Designing a New Global Health Architecture for the Middle East and Central Asia Region

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A Perspective from the Middle East and Central Asia Region

Recent political and financial shifts present an unprecedented challenge to global health, but also a long-awaited opportunity for significant reform. Wellcome has asked five global health thought leaders from different regions to explore what a reimagined global health architecture could look like. These five proposals are intended as a starting point to kick start regional and global conversations. The proposals are not expected to be representative, or consensus based, but to provoke discussion and debate.

Executive Summary

The Middle East and Central Asia (MECA) region includes countries that, while geographically combined in some international frameworks, vary widely in governance systems, demographic composition, economic development, conflict status, and health system functionality. This proposal for a reimagined global health architecture attempts to navigate such diversity and need with a sensitized context-specific approach to inform a realistic "reimagining" in a shifting, and very challenging, reality.

The proposal highlights key aspects of the reimagined architecture: (1) functions, (2) key characteristics (structures and forms), and (3) reform pathways.

In terms of functions, the reimagined global health architecture for MECA would reduce the out-of-pocket expenditure on health, expand pooled risk protection, promote inclusive governance and accountability, deliver equitable health outcomes, make regional and public goods more available, strengthen national and subnational health systems, and enhance crisis preparedness and response.

Guided by these functions, the forms and structure of the reimagined architecture is proposed to have regionally-anchored and globally-engaged global health institutions, creative health financing mechanisms that include a value-based approach to global health financing, strong coordination processes, with strategic investment in institutional strengthening, as well as regional context-specific innovation.

To achieve the proposed reform, five pathways are suggested. These include enhancing institutional and functional efficiency as well as implementing a financing reform that is based on solidarity, private sector engagement, and fund pooling while shifting power to regional and national actors. The need for **a data-driven approach** to allocation of funds is also key coupled with strengthening data systems, interoperability, and digital integration.

Overall, at the core of the proposed reimagined global health architecture for MECA is the aspiration for a more efficient, effective, and equitable global health system; with functions that connect the nexus of global significance, regional and local relevance to context, and geopolitical and political economy factors. Complementary roles for the international health financing stakeholders including the Global Health Initiatives (GHIs) and regional actors are currently - and will remain, key in any reimagined architecture.

Background

MECA: A region of heterogeneity and unique contexts

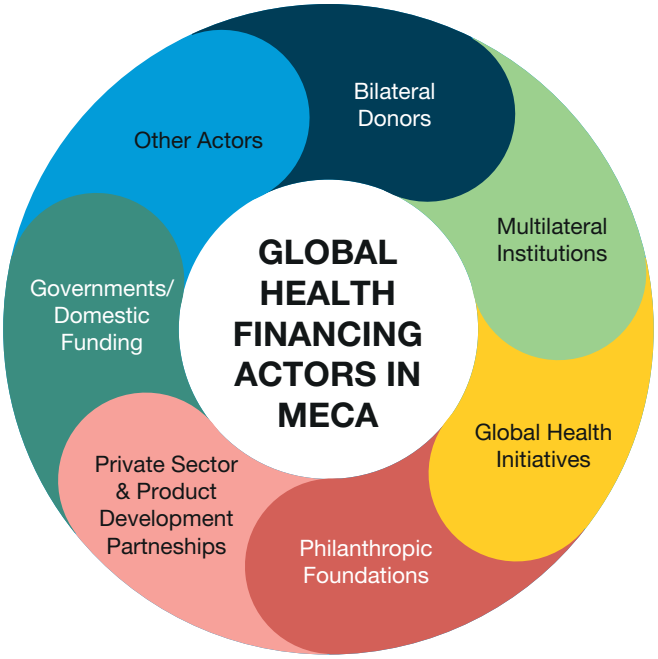
The Middle East and Central Asia (MECA) region includes countries that, while geographically combined in some international frameworks, vary widely in governance systems, demographic composition, economic development, conflict status and health system functionality[1].

A defining characteristic of many countries in this region is a **chronic exposure to protracted conflicts, massive human displacements, and political and economic instabilities** with Central Asia region being relatively more stable compared to the Middle East and North Africa (MENA) region[2]. In fact, the MENA has around 3.2 million refugees and asylum seekers in addition to 13 million internally displaced people, a figure that is among the highest globally in proportion to its total population size[3]. These factors compound global health crises, including population migration and displacement, food insecurity, poor physical and mental health, and disruption of health services and supply chains among others[2].

