

Improving global and regional health governance and cooperation: perspective of South and Southeast Asia



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Preface

This document serves as a briefing paper, produced by the Centre for Social and Economic Progress (CSEP) and the United Nations University International Institute for Global Health (UNU-IIGH) under the umbrella of The Asian Collective for Health Systems (TACHS).

It collates a broad spectrum of data and information, based mostly on a non-systematic desk review of academic and grey literature, to feed into discussions about how countries in South and Southeast Asia can contribute to and improve the system of global health governance; ensure that South and Southeast Asian needs and perspectives are better accommodated within the system of global health governance; reduce their reliance on external funding and expertise; enable more effective pooling of resources and expertise at the regional level; promote greater intra-regional health equity; and contribute to more effective regional governance and cooperation in South and Southeast Asia.

Introduction: Global Health Governance

The term global health governance (GHG) is defined here as the formal *and* informal structures, systems and institutions through which actors: i) make decisions about global health standards, policies and priorities; ii) finance, organize and implement global health initiatives, programmes and plans; and iii) influence and engage with actors, systems or institutions that lie outside the health sector but which impact on health.

This definition encompasses governance *within* the global health sector (i.e. the way global health-specific institutions, initiatives and programmes are governed and managed); governance *of* the global health sector (i.e. how the global health system as a whole is governed); and global governance *for* health (i.e. how global health actors influence the impact of non-health-specific structures, systems and institutions on global health). Such a definition acknowledges that global health outcomes and the system of GHG are influenced by actors, structures and institutions that lie outside the health sector.

In general, global governance is based on a system of inter-governmental organisations (IGOs) that emerged after the Second World War (WW2). Key among these are the institutions of the United Nations (UN) and the Bretton Woods institutions. They include political bodies such as the UN Security Council and General Assembly; institutions of economic governance such as the World Bank, the International Monetary Fund (IMF) and the World Trade Organisation (WTO); specialised agencies such as the World Health Organisation (WHO) and the Food and Agricultural Organisation (FAO); and a rudimentary global judicial system that includes the International Court of Justice (ICJ), International Criminal Court (ICC), *ad hoc* international tribunals, the WTO Appellate court and the World Bank's International Centre for Settlement of Investment Disputes (ICSID). Various international treaties and agreements also represent agreed principles and standards for the conduct of international and national affairs. These include the UN Charter, the Universal Declaration of Human Rights, the Geneva Conventions (International Humanitarian Law), and agreements such as the Sustainable Development Goals.

Since WW2, the system of global governance has evolved. In particular, the end of the Cold War and the deepening of globalisation coincided with various important developments. These include broad shifts of power from governments and state-based institutions towards global institutions; from local businesses to trans-national corporate actors; and from public institutions towards markets and private institutions. The system of global governance has further been transformed by the emergence of multi-stakeholder forums and public-private partnerships (PPPs) and even entirely private modes of global governance (e.g. the International Accounting Standards Committee and the unappealable judgments of credits ratings agencies).

Many of these changes have been mirrored in the global health sphere. For example, the past few decades have seen a weakening of the WHO and a corresponding shift of power to the World Bank and a range of global health PPPs such as the Global Fund and GAVI Alliance. Although WHO retains

its mandate as the world's 'directing and coordinating authority on international health work', its dependence on conditional grants has eroded its independence and autonomy and placed it more firmly under the influence of its funders. The proliferation of global health institutions, development banks, vertical funds, philanthropic foundations, and PPPs, has further diluted WHO's mandate and also made GHG more complex with less clarity about where responsibilities lie and how lines of accountability operate.

The past two years have seen additional changes and new challenges, precipitated by the USA's withdrawal from the WHO and attacks on multilateralism; increasing geopolitical tensions and major powers rivalry; drastic cuts to development assistance for health (DAH); a growing debt burden in many countries in the global South; and an increasing role for finance capital in fill universal health coverage (UHC) financing gaps. This has created an impetus to reappraise the system of GHG and DAH and examine opportunities to strengthen regional health governance and cooperation, including in Asia.

The document is structured as follows. It begins with the World Health Organization (WHO), with particular attention to its two regional offices in Asia: The Regional Office for Southeast Asia (SEARO) and the Regional Office for the Western Pacific (WPRO), as well as a deeper look at a selection of Country Offices. It then turns to the development banks, specifically the World Bank (WB), the Asian Infrastructure Investment Bank (AIIB), and the Asian Development Bank (ADB). Subsequently, it presents some data on development assistance for health (DAH), followed by a review of emerging platforms influential in global health agenda-setting such as the G77, the G20, and BRICS. Next, the document considers regional governance mechanisms, namely the Association of Southeast Asian Nations (ASEAN), the South Asian Association for Regional Cooperation (SAARC), and the Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation (BIMSTEC). It then presents some information about regional non-governmental networks. The document ends with a concluding section and key takeaway messages.

