons from recent emergencies, including disease outbreaks, the COVID-19 pandemic, and ongoing humanitarian crises, arguing that these events exposed structural weaknesses in governance systems, surveillance capacities, workforce preparedness, supply chains, and emergency coordination mechanisms. Respondents emphasized that preparedness should not be treated as a separate emergency function but rather as an integral component of health system strengthening and governance.

The interviews further highlighted the political dimensions of health governance in conflict-affected settings. Participants noted that political instability, insecurity, restrictions on movement, and broader geopolitical dynamics often influence health priorities, access to services, resource allocation, and the ability of institutions to function effectively. In such contexts, health governance challenges extend beyond technical considerations and become closely linked to broader questions of equity, rights, access, and accountability.

At the same time, several interviewees pointed to examples of resilience and innovation emerging from crisis settings. Communities, civil society organizations, humanitarian actors, and local health workers were frequently described as playing critical roles in sustaining essential services and supporting vulnerable populations despite difficult circumstances. Participants argued that these experiences offer valuable lessons for strengthening health governance across the wider region.

Overall, the findings suggest that conflict and displacement are not peripheral issues but central determinants of health governance in the MENA region. Future reforms must therefore incorporate humanitarian realities, strengthen resilience and preparedness capacities, improve coordination between humanitarian and development actors, and ensure that the needs of displaced and conflict-affected populations remain integral to health governance discussions.

“Preparedness is not a separate activity. It is a function of how strong the health system is every day.”

— PUBLIC HEALTH PREPAREDNESS EXPERT

3.8 EVIDENCE, RESEARCH, AND THE PERSISTENT POLICY IMPLEMENTATION GAP

A recurring theme across interviews was the recognition that while the MENA region has made significant progress in generating health-related evidence, substantial challenges remain in translating research findings into policy decisions, programme implementation, and measurable health outcomes. Participants consistently emphasized that the issue is not necessarily a lack of data, expertise, or technical knowledge, but rather weaknesses in the mechanisms that connect evidence generation to policy action.

“The challenge is not the absence of knowledge or technical expertise. The challenge is ensuring that governance structures are capable of translating priorities into implementation.”

— HEALTH GOVERNANCE EXPERT

Several interviewees observed that the region possesses growing academic capacity, increasingly sophisticated research institutions, and expanding technical expertise. Universities, research centers, public health institutes, and international organizations are generating important evidence on health systems, non-communicable diseases, health financing, migration, climate change, emergency preparedness, and other priority issues. However, respondents noted that much of this knowledge does not consistently influence decision-making processes.

Participants identified a number of factors contributing to this evidence-to-policy gap. These included limited engagement between researchers and policymakers, differences in institutional incentives, short political timelines, fragmented governance structures, and insufficient mechanisms for translating research into actionable recommendations. Several respondents suggested that evidence often remains confined to academic publications, technical reports, and conferences rather than informing operational planning, policy reform, or budget allocation decisions.

Interviewees also highlighted the importance of strengthening relationships between academia, governments, civil society organizations, and international agencies. Participants argued that effective health governance requires continuous dialogue between those generating evidence and those responsible for policy implementation. Several respondents emphasized that researchers should play a more active role in policy engagement, while policymakers should be better supported in accessing and applying available evidence.

Capacity building emerged as another important consideration. Participants stressed the need to strengthen public health education, workforce development, implementation science, and knowledge translation capacities across the region. Investments in training future public health leaders, researchers, and practitioners were viewed as critical for ensuring that evidence can be effectively transformed into action.

Several interviewees further emphasized that evidence-informed decision-making should extend beyond the health sector. Given the growing importance of social determinants, climate change, migration, and multisectoral governance challenges, participants argued that research and evidence must increasingly support cross-sectoral policymaking and integrated governance approaches.