Countries in MECA vary widely in income, from high-income countries (HIC) to low-income fragile countries, leading to differences in health system needs, financing, and aid reliance. Low and middle income countries (LMICs) face vulnerabilities due to limited resources, weak systems, and reliance on external aid, hindering investments in workforce, infrastructure, and services, and weakening routine and emergency health response capacity[4, 5]. There are also major **disparities in health coverage** with LMICs relying more on out-of-pocket payments (OOP), increasing inequities and financial strain[6].

Lastly, the MECA region exhibits a remarkable variation in **health systems fragility between fragile and conflict-affected states (FCAS)** and **non-fragile countries**. FCAS which are often affected by conflict, displacement, and weak institutions—suffer from disrupted health services, damaged infrastructure, shortages of health workers, and limited access to healthcare, especially for vulnerable populations like refugees and internally displaced populations[7]. In contrast, non-fragile states in MECA are characterized by more robust health systems, higher expenditure on health, and overall better health outcomes albeit that the majority of these countries continue to face challenges related to rising chronic diseases[8, 9].

Figure 1: Global Health Financing Actors in MECA



The current architecture of global health financing in MECA reflect the global architecture and is shaped by a wide array of actors. **(Figure 1)**. These actors vary in their sources of capital, funding mechanisms, and strategic priorities.

Despite all this effort, the field of global health remains heavily reliant on a few major donors and global health programming remains highly dependent on a donor-driven agenda further aggravated by power asymmetries, limited flexibility, and varied levels of accountability with a major oversight of national and context-specific health[10]. As momentum builds toward more equitable and effective financing structures, future reforms in MECA and other regions of the world must emphasize a contextually grounded reimagining of global health that takes into account the diversity of regional needs, the political economy of health systems, and the differentiated capacities of actors on the ground. New proposed architectures must not merely tweak old models but rather embody new functions that strengthen sustainable health financing, ensure regional anchoring, uphold inclusive governance, and focus on outcomes.

A reimagined global health architecture: the proposal

The global health ecosystem is currently in a state of strategic transition, and it must be acknowledged that it is not by choice. These transitional phases, whether self-initiated or dictated, present generational opportunities for reflection, reimagination, and positioning.

The MECA region comprises a contrasting blend of economic and geopolitical factors that require a contextualized understanding and unique approach to its share of global health challenges.

In that backdrop, this proposal for a reimagined global health architecture attempts to navigate such diversity and need with a sensitized context-specific approach to macro-global movements and dynamics that would inform a realistic "reimagining".

A reimagined global health architecture: functions & forms

At the heart of this reimagining effort is the aim to build a more efficient, effective, and equitable global health system. Though these ideals have long been echoed in global health discourse—often reduced to mere slogans with limited real-world application—they remain essential guiding principles for any future global health architecture.

Below is a proposed list of functions that intersect global importance, regional and local context, and geopolitical and political economy dynamics. A key caveat—particularly relevant, though not unique, to MECA—is the diversity of country profiles discussed earlier. This diversity presents challenges in standardization. Nonetheless, the following functions strive to reflect that diversity as concretely as possible, offering a framework that can adapt across varying settings while anchoring in realities, shared priorities and systemic goals.

It will become clear that although the overall functions (titles) are not revolutionary, quite a bit of what is proposed requires a considerable shift in the status quo and business as usual.

Key functions of a reimagined global health architecture: a global view and a regional context

Function 1. Catalyze and coordinate sustainable health financing models and efficiency in global health architecture

In a reimagined global health system, informed by recent developments, creative and sustainable health financing models become a necessity, both at international and regional and national level. At a global level, that would require better, more structured, and formalized coordination mechanisms and processes to do more with what is available. In addition, regional and national resources actors (donors, private sector, HIC governments etc.) must be more engaged, efforts streamlined and coordinated.

It must be noted that system efficiencies and more adoption of value-based approaches, especially looking forward, would be as critical as contemplating funding sources in a reimagined sustainable health financing model. This has to be pursued from the financing side (reducing intra- and inter-agency redundancies, efficient operational maps for GHIs [service and geography], efficient internal human resourcing, and value-based financing) AND the receiving end with clear value propositions and transparency.