**WORLD HEALTH ORGANISATION
(WHO)**

WHO: Structural Constraints and Regional Possibilities in South and Southeast Asia

WHO occupies a core position in GHG. Its Constitution establishes it as the primary directing and coordinating authority on international health within the UN system, endowed with a unique normative mission as well as the authority to craft international legal instruments and issue evidence-based technical standards. It is explicitly mandated to promote “the highest attainable standard of health” as a fundamental right and to use law and policy to achieve that objective.¹

Within this framework, WHO has used its treaty-making powers to establish the International Health Regulations (IHR) and the Framework Convention on Tobacco Control (FCTC). The FCTC, the first legally binding global health treaty, sets out policies and standards on tobacco taxation, advertising, and smoke-free environments and has been widely credited with accelerating regulatory reforms and contributing to declines in tobacco use, particularly where domestic law was initially weak.² The 2003 FCTC marked a pivotal step in advancing international health law.³

Following that, in 2005, the revised IHR created binding legal duties for States Parties that sign on to the treaty. These include requirements for countries to detect, report, and respond to events that could become public health emergencies of international concern (PHEIC), thereby setting a legally-binding basis for surveillance and timely information-sharing. While the IHR are legally-binding for such State Parties, WHO also advances global health security through other non-coercive means including through the provision of public reports and technical assistance, and through diplomacy.

WHO also operates through various “soft laws”.⁴ The Model List of Essential Medicines, for example, functions as a global reference for national medicines policy and influences procurement and price negotiations in low- and middle-income countries (LMICs).⁵ The International Code of Marketing of Breast-milk Substitutes,⁶ adopted by the World Health Assembly in 1981, similarly sets standards that many states have then incorporated into domestic law.⁷ Despite its unique and important mandate, significant political and economic factors constrain WHO’s capacities and abilities.

Organizational structure and governance

At the apex of WHO is the World Health Assembly (WHA), composed of delegates from all 194 Member States. Its key functions include setting policy and strategic direction; approving the biennial Programme Budget; appointing the Director-General; and supervising financial policies.

¹ World Health Organization. The Constitution of the World Health Organization. In: Basic documents. 49th ed. Geneva: WHO; 2020 [cited 2026 Mar 28]. Available from: https://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf#page=6

² Puska P. WHO FCTC as a pioneering and learning instrument. *Int J Health Policy Manag.* 2017;7(1):75-77.

³ Gostin LO, Meier BM, Karim SA, Mesquita JB de, Burci GL, Chirwa D, et al. The World Health Organization was born as a normative agency: seventy-five years of global health law under WHO governance. *PLOS Glob Public Health.* 2024;4(4):e0002928.

⁴ Ruger JP, Yach D. The global role of the World Health Organization. *Glob Health Gov.* 2009;2(2):1-11.

⁵ World Health Organization. WHO model lists of essential medicines [Internet]. Geneva: WHO; [cited 2026 Mar 28]. Available from: <https://www.who.int/groups/expert-committee-on-selection-and-use-of-essential-medicines/essential-medicines-lists>

⁶ World Health Organization. International code of marketing of breast-milk substitutes [Internet]. Geneva: WHO; [cited 2026 Mar 28]. Available from: <https://iris.who.int/items/316157c5-f214-4807-8ddc-df418aa96e56>

⁷ Wood B, O'Sullivan D, Baker P, Nguyen T, Ulep V, McCoy D. Who benefits from undermining breastfeeding? Exploring the global commercial milk formula industry's generation and distribution of wealth and income [Internet]. [cited 2026 Mar 28]. Available from: <https://collections.unu.edu/eserv/UNU:8970/CMF-industry-wealth-and-income-report.pdf>

Agenda-setting power also resides substantially with a 34-member Executive Board (EB), composed of technically qualified members designated by Member States who sit on the EB for three-year terms. Seats are distributed to ensure representation from all WHO regions. The EB prepares resolutions for WHA consideration, structures debates, and works closely with the WHO Secretariat to set priorities and shape the agenda for the WHA.

The Director-General (DG), appointed by the WHA, is the chief technical and administrative officer of WHO and leads the WHO Secretariat based in Geneva. The informal 'gentleman's agreement' of rotating leadership between regions has periodically been disrupted by great power intervention,⁸ while the DG's effective autonomy is constrained by financial dependencies discussed below.

WHO's regional architecture comprises six Regional Offices (ROs): AFRO (Africa), AMRO/PAHO (Americas/Pan American), EMRO (Eastern Mediterranean), EURO (Europe), SEARO (Southeast Asia) and WPRO (Western Pacific), exercise substantial autonomy and are highly responsive to the members states of their region. Regional Directors are elected by regional committees of member states representatives, creating a stronger line of accountability to regional member states than to the DG.^{9,10} This structure creates responsiveness to regional specificities and protects against centralized imposition of policies and priorities, but also fragments WHO, with regional offices also competing for resources and attention and developing separate technical capacities.

WHO's Country Offices provide operational presence in member states. Their presence and size vary from country to country. Country Office heads are appointed by the WHO DG following consultation with the Regional Directors and host governments. In practice, Country Offices operate primarily under Regional Office oversight.^{11,12} Nonetheless, Country Offices often find themselves balancing competing regional and headquarters priorities against national health needs.

