South and Southeast Asia in Global Health Governance

A Regional Consultation Summary Report

New Delhi, 26–27 November 2025

In late **November 2025**, the **Centre for Social and Economic Progress (CSEP)** and the **United Nations University's International Institute for Global Health (UNU-IIGH)** co-hosted a two-day regional consultation on **South and Southeast Asia in global health governance**. Experts and practitioners from Sri Lanka, India, Brunei, Indonesia, Thailand, Malaysia, Singapore, and other countries participated in the meeting. The consultation aimed to identify what the region needs from global and regional health institutions and to explore how Asian countries can better shape evolving health governance frameworks and mechanisms of cooperation.

Over two days, participants explored gaps and opportunities in regional and global health cooperation, financing challenges, and the impact of geopolitical shifts on health collaboration. They discussed ways to strengthen global health governance so that South and Southeast Asian needs are better represented. A SWOT analysis of the current global and regional health governance architecture was conducted. The consultation's findings will feed into ongoing joint research by UNU-IIGH and CSEP on how Asian countries engage with health governance amid shifting geopolitical dynamics.

Day 1| November 26, 2025

Welcome Remarks

• **Sandhya Venkateswaran (Senior Fellow, CSEP)** and **David McCoy (Research Lead, UNU-IIGH)** opened the session with a joint address. They noted that global health governance is undergoing a "rupture": multilateral institutions are weakening, while development banks and private actors are becoming more influential, all amidst strained health systems, in large part due to COVID-19. They highlighted trends such as declining health aid and rising debt in some Global South countries. While the WHO remains central to health governance, accountability is fragmented and power is shifting across institutions. They argued that regional health governance is gaining importance in this context.

The speakers observed that Asia's role in global health is growing, as countries expand their economies, manufacturing, and technical expertise, and engage in forums like the G20. However, this influence is uneven due to geopolitical tensions and an insufficient focus on health within regional bodies like ASEAN, SAARC, and BIMSTEC. They referenced a background paper by the Asian Collective for Health Systems, which examined how South and Southeast Asian countries engage with global institutions (e.g. World Bank, WHO, G20) and regional bodies (ASEAN, SAARC, BIMSTEC, ADB). The consultation included civil society perspectives on how stronger regional coordination could help represent regional priorities in global forums and contribute to the evolving health governance architecture.

Opening Remarks

• **Prof. K. Srinath Reddy (Founder President, Public Health Foundation of India)** reflected on past global health goals, noting that the Millennium Development Goals focused on narrow primary care targets, fracturing health systems. This was later corrected by the broader Sustainable Development Goals. He emphasized that regional institutions in the Global South are crucial for setting norms, coordinating policies, and sharing technical resources—ideally through the WHO. Using the example of WHO tobacco treaty negotiations, he explained how regional consultations (with civil society input) helped countries negotiate as a bloc and achieve stronger outcomes. In contrast, recent non-communicable disease talks faltered due to unilateral actions. Prof. Reddy stressed that a strong collective regional voice is essential to influence global health decisions.

• **Prof. Hsu Li Yang (Director, Asia Centre for Health Security, National University of Singapore)** underscored that no country is immune to health threats and that no ASEAN member can produce all essential health goods alone. He argued that, instead of retreating from global institutions, Asia should actively shape them. Key priorities include strengthening regional data sharing, surveillance, and digital health security, as well as diversifying regional financing (for example, by engaging partners like Japan and Australia). Prof. Hsu noted that the new Pandemic Accord is a step forward but falls short of demands from low- and middle-income countries, especially on pathogen access and benefit-sharing. He pointed out that ASEAN was originally established as political and security cooperation platform, and has since expanded to include social and cultural agenda items such as health; therefore, health considerations must be integrated into broader policy discussions. He noted that inequitable access to vaccines and treatments ultimately undermines global health security.