Function 2. Promote "real" inclusive governance and accountability at the global, regional and local level

One can debate whether inclusive governance and accountability are two separate constructs - which they can be, depending on the context. On the issue of inclusive governance, most global health publications and forums mention inclusive governance as a tenet. Furthermore, international bodies such as UN organizations, global foundations among others make an active effort to achieve that. However, it seems that the power dynamics resulting from funding sources (included in the political economy discussion), more established systems in HICs and geopolitics are stronger than any written and advocated dedication to the principle of inclusive governance. Some have coined the term "global health neocolonialism" to describe this phenomenon.

In a reimagined global health architecture, the global community must acknowledge these pull factors, be vocal on their "unspoken" influence, and systematically (and aggressively) buffer their effect. It also must be noted that inclusive governance as a function should be multi-layered from the macro global health architecture all the way down to regional, national, and subnational levels (affected communities and end users, policy stakeholders, etc.).

Accountability should remain a function within a reimagined health system. The de-facto approach of including it, along with inclusive governance, as a mere "formality" must be challenged and replaced with meaningful integration into systems design, resource allocation, and practice.

Function 3. Deliver Equitable Health Outcomes by Addressing Entrenched System Shortcomings and Disparities

The dominant approach to enhanced global health has been to tackle the inputs (e.g. number of available vaccines to eligible children, human resource capacity etc.) and process models that are tested in settings that may or may not be applicable to the respective context. Although these are key factors towards equitable global health, the proposed function calls for a context-informed approach. The rationale is that context can scramble the golden standard of inputs and processes. An international body may be able to provide the right number of vaccines based on the number of eligible children, but the supply chain may be disrupted due to conflict; displacement can hinder outreach; there may be insufficient human resources to deliver the vaccines; and data systems may be unable to properly track areas with low vaccination rates, among other challenges. That is why the focus of the function in a reimagined system should further highlight outcomes. It is undoubtedly more logistically challenging and require more tailored approaches, but it is what will ultimately drive global health impact.

Function 4. Special consideration to refugees, displaced populations, and marginalized communities

MECA has a disproportionate burden of refugees as well as displaced and marginalized populations mostly from conflicts, but also due to economic factors and more recently climate factors. A main function of a reimagined global health architecture should consider that and acknowledge that proactive efforts are needed to address inequities among those hard-to-reach populations through active engagement, tailored global health interventions, and operational flexibility within health systems.

At a global level, this would require a contextual, sometimes micro knowledge, of the complexities of addressing the unique challenges of these vulnerable populations. This is better approached through relegating operational and implementation components to local actors. Real life experiences have shown that GHIs frequently deploy international (well-paid) staff to perform these functions which ends up being a costly, inefficient learning exercise and a discovery journey for most.

Function 5. Strengthen national and subnational health systems

Although not a novel function, strengthening national and subnational health systems while giving the priority to primary health care (PHC) and public health capacities has been and should continue to be a core function of any global health architecture. Closely intertwined with many other functions, a strengthened health system with upgrading and upskilling of PHC infrastructure and public health capacities are key enabling factors to an equitable, effective, and efficient global health.

Considerable attention and resources have been dedicated to PHC, as a significant cornerstone of UHC efforts especially after the 2018 Astana Declaration that renewed commitment to PHC (after the 1978 Alma Ata Declaration); these efforts should continue in a reimagined global health architecture. In addition, strengthening public health functions have proven critical at several levels including in the COVID-19 as a strong backbone to supporting health system functioning during such challenging contexts. Both components are particularly important in the MECA context, where many countries are either conflict-ridden or conflict-prone, host significant refugee and displaced populations, and have fragile health systems with limited resources for secondary and tertiary care.

Although most of the investment has to be led and coordinated at the national level, many experiences from the region and Global South have shown that GHIs' support of health systems structurally and operationally (programmatic support and deferred implementation) have resulted in more able and resilient systems.

Function 6. Provide Regional and Global Public Goods such as Disease Surveillance, Health Workforce Development, and Equitable Access to Medicines and Vaccines

In a reimagined global health architecture, global public goods are more available and shared across borders from HICs to HICs, HICs to LMICs, LMICs to LMICs and yes, LMICs to HICs (e.g., geo-surveillance, context-specific research and development (R&D), and workforce developments etc.).

Frameworks must be developed (or reimagined) to allow such seamless sharing of public goods. It is a well expected tenet that regional provision of such goods takes precedence over global ones. Such a function would be considered key to enhance global health outcomes and enhance equity and access.