The interviews also highlighted the value of locally generated evidence. Respondents cautioned against relying exclusively on global models or externally produced recommendations, emphasizing the importance of context-specific knowledge that reflects the social, political, economic, and health realities of the MENA region. Participants argued that stronger regional research networks and knowledge-sharing platforms could help support more relevant and responsive policymaking.

AREAS OF CONVERGENCE & DIVERGENCE

While participants represented diverse sectors, institutions, and country contexts, several areas of broad agreement emerged across the consultation. At the same time, important differences in perspective were identified regarding financing, governance, and participation. These divergences do not necessarily reflect disagreement about desired outcomes; rather, they highlight different assessments of how health governance challenges should be addressed within the MENA region.

4.1 AREAS OF CONVERGENCE

Despite differences in institutional backgrounds and national contexts, participants broadly agreed on several key issues:

- Current health governance arrangements across the MENA region remain fragmented and require stronger coordination and accountability mechanisms
- Prevention and health promotion remain underfunded relative to their importance in addressing the growing burden of non-communicable diseases and improving population health outcomes
- Universal Health Coverage (UHC) remains a central objective for health system reform across the region
- Stronger multisectoral collaboration is required to address the social, economic, environmental, and commercial determinants of health
- Evidence-informed policymaking should play a greater role in governance and priority-setting processes

- Civil society organizations, communities, and affected populations should have a more meaningful role in health governance discussions and decision-making processes
- Health systems require greater resilience and preparedness to respond to future emergencies, pandemics, climate-related threats, and protracted crises.

4.2 AREAS OF DIVERGENCE

Regional Financing and Regional Ownership

Participants expressed differing views regarding the future role of regional financing in health governance. Several interviewees viewed Gulf countries as potential drivers of stronger regional solidarity, financing, and technical cooperation. From this perspective, greater regional investment could reduce dependence on external aid and strengthen regional ownership of health priorities.

Others emphasized that financing relationships inevitably shape priorities regardless of the source of funding. This perspective suggests that regional financing may reduce dependence on traditional donors while still creating new forms of influence over agenda-setting and resource allocation. The consultation therefore highlights an unresolved question regarding whether expanded regional financing would fundamentally alter existing governance dynamics or primarily shift influence among financing actors.

Humanitarian Response and Long-Term System Strengthening

A second area of divergence emerged around the relationship between humanitarian action and health system development.

Participants working in fragile and conflict-affected settings emphasized the importance of humanitarian mechanisms in maintaining access to essential health services when national systems face severe constraints. These mechanisms were viewed as necessary and often life-saving responses to immediate needs. At the same time, several participants raised concerns regarding the long-term effects of parallel humanitarian structures. Prolonged reliance on externally financed emergency mechanisms was seen as potentially contributing to fragmented governance arrangements, weakened national ownership, and delayed investments in sustainable health system development.

This divergence reflects different perspectives on how to balance immediate service delivery needs with longer-term governance and system-strengthening objectives.

Civil Society Participation: Consultation or Shared Decision-Making?

Participants broadly agreed on the value of civil society engagement; however, views differed regarding the depth of participation required.

Some participants emphasized the importance of civil society organizations as implementation partners, advocates, and community representatives. Others argued that meaningful participation requires a stronger role in agenda-setting, oversight, accountability, and policy development.

This tension highlights an important governance question: whether participation is primarily understood as consultation and engagement, or whether it should extend to shared influence over decisions regarding priorities, financing, and accountability.

EMERGING PRIORITIES FOR REFORM

Across interviews, participants identified several strategic priorities that should guide future efforts to strengthen health governance and contribute to ongoing discussions on global health architecture reform in the MENA region. While perspectives varied according to institutional background and professional experience, a strong degree of convergence emerged around the need for more coordinated, inclusive, prevention-oriented, and resilient governance systems.

5.1 STRENGTHENING REGIONAL HEALTH GOVERNANCE AND COORDINATION

Participants consistently highlighted the absence of a coherent regional platform capable of facilitating collective action on shared health challenges. Interviewees emphasized the need for stronger regional governance mechanisms that move beyond ad hoc coordination and support sustained collaboration between governments, international organizations, civil society, academia, and technical institutions.