Funding and budgets

WHO is financed through two primary mechanisms: Assessed Contributions (ACs) and Voluntary Contributions (VCs). ACs are mandatory membership fees paid by all member states and currently constitute less than 20% of the Organisation's total budget.¹³

⁸ Council on Foreign Relations. Will the Director General election bring about the change the World Health Organization is looking for? [Internet]. 2017 Apr 14 [cited 2026 Apr 23]. Available from: <https://www.cfr.org/articles/will-director-general-election-bring-about-change-world-health-organization-looking>

⁹ World Health Organization. Process for the nomination and appointment of Regional Directors (decision EB154(14)) [Internet]. Geneva: WHO; 2024 [cited 2026 Apr 23]. Available from: https://apps.who.int/gb/ebwha/pdf_files/EB157/B157_8-en.pdf

¹⁰ Clift C. What's the World Health Organization for? [Internet]. London: Chatham House; 2015 [cited 2026 Apr 23]. Available from: https://www.chathamhouse.org/sites/default/files/field/field_document/20140521WHOHealthGovernanceClift.pdf

¹¹ World Health Organization. WHO's presence in countries [Internet]. Geneva: WHO; [cited 2025 Nov 5]. Available from: <https://www.who.int/countries/country-presence>

¹² World Health Organization. WHO country offices and country focus [Internet]. Geneva: WHO; 2005 Apr 21 (Document EB116/6) [cited 2025 Nov 5]. Available from: https://apps.who.int/gb/ebwha/pdf_files/EB116/B116_6-en.pdf

¹³ World Health Organization. Assessed contributions [Internet]. Geneva: WHO; [cited 2025 Oct 25]. Available from: <https://www.who.int/about/funding/assessed-contributions>

ACs are determined using a formula based on each nation's Gross National Income (GNI), with adjustments for factors like debt burden and population size.¹⁴ By design, ACs reflect principles of collective responsibility and capacity-to-pay and offer independence and financial stability to WHO. Yet the level of ACs has been frozen in nominal terms for decades resulting in WHO becoming increasingly dependent on VCs. This marks a major transformation since a time 3-4 decades ago when 80% of WHO's funding came from ACs. Since 2020, efforts to increase the amount of ACs have led to a 20% increase approved for 2024-2025, and a further 20% increase for 2026-2027 (coinciding with the 2025 US withdrawal).¹⁵ Despite this, WHO remains highly dependent on VCs.

VCs are provided by a wide range of actors, including member states, other UN organisations, global health partnerships (GHPs), international development banks and private actors.¹⁶ They consist of three categories with distinct governance implications:

1. *Core Voluntary Contributions (CVCs)* which are unconditional and account for 6.6% of all VCs.
2. *Thematic Contributions* which are earmarked for broad, WHO-defined strategic areas (e.g., universal health coverage, health emergencies) and account for 6% of all VCs
3. *Specified Contributions* which are earmarked to a specific project and/or geographic area and represents 87% of all VCs.

With 87% of all VCs attached to donor-specified conditions, WHO's strategic and independent planning capacity is constrained, and it risks WHO functioning more as an implementation agency for its major donors. WHO's funding also exhibits significant concentration, with a small number of funders accounting for a large share of resources. For the 2024-2025, five funders, i.e. Gates Foundation, the USA, Gavi, EC and the UK, accounted for approximately 35% of total resources (see Figure 1 below).¹⁷ The withdrawal of the USA in January 2025, which had provided roughly 15% of total resources, prompted immediate 25% budget cuts across the organization, highlighting the fragility of the current financing structure and the limited cushion provided by ACs.

The concentration visible in Figure 1 has significant implications. Donor preferences can exert considerable influence over programmatic priorities or member state expressed needs. Issues such as health equity, health systems strengthening, and the social determinants, where WHO holds comparative advantage and a constitutional mandate, tend to receive less funding relative to disease-specific interventions that are more amenable to metric-driven, time-limited projectization.

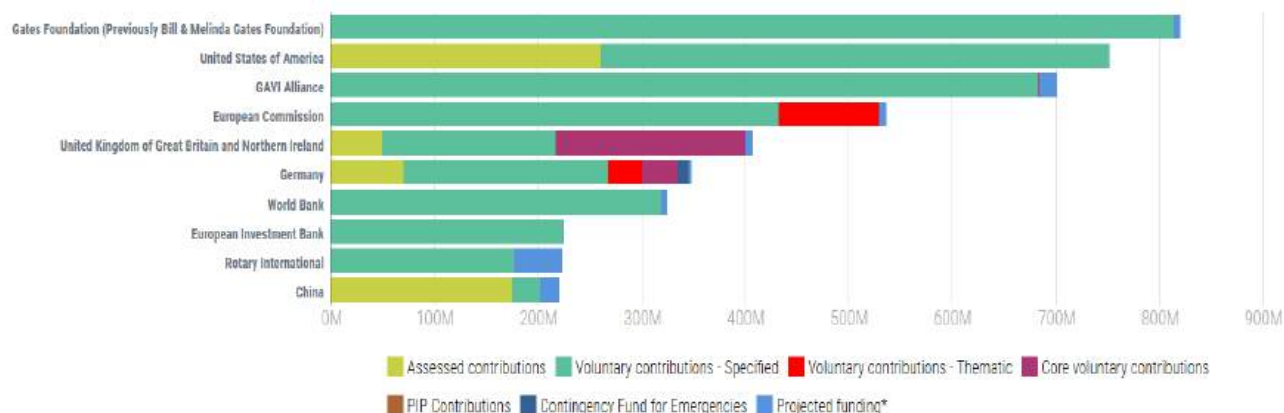
¹⁴ Schaefer BD. The window of opportunity to overhaul the U.N. scale of assessments is closing [Internet]. Washington, DC: The Heritage Foundation; [cited 2026 Mar 20]. Available from: <https://www.heritage.org/global-politics/report/the-window-opportunity-overhaul-the-un-scale-assessments-closing>