Function 7. Ensure effective crisis preparedness and response mechanisms, especially in fragile and conflict-affected settings

The MECA region is considered an epicenter of humanitarian crises. This is coupled with many countries in the region characterized as fragile states, with weak/er health care systems. In that context, a key function of a global health architecture should be to ensure effective crisis preparedness and response mechanisms through regionalization of plans, structures and processes. The recently adopted WHO Pandemic Agreement of 2025 is a key milestone in ensuring less-resources countries and regions have access to resources and expertise [26]. However, experiences of LMICs (old and new) have demonstrated the importance of self-dependency in these areas at a national and regional level.

At the global level, this would translate into infrastructural support, knowledge sharing and capacity building, in addition to global network strengthening (especially South-South). At the regional level, there is an opportunity to capitalize on advanced technical and digital tools, including AI-aided modeling and resource deployment that can support that function. This can be facilitated by strategic efforts in some countries within MECA to serve as hubs for AI and recent deployment of AI tools in major regional occasions (e.g., in KSA during the hajj season). Such interventions can serve as basis for further deployment in less-resourced settings and enhance preparedness efforts.

The operational translation of such efforts has to range from modeling to supply chain management in crisis and should include reviewing capacities in the health and other relevant systems at the local, regional, and international levels.

In conclusion, these seven functions must be considered as intertwined and co-facilitators of one another. The advancement in one or more will have a favorable impact on the ability of the other functions to reach its potential or even progress.

The envisioned form, structure, and flow of a reimagined global health architecture

The envisioned global health architecture should be guided by the above-mentioned functions and the global principle of a people-centered approach to global health. **The proposed aligned structure and form** envision strengthened regional initiatives and institutions, creative financing mechanisms, proactive engagement in technology and digital tools, and a strive to adopt a more value-based approach that encourages efficiency while promoting effectiveness and equity.

Furthermore, current events may present an opportunity for a global commissioning of a review of mandates and functions of GHIs with the aim to streamline efforts, enhance efficiencies and reimagine a new model of cooperation and functioning of GHIs. Recommendations from such a review would be cascaded into coordination structures and intra-agency strategic discussions for implementation.

1. Global health institutions are regionally anchored and globally engaged.

In a reimagined global health architecture, more global health institutions and initiatives are regionally anchored. The "regionality" dimension has proven to be more responsive to the specific needs of regions and countries, accounting for their unique political economies and geopolitical contexts, while also fostering a sense of pride in regional achievements. The Africa Centers for Disease Control and Prevention (CDC) has been a prime example on how "regional" institutions can be an anchor to global health efforts and advancement. Specifically, the main functions of global health, including ones covered in the earlier section, should be anchored in standing institutions within the region. This does not mean that each function has to have a separate institutional entity, but rather a regional structure as a reference (and for accountability). From a financial flow perspective, it is envisioned that some of these structures or institutions be funded by a regional collective, e.g. League of Arab States, Organization of Islamic Cooperation, Gulf Cooperation Council (GCC). Others can be funded by countries that have a strategic interest in specific areas, e.g. Regional AI in Global Health hubs in UAE, Disease Surveillance Centers in KSA among others. The role of global health players would be to support functions and geographies that are less resourced and partner with anchor organizations on knowledge exchange, capacity building and global health dialogues and strategies including on macro global health directions, trends, concerns and investments.

Embedded in this movement should be a dedicated effort, supported and encouraged by global health and international health financing community to support such efforts. Initial financial support, although envisioned to be mostly from regional sources, can be supplemented from global health institutions, especially bilateral and multilateral organizations. Furthermore, capacity building and knowledge exchange would be a key contributing asset. Special consideration should be given to South-South collaborations and relevant knowledge sharing.

2. Creative and engaged financing mechanisms

It is quite plausible that the shift (reduction) in international health financing is not a short-term concern; and what would be available and committed will be prioritized and carefully administered. As such, there is a need for the global health community to think creatively of financing models that include, but not totally depend, on traditional sources.

This proposal does not expect a termination of international health financing to LMICs, including those in MECA. Rather, it highlights some non-exclusive complementary proposals to reimagined international and regional health financing architecture. It has to be noted that this has to be accompanied with a reframing of "narrative" from international health financing or international assistance to a macro investment in health and, more importantly, development.