Discussion Theme 1: Regional Cooperation in South and Southeast Asia

A presentation by **Nadine Monteiro (Research Analyst, CSEP)** outlined opportunities for regional health cooperation in South and Southeast Asia, highlighting strong potential for collaboration given shared epidemiological transitions, environmental risks, and health system challenges. The presentation highlighted the various institutions present in the South and Southeast Asian region—ASEAN in Southeast Asia, and SAARC and BIMSTEC in South Asia. The existing architecture offers opportunities but is currently limited by constraints in effectively enabling health cooperation across the region. Some institutions possess more established organizational structures, such as ASEAN's political, bureaucratic, and technical clusters, and well-established diplomatic norms that encourage cooperation. These norms emphasize consensus-building and respect for state sovereignty, enabling collective action when interests align. There are successful examples of regional health cooperation—notably through ASEAN—and modest cooperation with multilateral partners, including SAARC and WHO on tuberculosis and HIV/AIDS. However, challenges persist, including limited budgets and donor dependency (e.g. ASEAN); a fragmented financing landscape; limited capacity among member

states and limited authority in secretariats; political tensions and mutual mistrust (e.g. SAARC due to the India–Pakistan standstill); and a narrow framing of health driven by technocratic (BIMSTEC) or security-related agendas (ASEAN). This is exacerbated by the limited contiguity between regional institutions and WHO regional groupings. Countries in ASEAN are split between SEARO and WPRO, while SAARC countries are split between SEARO and EMRO. SEARO currently consists of 10 member states, of which six are part of SAARC (Bangladesh, Bhutan, India, Maldives, Nepal, and Sri Lanka), three are part of ASEAN (Myanmar, Thailand, and Timor-Leste), while North Korea is from East Asia. Meanwhile, Pakistan and Afghanistan are part of EMRO.

The presentation concluded by posing key questions for the region:

- What roles are regional health governance institutions (RHGIs) currently playing?
- How can the distinct focus of the three institutions combine to address health cooperation in a cohesive manner?
- Fragmented financing across institutions raises questions regarding who defines regional priorities, and to what extent these are driven by country cooperation, secretariats, or donors. Can financing be re-architected towards country ownership?
- Can redefining the roles and responsibilities of member states better address the escalating complexity of health threats, including pandemics, non-communicable diseases, and climate change impacts?
- One platform versus many—does meaningful cooperation necessarily require aggregation into one regional institution?
- Is a single platform a practical strategy, given the economic diversity in the region—for example, Singapore and Bangladesh?
- How best can one (or multiple) regional institutions help smaller countries better engage with global health governance institutions?

Participants discussed these questions in two breakout groups and broadly explored how South and Southeast Asian countries can tackle shared health challenges through cooperation at regional and global levels. Discussions began by identifying the roles currently played by regional institutions and those that need to be played, based on country requirements.

Regional Priorities and Challenges

Participants identified what South and Southeast Asian countries want from global and regional health institutions. Four main themes of regional priority needs emerged:

- **Cross-border collaboration**: Countries emphasized the need to share knowledge and best practices in primary health care and other cross-border areas, especially among countries facing similar challenges.

- **Pooled procurement and service delivery**: Cooperation on bulk procurement of medicines and shared service delivery/ workforce (for example, in disaster-prone settings) can help countries facing resource constraints.
- **Transnational issues:** Pollution, pandemics, and other transboundary threats require coordinated regional or global action. Participants noted that collective bargaining could improve outcomes on these issues.
- **Collective bargaining**: Acting as a region can strengthen diplomatic and negotiating capacity. For instance, a unified regional position on health worker migration or medicines pricing could give individual countries more leverage.

Defining "Asia" itself was flagged as a deeper question, touching on identity, solidarity, and the foundation of regional cooperation. Complicating factors in achieving pan-Asian solidarity were discussed, including differing levels of regionalization between South and Southeast Asia. Political sensitivities, low trust, capacity gaps, and donor-driven agendas were noted as particularly stark in the former. Speakers agreed that Asia's diversity necessitates flexible governance approaches: a mix of issue-specific coalitions, bilateral agreements, and broader regional initiatives. Existing bodies like ASEAN, SAARC, and BIMSTEC have some health mandates but remain under-resourced and under-leveraged. Participants debated whether these organizations can be adapted for health priorities or whether a new regional structure is needed. Some called for clear mandates and stronger leadership within existing institutions, while others left open the question of creating new frameworks to unify the region's voice.