¹⁵ World Health Organization. Seventy-eighth World Health Assembly concludes: historic outcomes, consequential highlights [Internet]. Geneva: WHO; 2025 May 28 [cited 2025 Nov 4]. Available from: <https://www.who.int/news/item/28-05-2025-seventy-eighth-world-health-assembly-concludes--historic-outcomes--consequential-highlights>

¹⁶ World Health Organization. How WHO is funded [Internet]. Geneva: WHO; [cited 2025 Oct 25]. Available from: <https://www.who.int/about/funding>

¹⁷ World Health Organization. Funding by contributor [Internet]. Geneva: WHO; 2024-25 [cited 2026 Apr 23]. Available from: <https://open.who.int/2024-25/contributors/contributor>

Figure 1. Top ten funders for the 2024-25 biennium



WHO’s budget itself is split into 3 main components (Table 1). The largest is the *Base Budget*, which is allocated in accordance with the strategic goals of the current General Programme of Work (GPW).¹⁸ This component has the broadest participation of contributors to WHO’s budgetary structure. The second component is for *Special Programmes* such as the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) and the Special Programme for Research and Training in Tropical Diseases (TDR), which are typically structured as partnerships with other organisations like UNICEF, UNDP and the World Bank. The third component is *Emergency Operations and Appeals* which caters for responses to disasters and outbreaks. This component has become increasingly prominent in public perception and donor interest yet remains episodic and unpredictable in nature.

Table 1. WHO 2024–25 Programme Budget: Components, Financing Sources, and Governance Arrangements¹⁹

Budget Component	Approved Budget 2024–25	Main Financing Source(s)	Governance / Budgetary Effect
Base budget	US\$ 4,968.2 million (72.7%)	ACs, programme support costs, core VCs, thematic VCs, specified VCs	Most closely aligned with WHO’s collective priority-setting and results framework; the segment is described as embodying WHO’s core mandate.

¹⁸ The term “base budget” is used here for consistency across biennia. In the Proposed Programme Budget 2026–2027 WHO refers to this segment as “base programmes,” which now appears as one of four budget segments (base programmes, emergency operations and appeals, polio eradication, and special programmes). This terminological shift is aligned with the GPW 14 results framework and WHO’s broader results-based management reforms, as set out in the Draft Proposed Programme Budget 2026–2027, Regional Committee version, August 2024 (especially the discussion of the results framework and budget segments).

¹⁹ WHO’s 2024-25 budgetary documentation includes four segments: base budget, polio eradication, special programmes, and emergency operations. For clarity of analysis, this table excluded the polio component (US\$694.3 million) to focus on the three main operational segments. AC/VC splits for these segments require cross-checking across multiple WHO sources and involve some estimation where exact figures and breakdowns are not explicitly stated. This limitation underscores the need for more systematic and transparent WHO budget reporting.

Special programmes	US\$ 171.7 million (2.5%)	Mainly specified VCs / special programme funds	Separate oversight and partnership arrangements; comparatively limited integration with the core budget process.
Emergency operations and appeals	US\$ 1,000 million (14.6%)	Mainly specified VCs and appeals	Appeal-based financing; highly contingent and reactive.

SEARO and WPRO: The WHO Architecture for Asian Health Governance

While the regional boundaries correspond to some shared administrative histories and disease patterns, they also encode colonial legacies and Cold War divisions from the past.^{20,21} Scholars have documented how this impedes coordinated responses for countries sharing cultural, ecological and epidemiological similarities but divided by administrative boundaries.

The countries of Asia are mostly split across two ROs: SEARO and WPRO. While there is some geographic rationale to the composition of these two ROs, geopolitical factors also play a role. Thus, for example, Pakistan is not part of SEARO but is part of EMRO, while North Korea and South Korea are in different ROs.

SEARO currently comprises 10 member states (following Indonesia's departure in 2025): Bangladesh, Bhutan, North Korea, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste, covering approximately 1.8 billion people.²² Indonesia's transfer to WPRO left India as the dominant member state followed by Thailand.²³ Indonesia's departure was explained by its wish to align more with countries facing similar health challenges and has been a significant blow to the size and clout of SEARO.^{24,25}

WPRO's membership currently comprises 38 countries, areas, and territories, covering nearly 2.2 billion people²⁶ with substantial diversity: high-income economies (Australia, New Zealand, Japan, South Korea, Brunei, Singapore), middle-income states (China, Mongolia, Malaysia, Indonesia, Laos, Philippines, Vietnam), and small island developing states with distinct health system challenges.

²⁰ Fee E, Cueto M, Brown TM. At the roots of the World Health Organization's challenges: politics and regionalization. *Am J Public Health.* 2016;106(11):1912-1917.

²¹ Afriyie EK, Mbwoye RN, Koray MH. Decolonizing global health in an age of fragmentation: reimagining equity for universal health coverage. *Health Policy Plan.* 2026;41(2):336-339.