A proposed "engaged" health financing mechanism that can be applied at regional levels, but especially in MECA, is the launch of **MECA Health Solidarity Fund**. As highlighted in a previous section, the region is quite diverse in terms of income levels. Based on a World Bank estimate, the MECA has a higher share of low-income countries in 2023 compared to just few decades ago, while having six high-income countries and another six in the higher middle-income category. This proposal calls for the establishment of a regional solidarity fund that solidifies the regional commitment to global health. The Fund will adopt a governance structure that elevate LMIC voices within the region by formalizing their leadership in priority-setting and oversight bodies. It is also envisioned to have transparent, value-based, efficient and equitable processes. In addition, the fund will have a component for flexible, rapid-response humanitarian funding for essential health services in conflict-affected countries. Financial flows into the Fund will follow a commissioned mapping of current resource deployment FROM the region and INTO the region. The mapping should be followed by a high-level meeting for a more targeted financial pool of such funds.

Importantly, there is a need and an opportunity for the private sector to be engaged in global health financing, even if at the regional or national levels. Few of the pharmaceutical and biomedical engineering companies already support global health initiatives, although mostly aligned with their commercial and branding interests. The further engagement in private sector can be enhanced through multiple paths including an alignment of committed funding with regional and national health priorities (including a joint public-private alignment on strategic health needs and mapping of support based on that), expansion of private sector "players" pool into yet-to-be engaged industries (e.g. electric vehicles manufacturers and health impacts of climate change, plastic-based industries and water bodies' pollution, etc.) and structurally encouraging private sector to invest in manufacturing or process reengineering of good and services that would enhance efficiency within global health (e.g., local PPE industries, low-cost vaccine manufacturing etc.). These are some examples in which the private sector can engage further in the "business" of global health with many other potential win-win scenarios that would complement financing needs, encourage innovation, and promote efficiencies. While it may be somewhat expected that the increased engagement of the "traditional" private sector will help with the efficiency aspect much more than equity of health, social entrepreneurship should be encouraged and supported. This can be achieved through investment pools and seed funding by global and regional health entities. The AI in global health space is an example in which such an approach has shown early positive results; that can be extended into other areas within global health.

3. Establishing or strengthening formal coordination mechanisms & structures of international & regional health financing

The proposal calls for the establishment or strengthening of coordination mechanisms among existing "financing" pools, including the proposed Solidarity Fund. The establishment of such coordination structures or mechanisms should be intended to **streamline** and not duplicate portfolios and geographies, create efficiencies across and within organizations, and **identify yet-to-be explored stakeholders** (e.g. regional, private sector, etc.) and creative financing mechanisms.

It must be noted that this proposal calls for a **more structured and formal approach to coordination** beyond meeting and common stand-alone field-specific plans. This proposal calls for establishing secretariats with governance structures. It is understood that this would disrupt the status quo on how established funds and GHIs operate, so that is why it is proposed to be done in gradual, but short, phases. It can start with establishing a coordinating secretariat of top financial contributors, e.g. EU global health portfolio, GHIs operating in a certain geography, then be expanded. The governance structure should be in the early phases focused on programmatic and geographical planning and coordination of activities. It would be ideal if biennial plans are developed that would outline needs, role of the different stakeholders, funding calls and operational mechanisms and metrics. These can be revised in a biannual phase based on progress and shifting dynamics (funding, resources, operational challenges, conflicts, emerging needs among others). As a proof of concept, such an approach has been adopted in FCAS on health (Lebanon with a standing coordination structure and mechanism) and was relatively effective. A regional model will undoubtedly be more complicated, but nonetheless doable.

Naturally, the proposal calls to engage all stakeholders, including civil society organizations (CSOs), the private sector, and other relevant actors.

4. Contextual innovation and regional manufacturing

COVID-19 has shown the importance and relevance of a decentralized approach to global health challenges. Even with new global solidarity initiatives, such as the Pandemic Agreement (adopted in May 2025), the need for investing in and strengthening regional centers of R&D and manufacturing is quite clear. This is a strategic component of a reimagined health architecture that would not only support contextualized solutions, but also greatly support the development of economics and societies while safeguarding against logistical and financial challenges of supply chains and geopolitical contexts.

Academic institutions should serve as "anchors" for this movement as this aligns with its missions and "products or outcomes" of skills, ideas, and human development. The private sector is also a key partner and incubator in the space with public support and endorsement.

The international health financing community has for many decades supported initiatives in that context. However, a more strategic approach should be adopted with a focus on concentrated priority areas and a sustainability and development lens.

5. Institutional building and strengthening as strategic investment

Over the past few decades, several disease- and population-specific approaches and programs were adopted by many GHIs and injected into the health system structures and delivery apparatus of many LMICs, including several in MECA. Although the aim of such efforts was, and is still, needed, it has resulted in silos of power as a byproduct of financial support for these programs within the health system architecture. The "reformed" version of these programs would include a declared strategic goal of strengthening health systems; still, the operational translation of that has not trickled strongly enough given the money and power dynamics from the main stated goals of GHIs.