Many participants argued that the region would benefit from a more structured platform for knowledge exchange, joint priority-setting, policy dialogue, preparedness planning, and collective advocacy on regional and global health issues.

5.2 REBALANCING HEALTH SYSTEMS TOWARD PREVENTION

A second priority concerned the need to shift health systems away from their current emphasis on treatment and toward prevention, health promotion, and primary health care. Participants repeatedly noted that while prevention is widely recognized as important, it remains inadequately funded and insufficiently integrated into governance and financing structures.

Interviewees emphasized that future reforms should prioritize preventive action, address the growing burden of non-communicable diseases, and invest in interventions capable of improving long-term population health outcomes.

5.3 ADVANCING MULTISECTORAL APPROACHES TO HEALTH

Participants stressed that many of the region's most pressing health challenges cannot be solved by the health sector alone. Interviewees highlighted the importance of integrating health considerations into policies related to education, urban planning, transportation, food systems, employment, climate adaptation, and social protection.

This reflects a growing recognition that sustainable improvements in population health require governance approaches that address the broader determinants of health and promote collaboration across sectors.

5.4 INSTITUTIONALIZING MEANINGFUL CIVIL SOCIETY PARTICIPATION

Respondents consistently emphasized the value of civil society organizations as partners in health governance. However, many noted that participation remains inconsistent and frequently limited to consultation rather than meaningful engagement in decision-making processes.

Participants called for the establishment of more formal and transparent mechanisms that enable civil society organizations, community groups, patient representatives, youth-led organizations, and affected populations to contribute to governance processes at national, regional, and global levels.

5.5 STRENGTHENING PREPAREDNESS, RESILIENCE, AND HEALTH SECURITY

The experience of recent conflicts, humanitarian crises, disease outbreaks, and the COVID-19 pandemic reinforced the need to strengthen preparedness and resilience across health systems. Participants emphasized that preparedness should not be viewed solely as an emergency response function but rather as an integral component of health system governance and development.

Several interviewees highlighted the importance of investing in public health institutions, surveillance systems, workforce development, emergency coordination mechanisms, and resilient service delivery models capable of maintaining continuity of care during crises.

5.6 INTEGRATING CLIMATE CHANGE, MIGRATION, AND DISPLACEMENT INTO HEALTH GOVERNANCE

Participants repeatedly identified climate change, migration, displacement, and demographic transitions as increasingly important drivers of health outcomes in the region. However, many felt that current governance arrangements have not yet adequately adapted to these emerging realities.

Future governance reforms should therefore incorporate climate resilience, migrant and refugee health, and displacement-sensitive approaches as core components of health planning and policy development rather than treating them as peripheral concerns.

5.7 STRENGTHENING EVIDENCE-INFORMED POLICYMAKING

Finally, interviewees highlighted the need to strengthen the relationship between research, evidence generation, and policymaking. Participants called for improved mechanisms to ensure that evidence informs policy decisions, resource allocation, programme design, and governance reforms.

Several respondents also emphasized the importance of supporting locally generated evidence and strengthening collaboration between researchers, policymakers, civil society organizations, and practitioners to facilitate more responsive and contextually relevant decision-making.

RECOMMENDATIONS

6.1 ESTABLISH A REGIONAL MULTI-STAKEHOLDER PLATFORM FOR HEALTH GOVERNANCE

WHO EMRO, the League of Arab States, civil society networks, academic institutions, and public health organizations should establish a standing regional platform for dialogue, coordination, and collective action on health governance. Such a mechanism could facilitate joint priority-setting, policy exchange, preparedness planning, and accountability across countries while strengthening regional ownership of health agendas.