²² World Health Organization. About WHO in the Southeast Asia Region [Internet]. Geneva: WHO; [cited 2026 Mar 20]. Available from: <https://www.who.int/southeastasia/about>

²³ Tandon A, Ratanaburi N, Dureja S, Pattanaphesaj J. Financing health care in the WHO Southeast Asia Region: time for a reset. *WHO Southeast Asia J Public Health.* 2021;10(Suppl 1):S64-S70.

²⁴ Science Watchdog. Indonesia just left WHO's Southeast Asia Region: here's why that matters for global health [Internet]. 2025 May 26 [cited 2025 Sep 15]. Available from: <https://sciencewatchdog.id/2025/05/26/indonesia-just-left-whos-southeast-asia-region-heres-why-that-matters-for-global-health/>

²⁵ Benzian H, Mathur MR. Indonesia leaves SEARO: what it means for regional health and WHO. *Lancet Reg Health Southeast Asia.* 2025;100660.

²⁶ World Health Organization. About WHO in the Western Pacific Region [Internet]. Geneva: WHO; [cited 2026 Mar 20]. Available from: <https://www.who.int/westernpacific/about>

The financial contribution of South Asian and Southeast Asian nations to WHO remain modest relative to their combined population of over 3.8 billion people. Table 2 below shows the absolute and relative financial contributions of all SAARC and ASEAN countries. With the exception of Bhutan, Maldives, Brunei, and Myanmar, all countries provide VCs in addition to their ACs, although none offer unrestricted VCs.²⁷

The disparities in financial contributions and population size are striking. India, representing nearly 18% of the world's population, contributes 1.04% of all ACs and 1.72% of WHO's overall budget. Collectively, SAARC nations account for nearly a quarter of global population (24.2%) but only 2.6% of WHO's budget. ASEAN presents a more varied picture: Singapore and Thailand demonstrate contribution ratios that exceed their population sizes, while Indonesia's and the Philippines' contributions are more modest. Timor Leste presents an interesting case with small ACs and greater VCs (\$1.7 million). Collectively, ASEAN nations, while comprising 8.5% of the world's population, contribute 2.1% of WHO's ACs and 0.49% of its total budget.

This pattern suggests both strategic calculation and institutional caution. Beyond shaping issue prioritization, VCs offer member states flexibility: they can adjust commitments in response to domestic fiscal pressures or political shifts without the diplomatic friction of renegotiating ACs. The channeling of these contributions reveals varying models of engagement. India and Indonesia direct most of their VCs to their own country offices, helping to embed WHO operations within national health systems. The Philippines directs most of its VCs to the WPRO regional office; Malaysia sends over 90% of its contributions to WHO headquarters; and Thailand splits its contributions between country and regional offices. Significant resources thus flow outside WHO's centralized allocation mechanisms, which can complicate governance and constrain the organization's ability to distribute funding based on equity or need.

Table 2. Assessed and Voluntary Contributions 2024-2025 of SAARC and ASEAN countries

Country	Country's AC 2024- 2025 ²⁸	Country's VC 2024- 2025	Total WHO ACs for 2024-2025	Total WHO Budget 2024-2025 (ACs and VCs)	Percentage of Country AC to Total WHO's ACs	Percentage of Country Total Contributions to WHO's Total Budget	Percentage of World Population (2025) ²⁹
SAARC							
<i>Afghanistan</i>	\$71,300	\$526,745			0.01%	0.01%	0.54%
<i>Bangladesh</i>	\$114,830	\$1,923,000			0.01%	0.03%	2.13%
<i>Bhutan</i>	\$11,880	N/A			0.00%	0.00%	0.0097%
<i>India</i>	\$11,989,000	\$105,275,000			1.04%	1.72%	17.78%
<i>Maldives</i>	\$47,540	N/A			0.00%	0.00%	0.0064%
<i>Nepal</i>	\$114,840	\$10,121			0.01%	0.00%	0.36%
<i>Pakistan</i>	\$1,354,750	\$55,900,000			0.12%	0.84%	3.12%

²⁷ WHO's funding portal categorizes contributions by fund type and earmarking to aid assessment of WHO's spending flexibility. However, VCs data are spread across categories, so country-level totals are not consolidated. ACs show amounts invoiced, not necessarily paid. Total budget data is not on the portal and requires cross-referencing with other WHO sources. Thus, figures here indicate funding channels and obligations, not a harmonized real-time country-level account. Data retrieved on 23 March 2026 from <https://open.who.int/2024-25/> (updated through December 2025).

²⁸ World Health Organization. Assessed contributions payable by Member States and Associate Members, 2024–2025 [Internet]. Geneva: WHO; 2024 [cited 2026 Apr 23]. Available from: <https://cdn.who.int/media/docs/default-source/ac-docs-2024-2025/assessed-contributions-payable-by-member-states-and-associate-members-in-2024-25.pdf>

²⁹ Worldometer. Population by country (2025) [Internet]. [cited 2025 Nov 5]. Available from: <https://www.worldometers.info/world-population/population-by-country/>