Discussion points then included financing, research and development (R&D), procurement, data governance, and health system strengthening. There was broad agreement that domestic needs must be met first, but cross-border collaboration is essential for issues such as regulatory harmonization, access to technologies, and setting common norms.

Broad takeaways from the discussions on regional approaches to health governance included:

- **Institutional fragmentation:** Participants observed that Asia has many overlapping health platforms with limited coordination. BIMSTEC, for example, could potentially coordinate on pharmaceutical regulation and traditional medicine but currently suffers from a lack of structure and focus. In contrast, ASEAN has a more developed institutional structure (e.g. allowing flexible participation through ASEAN Minus X formula), though this has mainly served economic cooperation so far. Stronger regional leadership—possibly with roles distributed according to each country's strengths—was suggested to advance health priorities. This would require empowering secretariats and, where necessary, allowing member states to cede some limited sovereignty.
- **Data sharing:** Participants noted that timely data is critical for regional preparedness and for meeting global reporting standards. However, data sharing raises concerns about sovereignty, regulation, trust, and varying technical capacity. In practice, bilateral data-sharing agreements

are easier to negotiate, whereas multilateral regional mechanisms face higher barriers. Building trust and political will were seen as key enablers of sharing health data regionally, and how such trust can be built remains a key area for further exploration. Data governance surfaced as a cross-cutting issue. Participants acknowledged the potential of interoperable surveillance systems and shared reporting mechanisms but emphasized that data is neither neutral nor purely technical.

- **Multisectoral health agendas:** It was recognized that health issues intersect with finance, trade, climate, and intellectual property. Participants emphasized that health governance cannot remain confined to health ministries alone. Areas identified for deeper cooperation included climate and health, pharmaceutical regulation, and disease elimination.

- **Aligning global and regional governance:** At the international level, there were mixed views on current governance arrangements. The WHO was acknowledged as the primary body for global health norms, but concerns were raised about its bureaucracy, uneven regional voice, and accountability gaps. Many argued for strengthening existing institutions rather than creating new ones, with increased transparency and preparedness. Participants also noted that issue-based partnerships (rather than strictly geographic blocs) are becoming more influential in negotiations, reflecting shifting geopolitics and advocacy strategies. Incentives for collaboration vary by country, depending on factors such as disease burden and national priorities. Common denominators across sectors—shared concerns that resonate region-wide—were viewed as useful entry points for cooperation that could form organically. Others argued that having several issue-based alliances could be detrimental and increase the fragmentation of the already splintered global health governance system.

Overall, participants stressed that trust, political commitment, and clear governance roles between different regional entities are essential for effective cooperation. While the proliferation of actors risks fragmentation—and several participants expressed concerns about overlapping mandates and a lack of coherence—some noted that it also offers opportunities for more distributed leadership. The central challenge is aligning regional and global mechanisms with national priorities, improving coordination across institutions, and ensuring that cooperation yields tangible system-level impacts.

Speaker Presentation

This was followed by a presentation by **Dr. Vinya S. Ariyaratne (President, Sarvodaya Shramadana Movement, Sri Lanka)** on the role of civil society organizations (CSOs) in global and regional health reform.

He noted that current regional cooperation mechanisms, such as SAARC, have not, in his view, played a decisive role in regional health governance. WHO has had, and continues to have, an influential position as a specialized agency respected by governments, which has been leveraged to promote regional governance. CSOs have largely relied on their own national networks (e.g. the People's Health

Movement) and mechanisms such as the Civil Society Policy Forum with the World Bank, which includes regional representation at the policy level in health governance. A similar formal mechanism exists for CSO engagement with the Asian Development Bank. CSOs actively participate in the Annual Meetings of the World Bank/IMF and the ADB, influencing global health governance. Between the World Bank and the ADB, there is a large portfolio of health sector projects financed as concessional loans and other instruments supporting health governance. CSOs have contributed to setting up grievance mechanisms for health sector projects funded by multilateral financial institutions. CSOs have also interacted with the IMF (particularly in Sri Lanka after the 2022 economic crisis), demanding accountability and good governance by governments. Religious leaders and institutions (considered part of civil society) have significant influence on health policy matters (e.g. sexual and reproductive health). Professional organizations, such as medical associations, also have a definitive role to play and can be leveraged regionally for health governance.