6.2 REBALANCE HEALTH FINANCING TOWARD PREVENTION AND PRIMARY HEALTH CARE

Ministries of Health and Ministries of Finance should increase the proportion of health budgets allocated to prevention, health promotion, and primary health care. Development partners and regional financing actors should align investments with long-term population health outcomes rather than short-term project cycles. Participants emphasized that sustainable progress toward Universal Health Coverage (UHC) will require correcting the persistent imbalance between curative and preventive spending. Building on the first-round consultation, the region should also explore a regional solidarity health fund that enables collective investment in cross-border challenges and ensures that no single country – particularly those hosting large displaced populations – carries a disproportionate burden.

6.3 INSTITUTIONALIZE CIVIL SOCIETY PARTICIPATION IN HEALTH GOVERNANCE

Governments, regional institutions, and international organizations should establish formal mechanisms that enable civil society organizations, patient groups, youth networks, and affected communities to participate in agenda-setting, policy development, implementation, monitoring, and accountability processes. Participation should move beyond ad hoc consultation toward structured and sustained engagement in decision-making.

6.4 STRENGTHEN REGIONAL HEALTH GOVERNANCE AND COOPERATION

Regional institutions, including WHO EMRO and the League of Arab States, should expand mechanisms for cooperation in surveillance, workforce development, procurement, emergency preparedness, and health financing. Participants highlighted the need to build on existing examples of regional collaboration while creating stronger platforms for collective action on shared health challenges. The first-round consultation framed this as a shared regional health defence capability: interoperable data systems and coordinated preparedness that allow the region to detect and respond to cross-border threats collectively rather than country by country.

6.5 STRENGTHEN PREPAREDNESS AND HEALTH SYSTEM RESILIENCE

Governments and development partners should embed preparedness within broader health system strengthening efforts. Investments should prioritize public health institutions, surveillance systems, workforce development, emergency preparedness capacities, and resilient service delivery models capable of responding to pandemics, conflicts, climate-related shocks, and other emerging threats.

6.6 ADVANCE A HEALTH-IN-ALL-POLICIES APPROACH

Governments should strengthen cross-sectoral governance mechanisms that integrate health considerations into decision-making across education, urban planning, transportation, agriculture, labor, social protection, and environmental policy. Addressing the social, environmental, and commercial determinants of health will require stronger coordination across sectors and levels of government.

6.7 INTEGRATE CLIMATE, MIGRATION, AND DISPLACEMENT INTO HEALTH GOVERNANCE FRAMEWORKS

National and regional health strategies should explicitly address the health implications of climate change, migration, displacement, and protracted humanitarian crises. Particular attention should be given to refugees, internally displaced populations, migrants, and conflict-affected communities whose health needs often fall between humanitarian and development programming.

6.8 STRENGTHEN EVIDENCE-TO-POLICY AND EVIDENCE-TO-IMPLEMENTATION PATHWAYS

Governments, universities, public health institutions, and civil society organizations should invest in stronger mechanisms for translating evidence into policy and practice. Participants emphasized the need for implementation science, policy-relevant research, and stronger institutional linkages between researchers and decision-makers to reduce the gap between evidence generation and implementation.

6.9 IMPROVE ACCOUNTABILITY AND TRANSPARENCY IN HEALTH GOVERNANCE

Governments and public institutions should strengthen transparency, regulatory oversight, performance monitoring, and accountability mechanisms across health systems. Participants emphasized that stronger accountability structures are essential for improving public trust, reducing inefficiencies, and ensuring that health investments produce measurable outcomes.

6.10 PLACE EQUITY AT THE CENTRE OF HEALTH GOVERNANCE REFORM

All governance reforms should be guided by principles of equity, inclusion, and participation. Particular attention should be given to ensuring that refugees, internally displaced persons, migrants, women, youth, persons with disabilities, and conflict-affected populations are represented in governance processes and considered in financing, policy, and accountability decisions.