<i>Sri Lanka</i>	\$516,770	\$158,230	\$1,148,300 ,000	\$6,834,000 ,000	0.05%	0.01%	0.28%		
ASEAN									
<i>Brunei</i>	\$249,560	N/A					0.02%	0.00%	0.0057%
<i>Cambodia</i>	\$83,190	\$353,982					0.01%	0.01%	0.22%
<i>Indonesia</i>	\$6,305,000	\$1,364,000					0.55%	0.11%	3.47%
<i>Laos</i>	\$83,190	\$207,811					0.01%	0.00%	0.096%
<i>Malaysia</i>	\$3,996,000	\$18,066					0.35%	0.06%	0.44%
<i>Myanmar</i>	\$118,830	N/A					0.01%	0.00%	0.66%
<i>Philippines</i>	\$2,435,000	\$1,319,694					0.21%	0.05%	1.42%
<i>Singapore</i>	\$5,788,000	\$3,298,200					0.50%	0.13%	0.07%
<i>Thailand</i>	\$4,226,000	\$524,687					0.37%	0.07%	0.87%
<i>Timor Leste</i>	\$11,880	\$1,703,000					0.00%	0.03%	0.017%
<i>Viet Nam</i>	\$1,068,000	\$196,924			0.09%	0.02%	1.23%		

Budget allocations to WHO’s regions are made through a complex process of negotiation that considers multiple factors including population size, health needs and the preferences of donors. As shown in Table 3, SEARO and WPRO, while serving nearly half the world’s population, receive comparatively modest allocations relative to EMRO and AFRO. Higher disease burdens and acute health needs understandably attract greater resources and donor attention.

Table 3. Regional Office and HQ budgets 2024-25³⁰

Biennium	RO	Total Population	Total Regional Budget	Total WHO Budget	% of Regional Budget over Total Budget	Per Capita Budget (USD)
2024-25	AFRO	~1,298,916,859	\$1,600,600,000	\$6,834,000,000	23.42%	1.23
	PAHO	~1,046,253,866	\$308,600,000		4.52%	0.29
	EMRO	~937,776,131	\$952,400,000		13.94%	1.02
	EURO	~920,000,000	\$409,600,000		5.99%	0.45
	HQ	N/A	\$1,678,600,000		24.56%	N/A
	SEARO	~1,846,984,672	\$592,300,000		8.67%	0.32
	WPRO	~1,917,168,353	\$426,070,000		6.23%	0.22

*Population figures are sourced from the World Bank’s “Population Estimates and Projections” database (Last Updated: 07 February 2025). Values reflect the latest year available for each country/region.

Tables 4 and 5 show operational budgets for WHO offices within these countries, e.g. \$146 million for India and \$67 million for Bangladesh. These are not funds from the host government, but rather WHO's spending allocation for staff, programs, and activities in that country.

³⁰ Data on regional budgets for 2024–2025 are sourced from the WHO Programme Budget Digital Platform dashboards, accessed 24 March 2026 (https://www.who.int/about/accountability/budget/programme-budget-digital-platform-2024-2025/dashboards#PageContent_C088_Col00). The total WHO budget aligns with figures published in the Budget Portal. The sum of regional budgets presented here is \$5.97 billion, leaving \$865.9 million (12.67%) unallocated, likely reflecting cross-cutting programs, contingency funds, or other central allocations not included in this table.

Table 4. Budgets for SEARO countries over the past 5 years

Countries	2020-21 ³¹	2022-23 ³²	2024-25 ³³
	Available Resources	Available Resources	Available Resources
<i>Bangladesh</i>	\$42,700,000	\$62,200,000	\$67,300,000
<i>Bhutan</i>	\$4,700,000	\$5,000,000	\$7,900,000
<i>India</i>	\$69,700,000	\$87,500,000	\$145,900,000
<i>Indonesia</i>	\$27,400,000	\$23,200,000	\$25,000,000
<i>DPRK</i>	\$15,500,000	\$6,100,000	\$7,400,000
<i>Maldives</i>	\$6,300,000	\$4,700,000	\$6,800,000
<i>Myanmar</i>	\$28,400,000	\$21,200,000	\$41,400,000
<i>Nepal</i>	\$15,500,000	\$24,300,000	\$32,800,000
<i>Sri Lanka</i>	\$7,500,000	\$16,700,000	\$9,500,000
<i>Thailand</i>	\$14,100,000	\$8,800,000	\$10,500,000
<i>Timor Leste</i>	\$11,400,000	\$17,000,000	\$20,100,000

It's notable that WPRO does not allocate budgets to high-income member states like Australia, Japan, South Korea or Singapore.

Table 5. Budgets for WPRO countries over the past 5 years

Countries	2020-21 ³⁴	2022-23 ³⁵	2024-25 ³⁶
	Available Resources	Available Resources	Available Resources
<i>American Samoa</i>	\$100,000	\$100,000	\$100,000
<i>Brunei Darussalam</i>	\$100,000	-	\$120,000
<i>Cambodia</i>	\$23,000,000	\$22,200,000	\$17,020,000
<i>China</i>	\$16,000,000	\$12,400,000	\$12,980,000
<i>Cook Islands</i>	\$400,000	\$500,000	\$330,000
<i>Federated States of Micronesia</i>	\$1,500,000	\$1,700,000	-
<i>Fiji</i>	\$900,000	\$900,000	\$1,030,000
<i>Kiribati</i>	\$1,300,000	\$1,700,000	\$5,590,000
<i>Laos</i>	\$30,500,000	\$27,500,000	\$21,650,000

³¹ World Health Organization. Regional Office for Southeast Asia. Programme budget 2020–2021: implementation [Internet]. Geneva: WHO; 2020 [cited 2025 Oct]. Available from: <https://iris.who.int/server/api/core/bitstreams/97814e4a-5cd3-4efa-8a60-323ed57c8de4/content>