This proposal stresses on the importance of a consistent investment in global health and health system institutions as "whole" units. The reformed version described above must be operationalized and transfused to the full system, even if it requires more effort and a seemingly out-of-scope investment. It has been observed and documented that stronger health systems support and enhance the effectiveness and efficiency of national and global disease programming. As an example, if the focus is strengthening disease surveillance structures and processes on an infectious disease, an assessment and an investment has to be done in the whole disease surveillance program within the public health structure; and if possible (through coordination mechanism highlighted in an earlier section) strengthen the prevention and treatment aspects of such diseases. This comprehensive approach will undoubtedly pay dividends to funders, national entities and other stakeholders. This would be facilitated through approaching global health through a wider lens and facilitated operationally by having a coordinating mechanism where an entity can highlight and seek the support of other stakeholders in this approach.

It is well understood that "donor fatigue" from such investments is a realized occurrence, especially in fragile and poorly governed countries. However, it is these systems that are the best options for a sustainable approach to global and national priorities such as diseases surveillance and control, crisis preparedness, and health service delivery systems among many others. This is of further relevance to countries that are addressing challenges of refugees and displacement while being in fragile states, with many of these being in MECA.

An important consideration relates to **global public goods**. There are several forms and structures that are described below that would support the provision of such goods. These include the regional anchoring of global health institutions, coordination mechanisms and the move towards more regional innovation and manufacturing, with others definitely playing an enabling role.

This proposal assumes, through the proposed forms and structures, that the sharing of these public goods will be greatly facilitated with the realization of the reforms. For example, the focus on system strengthening at the national level coupled with regionally anchored institutions will help with sharing of cross-border disease surveillance data needed for monitoring, preparedness and action. Similarly, emphasis on more regional manufacturing would facilitate access to medicine and vaccines (Personal protective equipment (PPE) in a COVID-like scenario) that in normal contexts would be challenging to access given global competition for resources.

A reimagined global health architecture: reform pathways

Achieving the vision for a new global health architecture requires reforms at institutional, structural, and operational levels.

Reform pathways: advancing a regional agenda that aligns with global health priorities and needs

Without reform, health in MECA will remain fragmented, underfunded, and ill-equipped to manage emerging threats. Investing in regional coherence and locally-led solutions may involve up-front coordination and investment costs, but the long-term benefits in resilience, equity, and efficiency vastly outweigh the costs. Failure to act will deepen health inequalities and increase dependence on external aid for many countries in the region. In that context, this section lays out five reform pathways towards the reimagined global health architecture. In addition, the table on page 9 outlines concrete steps, actors and roles as well as timeframes for 2025-2027 to implement them.

Reform Pathway 1. Institutional and Functional Efficiency

There is a need to engage in re-engineering global health and health system institutions based on desired functions and characteristics of a reimagined global health architecture. That should be done at different levels including national institutions, regional entities, as well as UN and international agencies that support global health functions.

A close look into national health entities reveals a proliferation of units within the global health ecosystem, including in ministries of health, with many being redundant or having overlapping functions. This has to be reformed to be better aligned and create system efficiencies with an institutional strengthening component.

This observation is mirrored in many UN and international agencies. Most are now engaged in a "forced" downscaling of proliferating functions and units within and across organizations, unfortunately not through self-reflection but rather induced by funding cuts. Still, this can be a considerable reform opportunity to merge functions and have more lean operations in organizations that have self-admitted to inefficiencies.

As for the "how to get there", the process has to be initiated through commissioned review of institutional and functional structures and functions. The commissioned review, preferably by a combination of internal and external actors, will likely result in executive decisions that can range from functional and institutional mergers to more drastic elimination. This review is quite timely and has to be coupled with a high-level commitment for reform.

Reform Pathway 2. Financing reform: solidarity, fund pooling, efficiency and private sector engagement

Reform of regional and international health financing should focus on a set of key issues, and go hand in hand to enable financial sustainability.

Regional solidarity is key. The heterogeneity of the region in terms of income levels and institutional infrastructure and capabilities allows for a transfer of resources in multiple ways that does not only include financial resources (HICs to LMICs), but also shifts in human resources (mostly LMICs to HICs), institutional expertise, digital adoption, and non-financial resources (medicines and supplies). There is a need to join resources and efforts through regional initiatives such as the MECA Health Solidarity Fund.