Discussion Theme 2: Financing Regional Cooperation

The second group discussion focused on the political economy of regional health financing. Participants agreed that funding constraints are often symptoms of deeper structural constraints— such as institutional weaknesses and political challenges—rather than pure resource scarcity.

- **Reactive funding:** In much of the region, financing is reactive and tied to immediate crises rather than strategic or predictable. Official development assistance (ODA) plays a limited role in some South Asian countries.

- **Under-utilized funds:** Many existing funds and financial mechanisms are under-utilized due to weak absorption capacity in regional institutions. This is true for South Asian organizations and even for WHO regional offices. These challenges stem from institutional design flaws, political dynamics, and a lack of incentives for collective action.

- **Donor behavior:** Donors often impose tight earmarks, reducing flexibility and preventing funds from covering core needs. There is a trend of donors channeling money directly to individual countries or projects instead of regional bodies, reflecting declining trust in multilateral institutions. This undermines the ability of regional platforms to coordinate efforts.

- **Lack of regional identity:** It was noted that Asia lacks a strong, shared regional identity in health, unlike regions with cohesive bodies such as the Pan American Health Organization (PAHO) or the African Union (AU). In Asia, cooperation tends to be issue-based rather than geographical. Countries align on specific topics rather than as a bloc, complicating efforts to pool resources regionally.

- **Pooled financing:** While pooled regional funds can work under the right conditions (clear mandates and political agreement), there was concern that they could become overly top-down

or risk bureaucratic inefficiencies. Many argued that regional institutions should focus on coordination, negotiation, and standard setting rather than acting as funding agencies. Their value lies in helping countries articulate needs, navigate funding sources, and align on shared public goods, rather than directly managing funds.

- **Role of regional organizations:** Within Southeast Asia, ASEAN was seen as having potential to convene partners and broaden health discussions beyond traditional security frameworks. However, health remains peripheral in ASEAN, and strong political will is needed to raise its profile. SAARC's underused financial mechanisms were cited as an example of how even existing funds fail without institutional capacity and political alignment.

- **Strengthening existing platforms:** There was a broad agreement that creating new regional institutions is not the solution. Instead, participants advocated strengthening existing platforms and reevaluating their mandates and operating models. Regional bodies should emphasize enabling cooperation, supporting national priorities, and facilitating cross-sector dialogue (finance, trade, climate, etc.). Equity, transparency, and accountability were highlighted as essential principles in any reform.

The session concluded that the challenge is primarily political rather than technical: building trust, aligning incentives, raising health on the political agenda, and clarifying governance roles. In an increasingly fragmented global landscape, multiple mechanisms may persist, but effective regional cooperation will require clear purpose, stronger institutions, and a shift away from funding-centric models toward coordination and norm-setting.

Day 2 | November 27, 2025

Opening Remarks

Dr. Somsak Chunharas (President of the National Health Foundation of Thailand and former Deputy Minister of Public Health), began Day 2 with a keynote presentation. Key points included:

- **Global initiatives and country context:** Dr. Somsak noted several positive global health outputs (e.g. the WHO Essential Medicines List, the Ottawa Charter, and advocacy for Universal Health Coverage). However, he cautioned that global initiatives must align with national realities to be effective, citing Thailand as an example, which prioritized achieving UHC over complying with World Bank-driven privatization agendas.

- **Regional perspective:** At the regional level, Dr. Somsak argued that global health partnerships in South and Southeast Asia must become more equitable and relevant to national needs. He highlighted the shift needed from fragmented, surveillance-driven approaches toward collective action in crisis response. He also stressed integrating scientific and political perspectives when shaping global health norms and standards.