³² World Health Organization. Regional Office for Southeast Asia. Programme budget 2022–2023: implementation [Internet]. Geneva: WHO; 2022 [cited 2025 Oct]. Available from: <https://iris.who.int/server/api/core/bitstreams/21c0002e-8265-4c06-86b4-4f1cd9110432/content>

³³ World Health Organization. Regional Office for Southeast Asia. Programme budget 2024–2025: implementation and mid-term review [Internet]. Geneva: WHO; 2025 [cited 2025 Oct]. Available from: <https://iris.who.int/server/api/core/bitstreams/35bae652-2a1f-4699-9545-6b1d55e10f21/content>

³⁴ World Health Organization. Regional Office for the Western Pacific. Programme budget 2020–2021: budget performance (final report) [Internet]. Geneva: WHO; 2022 [cited 2025 Oct]. Available from: https://www.who.int/docs/default-source/wpro---documents/regional-committee/session-73/wpr-rc73-agenda-8.1-pb-2020-2021-final-report.pdf?sfvrsn=ecd28f9e_1

³⁵ World Health Organization. Regional Office for the Western Pacific. Programme budget 2022–2023: budget performance (final report) [Internet]. Geneva: WHO; 2024 [cited 2025 Oct]. Available from: https://cdn.who.int/media/docs/default-source/wpro---documents/regional-committee/session-75/wpr-rc75-03-agenda08-pb2022-2023.pdf?sfvrsn=43b0cb02_3

³⁶ World Health Organization. Regional Office for the Western Pacific. Programme budget 2024–2025: budget performance (interim report) [Internet]. Geneva: WHO; 2025 [cited 2025 Oct]. Available from: https://cdn.who.int/media/docs/default-source/wpro---documents/regional-committee/session-76/wpr-rc76-03-pb2024-2025_interim_report.pdf

<i>Malaysia</i>	\$6,300,000	\$5,800,000	\$4,590,000
<i>Marshall Islands</i>	\$400,000	\$200,000	\$270,000
<i>Mongolia</i>	\$17,600,000	\$11,900,000	\$10,280,000
<i>Nauru</i>	\$100,000	\$100,000	\$260,000
<i>Niue</i>	\$100,000	\$100,000	\$110,000
<i>Pacific island countries and areas</i>	\$44,200,000	\$43,100,000	\$25,920,000
<i>Palau</i>	\$100,000	\$200,000	\$310,000
<i>Papua New Guinea</i>	\$25,300,000	\$28,600,000	\$24,800,000
<i>Philippines</i>	\$29,300,000	\$27,000,000	\$16,990,000
<i>Samoa</i>	\$3,200,000	\$3,200,000	\$3,530,000
<i>Solomon Islands</i>	\$9,900,000	\$8,700,000	\$13,750,000
<i>Tokelau</i>	\$100,000	\$100,000	\$100,000
<i>Tonga</i>	\$1,000,000	\$1,400,000	\$2,380,000
<i>Tuvalu</i>	\$100,000	\$100,000	\$90,000
<i>Vanuatu</i>	\$4,400,000	\$5,000,000	\$6,150,000
<i>Viet Nam</i>	\$25,200,000	\$18,800,000	\$16,580,000
<i>Others*</i>	\$100,000	\$100,000	\$100,000

*Others include the total for budget centres with available resources less than US\$ 50,000

Country Offices in South and Southeast Asia: Five Case Studies³⁷

The division of Asia between SEARO and WPRO creates practical challenges for individual member states. The following cases (India, Thailand, Indonesia, Malaysia, and the Philippines) illustrate how this division affects the ability of countries to coordinate and engage with WHO, with each case highlighting a different dimension of the challenge. Crucially, all the countries presented below show a long list of donors providing VCs of varying amounts that are tied to particular themes or projects.

India

India's country office budget of \$136 million in 2024-25 involved over 25 different funders. Programmatically, two strategic objectives received the most funding: 'Improved access to quality essential health services' and 'acute health emergencies'. Funding for essential services grew substantially over the period, while emergency funding was highest in 2020-21, reflecting the pandemic response.

The funding base is diverse. The Indian government itself provides roughly half of all funding (\$71.7 million), suggesting strong commitment to WHO operations in the country. Beyond this, Gavi, the Gates Foundation and the USA provide significant VCs, followed by Germany, the UK, Norway, the European Commission, and numerous smaller contributors. Each external donor has specific requirements, e.g. Gavi for immunization, Gates Foundation for disease-specific programs, USA for surveillance, European Commission for health systems, requiring significant administrative capacity to align with national health planning.

³⁷ Data are sourced from the WHO Open Portal, accessed October 2025 (<https://open.who.int/2020-21/country/IND>). Figures in this section differ from those in Tables 4 and 5 due to differences in data sources, reporting periods, data extraction timing, or classification methods. Moreover, the 2020–21 and 2022–23 bienniums are may not be representative of prior periods due to COVID-19.