To overcome inefficiencies created by segregation of funding for health and health services, it will also be critical to engage in reform efforts to increase collation of resources into common funding pools.

These points are not exclusive to regional bodies but also apply to global health financing. Formal coordination mechanisms will play a key role in ensuring that programmatic and geographic duplication are minimized to ensure financing efficiencies (see also Reform Pathway V on why integrating efficiency and value into global health programming is key).

Private sector engagement has been sub-optimal beyond involvement in secondary and tertiary care and in selected countries; and an underwhelming pharmaceutical sector. Much remains to be done, especially if proper institutional arrangements are implemented and government-supported enablers are made to engage with the private sector.

Table 1: Proposed core functions of the global health nexus

Reform	Implementation pathways	Practical steps	Actors & roles	Timeframe
Institutional & Functional Efficiency).	Review of institutional and functional roles within national/ regional and international entities	Functional/Institutional reviews are commissioned and conducted	National, regional & international organizations facilitated by in-house or external experts	Q1-Q2 2026
		Executives decisions/decrees to restructure entities and/or delete/merge functions based on commissioned review	National, regional and international organizations	2026-2027
Financing Reform: A Focus on Solidarity, Fund Pooling, and Private Sector Engagement & Efficiency	Establishing of MECA Health Solidarity Fund	Preparatory work for the Fund (scope, proposed structure, governance, secretariat, portfolio, contributions)	National representatives, CSOs, regional entities (eg League of Arab States, UN agencies), experts [all through working groups]	2026- Q1 2027
		High level meeting for regional adoption		Q2-Q3 2027
	Private sector engagement	Commissioning of a regional strategy for private sector engagement (areas, enablers and facilitators, value proposition etc)	• Associations of private sector • Experts (with input from stakeholders)	2026
		Regional meeting for dissemination and adoption	Regional entities	Q1-Q2 2027
Shifting Power to Regional & National Actors	Establishing MECA CDC (can be common among MENA and Central Asia or a joint but with independent entities)	Preparatory work for the CDC (scope, proposed structure, governance, secretariat, portfolio, contributions)	National representatives, civil society, regional entities (eg League of Arab States, UN agencies), experts [all through working]	2026- Q1 2027
		High level meeting for regional adoption		Q2-Q3 2027
	Other regional entities to be identified	Commissioning of a scoping/exploratory review of needs and capacities	Experts (with active input from stakeholders)	2026- Q2 2027
A Data-driven Approach to Allocation of International & Regional Health Financing	Developing a matrix (and associated approach) for "country needs" for international/ regional assistance	Commissioning of the matrix design, parameters, inputs and methodology	National, regional and global stakeholders facilitated by experts	2026
		Adoption of the matrix through a international/regional meetings	International and regional donors, countries, GHIS, civil society, experts	Q1-Q2 2027
	Regional metrics on value-based global health metrics	Preparatory work on proposed framework, value metrics and guide (data sources, methodological approach)	Experts, representatives of national and regional health entities and associations, CSOs	2026- Q1 2027
		Regional meeting for dissemination and adoption	Regional entities	Q2-Q3 2027
Digital Health Reform: Standardizing Data Systems, Digital Integration, Interoperability, & Functional Efficiency	Scoping of current status and adoption/ adaptation of regional data and digital health integration	Scoping review of current status (infrastructure, needs, capacities, challenges and recommendations)	Experts	2026
		Executive regional meeting on minimum needs for data and digital integration/ operability	International and regional donors, countries, GHIS, civil society, experts	Q1-Q2 2027
	Responsible adoption of AI with clear data governance parameters	Commissioning of a regional strategy for responsible and contextualized adoption of AI (with proposed data governance component)	Experts (with active input from stakeholders)	2026
		Regional meeting for dissemination and adoption	Regional and international stakeholders	Q1-Q2 2027

Reform pathway 3. Shifting power to regional and national actors

While there is a continuous need to engage with global stakeholders, the recent global health challenges affecting the MECA region, and others, have highlighted the relevance and significance of investing in and strengthening regional and national entities and actors.

In that context, this proposal calls for the development of regional specialized entities such as MECA CDC, centers of excellence in crisis preparedness, AI and digital health among others. The location of these regional centers can be based in relevant countries ensuring a balanced governance system that favors a proper presentation among countries that are not affected by funding sources and among governance structures, including civil society.