- **Synergy across levels:** He emphasized that creating or reforming institutions is not enough; a change in mindset and business models is needed to synchronize global, regional, and national efforts. He advocated for "whole-system alliances" (covering broad health systems) rather than narrow, theme-based coalitions, particularly for LMICs in Asia. While noting that cooperation-oriented regional mechanisms (like ASEAN networks) have helped address cross-border issues, he pointed out persistent gaps in surveillance and data sharing, calling for mandatory data-sharing protocols.
- **Global institutions' roles:** Dr. Somsak critiqued global institutions' effectiveness in their core functions ("directing, convening, coordinating"). For example, setting up logistics for new health technology distribution in LMICs is complex, and politically charged areas such as trade and industry see weak health-protective norms. He argued that focusing solely on external resources is insufficient; instead, efforts should strengthen national health systems and leverage country resources. Formal and informal coalitions could combine "hard and soft power" to achieve health goals.
- **Next steps:** He suggested that improving global health governance requires stronger regional and national mechanisms to create a "collective voice." A key question is whether to reform existing UN/multilateral systems or build new alliances (regional or global) to directly influence actors such as corporations. He noted the G20's "South" leadership as a potential opportunity for actionable outcomes. Finally, he called for clarifying roles at national versus collective levels and deciding whether alliances should cover whole health systems or specific themes for better harmonization.

Dr. Medelina Hendytio (Deputy Executive Director of the Centre for Strategic and International Studies (CSIS) in Indonesia), spoke on ASEAN's health governance. Indonesia faces significant national health challenges, underscoring the importance of regional cooperation through ASEAN. She argued that ASEAN can achieve economies of scale and unified standards that no single country can achieve alone. ASEAN has built infrastructure for health emergencies (e.g. emergency funds or stockpiles), but she observed that these benefits are not fully realized. Surveillance systems across ASEAN member states are fragmented, and the region has been slow to adapt to health issues exacerbated by climate change. Dr. Hendytio emphasized that ASEAN's regional cooperation offers advantages (such as pooling resources) that individual countries cannot easily replicate. However, realizing these advantages requires overcoming current institutional weaknesses in surveillance and emergency response.

Discussion Theme 3: Global Health Governance in a Fragmented World

Ahead of the Day 2 group discussion, **Dian Maria Blandina (Research Associate, UNU-IIGH)** reflected on how the post-war, state-led global health model has evolved into a fragmented multi-stakeholder landscape, where power and financing are dispersed across public, private, and hybrid

actors. While the WHO retains unique normative authority, she noted that its autonomy is constrained by reliance on earmarked funding and uneven regional resourcing. She highlighted shifts in Development Assistance for Health toward private and vertical partnerships, the growing influence of development banks in shaping national health systems, and the expanding agenda-setting role of platforms such as the G20, alongside the Group of 77 as a collective Global South voice. Despite South and Southeast Asia's rising economic and technical capacity, she observed that fragmented regional platforms—such as the Association of Southeast Asian Nations, the South Asian Association for Regional Cooperation, and the Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation—continue to limit collective influence. She concluded by posing questions about whether the current WHO crisis creates space for reform; how dependence on earmarked private funding can be reduced; how fragmentation across global health governance can be addressed; how a unified regional bloc might correct power asymmetries for smaller countries; how private finance in health can be regulated to protect equity; and how regional cooperation might challenge entrenched neoliberal approaches to global health.

The discussion revisited ongoing themes and, without attributing comments to individuals, key points included:

WHO's role: Participants agreed that WHO's commitment to Universal Health Coverage and its capacity to set norms and standards are essential functions that must be preserved. However, WHO's mandate and influence were debated; some noted the need to clarify "WHO governance" (e.g. one member state, one vote; bloc influences) and the separation (or overlap) of its technical versus political roles.

- **National agendas**: It was noted that countries are free to define their own health agendas regardless of global structures. Strengthening national health systems was emphasized as crucial, since a strong global system depends on strong country-level capacity.
- **Politics in health governance:** Some participants noted that technical and political aspects of WHO's work are deeply intertwined. The recent Pandemic Agreement negotiations showed that political will can overshadow technical processes. Others pointed out that strategic politics (not just "technocratic" approaches) can be positive; for example, India and South Africa's political push for the TRIPS waiver on COVID-19 vaccines achieved outcomes that WHO leadership had struggled to secure. This highlighted how powerful member states can use politics to advance equity.
- **International organizations and regimes:** Observers remarked that international organizations (such as the Bretton Woods institutions) have historically served as tools of power for dominant countries. In collaborations involving WHO, the World Bank, and foundations (e.g. Gates), participants noted that WHO tends to focus on public health and epidemiology, while the World Bank emphasizes financing. They suggested that it is important to consider who adds value in each issue area. One suggestion was to apply international

regime theory to compare what organizations were intended to do versus what they actually do (for example, examining intellectual property rules in the WTO or the founding objectives of WHO).