LIMITATIONS

This consultation reflects the perspectives of eight experts representing academia, civil society, public health networks, humanitarian organizations, health promotion institutions, and regional health governance stakeholders across the MENA region. The findings are intended to provide qualitative insights into governance dynamics, emerging priorities, and areas of convergence and divergence rather than statistically representative conclusions.

The consultation was designed to explore perspectives on health governance reform, financing, participation, accountability, and regional cooperation. As with all qualitative consultations, findings are influenced by the experiences and expertise of participating stakeholders and may not capture the full diversity of perspectives across all countries and constituencies within the region.

Several contributions reflected regional perspectives, while others were shaped by experiences within specific national or institutional contexts. The findings should therefore be interpreted as analytical insights intended to inform ongoing discussions on health governance reform and global health architecture in the MENA region.

The first-round HEAR CSO consultation also found that engagement with the concept of global health architecture remains nascent among regional civil society organizations. The senior, system-level perspectives captured here should therefore be read alongside, not in place of, the broader community-level dialogue still needed to build familiarity with these debates and translate them into regional advocacy.

POTENTIAL ROLE FOR ITPC MENA & ALLIES

Potential Role for ITPC MENA
The consultation identified several areas where ITPC MENA could contribute to strengthening health governance discussions and reform processes across the region:

_Convene multi-stakeholder dialogue among civil society organizations, researchers, policymakers, and regional institutions on health governance reform and accountability.

_Advocate for more transparent, equitable, and participatory approaches to health financing and priority-setting.

_Amplify community and civil society perspectives within regional and global health governance discussions.
_Support evidence-informed advocacy by translating research and consultation findings into policy-relevant recommendations.

_Facilitate regional learning and exchange on governance innovations, prevention, health financing, accountability, and community participation.

_Promote greater attention to equity, inclusion, and the needs of marginalized populations within health governance reforms.

CONCLUSION

The findings of this consultation highlight both the significant challenges and important opportunities shaping health governance across the Middle East and North Africa region. Across diverse stakeholder groups, participants consistently emphasized that many of the region's most pressing health challenges are increasingly linked to governance, financing, accountability, participation, and political decision-making processes rather than technical capacity alone.

While substantial progress has been achieved in several areas of health system development, participants identified persistent challenges related to fragmented governance arrangements, underinvestment in prevention, limited institutionalized participation, unequal power dynamics in priority-setting processes, and insufficient coordination across sectors and countries. These challenges are further compounded by conflict, displacement, climate change, migration, demographic transitions, and growing pressures on already constrained health systems.

At the same time, the consultation revealed important opportunities for reform. Participants highlighted examples of regional cooperation, innovative public health initiatives, civil society engagement, and growing recognition of the importance of prevention, preparedness, and multisectoral action. These experiences demonstrate that the region possesses significant expertise, institutional capacity, and leadership that can be leveraged to strengthen health governance and improve health outcomes.

A central finding emerging from the consultation is that health governance in the MENA region is shaped by broader political and economic dynamics that influence how priorities are set, how resources are allocated, and whose voices are included in decision-making processes. Strengthening health systems will therefore require more than technical reforms. It will require governance approaches that promote accountability, transparency, participation, and equitable distribution of resources while creating stronger links between evidence, policy, and implementation.

The consultation also highlighted important tensions that will continue to shape future reform efforts, including the relationship between humanitarian response and long-term system strengthening, the role of regional financing and regional ownership, and differing perspectives on the scope of civil society participation in governance processes. Recognizing and engaging with these tensions will be essential for developing governance reforms that are both effective and politically feasible.

Participants repeatedly emphasized the importance of ensuring that regional and global health architecture reform processes reflect the realities and priorities of the MENA region. Future governance efforts should build on regional experience, strengthen collaboration across sectors and countries, and ensure that affected communities are meaningfully represented in decision-making processes.

Ultimately, the consultation revealed a strong appetite for more accountable, equitable, prevention-oriented, and resilient health governance systems.

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