It is important to note that such institutions would not be parallel structures to existing, as that would be counterintuitive from a duplicative and efficiency and resource allocation perspective. Instead, the review of functions and roles outlined in reform pathway I will be key to determine what functions and institutional arrangements would be the most effective and efficient. This may require some bold decisions involving the collating or termination of existing structures.

A specific focus of regional reform and investment should be on R&D and manufacturing. There is a need for regional investment, supported by governments, international health financing community, and the private sector. These investments can be coordinated through a **Regional Health Innovation and Manufacturing Fund** that focuses on regional health priorities.

Reform pathway 4. A data-driven approach to allocation of international and regional health financing.

Most, not all, current international health financing schemes especially bilateral and multilateral "international assistance" are guided by donor priorities and agendas with a recognized geopolitical positioning and influence. It would be practically unreasonable to propose a strategic shift to this model that has existed since this the birth of civilizations. However, a reimagined architecture aspires that support to be informed and driven by data and facts, reflecting needs. These include burden of disease in the receiving geographic locale (subnational, national and regional), infrastructural status (health system fragility), governance and transparency, stated priorities, and YES, efficiency-driven initiatives.

On the latter, for many decades the concept of efficiency in global health programming has been faced with scrutiny as unethical or not befitting of such a noble cause such as global health. However, changing times merit a changing mindset and perspective. Not only is there a need for efficiency to be a main component for global health programing, but this proposal also calls for adopting a value-based approach to global health. For the purposes of this proposal, value does not refer exclusively to direct financial cost – despite it being the main component. Value-based global health (VBGH) should be developed as a universal framework that prioritizes a minimal cost per unit of value outcome. The definition of value outcomes must integrate accepted metrics that include equity and relevant social values. That ranges from investing in PHC (as it has been proven cost-effective) to other public health initiatives, joint procurement, vaccines production at both regional and national, among many other examples.

For the whole concept to evolve into reality, there has to be a phased approach that includes as a first step an emphasis by global health institutions and donors on data infrastructure and generation at the national and regional level. Some of that data is already generated. However, its collating into useful formats, for the purpose of this proposal, is still sub-optimal. This phase should be followed by the development of an embedded weighted incentive system among international health financers (and could be national as well) that integrates key burden and performance metrics (that would also feed into the value-based metrics). The level and weight of the incentive will have to be gradual but enough to reflect the intricacies of the different needs AND push nations and systems to enhance responsiveness and performance.

Reform pathway 5. Digital health reform: standardizing data systems, digital integration, interoperability and functional efficiency

Reforming data generation infrastructure and processes is a cornerstone for improving progress in tracking and supporting broader reform efforts of the global health architecture. It should also promote regional data uniformity, interoperability, and greater digital integration wherever practical and feasible. Digital health application and integration should be a key component on this pathway. This would support national and regional efforts to integrate digital health tools into data collection and collating, as well as basic global health and health system functions. This reform path requires long-term commitment and infrastructural investment in data systems, ideally with AI components. In addition, systems and processes must emphasize globally responsible and contextualized adoption of AI with clear data governance parameters.

Conclusion

This proposal is calling for reform pathways that integrate a “global” view of global health but stresses the importance of decentralizing considerable components that are better designed and envisioned at the regional level for sustainability, effectiveness, and efficiency. It is envisioned that there is a complementary role between the international health financing stakeholders, GHIs and regional actors to engage in supporting these reform pathways. The proposal also calls for an overarching, non-exclusive, push to actively encourage and support South-South knowledge exchange and resource sharing. The MECA region is ready to lead. With targeted investments, regional solidarity, and bold reforms that enhance efficiency and value-based initiatives, countries can jointly build resilient and equitable health systems that factor the unique challenges of this diverse region. Stakeholders across governments, multilateral organizations, civil society, and the private sector must commit to take tangible steps toward this future.

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Acronyms

MECA	Middle East and Central Asia
MENA	Middle East and North Africa
HIC	High-Income Country
LIMCs	Low- and Middle-Income Countries
OOP	Out-of-Pocket
FCAS	Fragile and Conflict-Affected Settings
UHC	Universal Health Coverage
GHIs	Global Health Initiatives
R&D	Research and Development
PHC	Primary Health Care
GCC	Gulf Cooperation Council
WHO	World Health Organization
CDC	Centers for Disease Control and Prevention (CDC)
PPE	Personal Protective Equipment
CSOs	Civil Society Organizations
VBGH	Value-Based Global Health

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