- **Future challenges:** Debt dynamics and the financialization of health were mentioned as emerging factors that will affect global health governance in coming years. One representative noted that international law is important and that unified action is difficult given multiple interests. It was also mentioned that some countries receive benefits only when their contributions align with their own priorities. This distinction or lack thereof between technical support and funding was seen as crucial.

Synthesis Presentation

Building on these presentations, **Assoc. Prof. Borwornsom Leerapan (Faculty of Medicine Ramathibodi Hospital, Mahidol University)** offered a conceptual framing of Asia's position within global health governance, describing the system through an "orchestra" metaphor. He highlighted the region's exposure to intersecting "poly-crises" that extend beyond traditional health concerns, underscoring the need to move from siloed approaches toward a broader Health in All Policies perspective. He observed that, alongside the World Health Organization, multiple international actors now steer often conflicting global health agendas, while WHO itself faces limited capacity to adequately support health development in Asian countries. These challenges are compounded by declining development assistance for health in parts of Asia, unbalanced power in global health diplomacy, and persistent ambiguity between technical norms and geopolitical pragmatism. In his analogy, WHO functions as a conductor constrained by patrons and donors; regional blocs such as ASEAN and SAARC resemble string sections not seated together; development banks act as powerful brass sections influencing health system priorities; and global public–private partnerships emerge as virtuoso soloists shaping vaccine and disease programmes—leaving Asia as a group of increasingly capable musicians with limited airtime. He further distinguished between technical and scientific norms—such as essential medicines lists, primary health care principles, the Ottawa Charter, and Universal Health Coverage benchmarks—which provide a shared "musical score", and geopolitical norms, which determine how that score is interpreted based on power, ideology, and negotiation. He concluded by calling for new mutual goals, clearer guiding principles for global health actors, and realigned incentives at both global and national levels to strengthen domestic health systems while advancing collective priorities, ultimately questioning whether global health governance should aspire to function as a coordinated orchestra or accept its current reality as closer to a jazz ensemble marked by improvisation and shifting leadership.

Closing Remarks

In the closing session, **Dr. Nima Asghari (Director, Asia Pacific Observatory)** summarized the key themes and recommendations from the consultation:

- **Why review global health governance (GHG)?** There is a need to review GHG because of the large number of actors, funding challenges, eroding trust in multilateralism, growing Global South influence (and health decolonization movements), the imperative to reduce aid dependency, and the increasing importance of regional voices.
- **Key functions of GHG**: At both global and regional levels, GHG should provide scientific and political norm-setting, surveillance and data sharing, stakeholder convening, and facilitation of funding (including pooled regional funds). It should support solidarity in crises and help strengthen country health systems towards Universal Health Coverage.
- **Regional institutions:** Reforms should leverage regional bodies such as ASEAN, SAARC, and BIMSTEC. These bodies could be empowered to play stronger governance roles if given clearer mandates and resources.
- **WHO reform:** Structural and governance reforms in WHO were recommended. This includes better balance and coordination between WHO headquarters, regional offices, and country offices, as well as enhancing accountability and inclusivity beyond annual regional committee meetings. The aim is to make WHO more responsive and accountable to member countries, not just to donors or a few powerful stakeholders.
- **Broadening scope:** Participants noted that global health governance should more systematically address the social and commercial determinants of health (e.g. how trade, corporate interests, and social policies affect health). They also mentioned the ongoing UN reform process (sometimes referred to as "UN80") and called for understanding its implications for countries, multilateral agencies, and the global health agenda.

In closing, **Revati Phalkey (Director of the United Nations University – International Institute for Global Health)**, emphasized that form should follow function. She noted that as global health governance continues to evolve, institutional arrangements must be shaped by practical needs and challenges, and that the consultation's outcomes will inform next steps in ongoing research and advocacy for health governance reforms.