Table 6. India Country Office source of funding³⁸

2020-21		2022-23		2024-25	
Contributor	Amount	Contributor	Amount	Contributor	Amount
India	\$38,000,000	India	\$64,300,000	India	\$71,700,000
Germany	\$20,807,000	USA	\$24,636,000	Gavi	\$16,960,000
Gavi	\$17,800,000	Gavi	\$14,100,000	Assessed contributions	\$15,172,000
UK	\$17,469,000	Core Voluntary Contributions*	\$11,728,000	Gates foundation	\$8,681,000
Assessed contributions	\$11,798,000	Gates Foundation	\$9,500,000	USA	\$6,304,000
Gates Foundation	\$9,000,000	Assessed contributions	\$7,578,000	Programme support costs	\$4,255,000
USA	\$6,288,000	Programme support costs	\$3,500,000	World diabetes foundation	\$3,000,000
Programme support costs	\$4,070,000	Norway	\$2,978,000	Children's investment fund	\$1,900,000
Vital strategies	\$3,900,000	Resolve to save lives	\$2,500,000	Resolve to save lives	\$1,600,000
Core Voluntary Contributions*	\$2,508,000	European Commission	\$2,202,723	Core Voluntary Contributions*	\$1,268,000
Miscellaneous	\$2,400,000	Vital strategies	\$2,200,000	World Bank	\$740,000
Saudi Arabia	\$2,097,000	Germany	\$1,030,000	European Commission	\$626,000
Italy	\$2,000,000	ADB	\$983,000	Norway	\$610,000
European Commission	\$1,632,000	Canada	\$688,000	Bloomberg Foundation	\$416,000
Norway	\$1,229,000	Children Investment Fund	\$655,000	Sasakawa health foundation	\$351,000
National philanthropic trust	\$880,000	UK	\$633,000	UNEP	\$298,000
Canada	\$526,000	Bloomberg foundation	\$460,000	Rotary international	\$261,000
Bloomberg Foundation	\$491,000	Netherlands	\$425,000	Asian development fund	\$248,000
Netherlands	\$474,000	Sasakawa health foundation	\$402,000	UNAIDS	\$213,000
McArthur Foundation	\$394,000	UNAIDS	\$275,000	Janhavi Nilekani	\$208,000
Covid 19 Solidarity Fund	\$392,000	Rotary international	\$262,000	PIP framework contributors	\$205,000
Sasakawa Foundation	\$341,000	Luxembourg	\$205,000	Luxembourg	\$186,000
UNHCR	\$281,000	Miscellaneous	\$120,000	UK	\$182,000
UNFPA	\$280,000	GFATM	\$114,000	UN habitat	\$169,000
UNAIDS	\$277,000	Saudi Arabia	\$40,000	Germany	\$145,000
CDC foundation	\$250,000	Denmark	\$39,000	UNICEF	\$130,000
Rotary international	\$116,000	UNITAID	\$39,000	Fred Hollows foundation	\$69,000
UNDP	\$89,000	GlaxoSmith Klein	\$35,000	University of Edinburgh	\$59,000

³⁸ World Health Organization. Programme budget web portal (India) [Internet]. Geneva: WHO; [cited 2025 Oct 31]. Available from: <https://open.who.int/2024-25/country/IND>

<i>Eisia Co, Ltd.</i>	\$80,000	<i>Fondation Botnar</i>	\$25,000	<i>Fondation Botnar</i>	\$50,000
<i>Nippon Foundation</i>	\$65,000	<i>UPOPS</i>	\$25,000	<i>UNDP</i>	\$50,000
<i>PIP framework</i>	\$40,000	<i>UN MPTF</i>	\$15,000	<i>Zhongshan Ophthalmic Center</i>	\$41,000
<i>Japan</i>	\$21,000	<i>UNRCO</i>	\$15,000	<i>France</i>	\$40,000
<i>Spain</i>	\$18,000	<i>CDC Foundation</i>	\$11,000		
<i>UNITAD</i>	\$17,000	<i>Bayer</i>	\$10,000		
<i>Gilead sciences</i>	\$16,000	<i>Janhavi Nilekani</i>	\$10,000		
<i>Republic of Korea</i>	\$10,000				
Total	\$146,056,000	Total	\$151,738,723	Total	\$136,137,000

* Core Voluntary contributions reflect the aggregation of contributions from multiple countries. This pooling introduces the possibility of data overlapping and double counting within the total presented.

Thailand

As with India, Thailand's priority strategic objectives are 'acute health emergencies' and 'Improved access to quality essential health services and medicines'. Emergency funding was especially high in 2020-21, reflecting pandemic response needs. However, Thailand's funding structure differs significantly from India. A large proportion of Thailand's budget of \$10.5 million (2024-25) comes from Voluntary Core Contributions and Assessed Contributions, which together make up over 50% of the current biennium budget. The Thai government's own contribution is relatively small (less than 5%). Thus, there is decreasing reliance on a wider array of bilateral and philanthropic partners.

The funding base is also diverse involving over 20 different sources, including Japan, the USA, the European Commission, Australia, and Germany. The volatility of these partnerships is notable: the USA contributed \$8.2 million in 2020-21 but scaled back considerably in 2024-25.

Table 7. Thailand Country Office source of funding³⁹

2020-21		2022-23		2024-25	
Contributor	Amount	Contributor	Amount	Contributor	Amount
USA	\$8,171,000	Core Voluntary Contributions*	\$3,340,000	Assessed Contributions	\$4,633,000
Core Voluntary Contributions*	\$3,170,000	USA	\$3,121,000	<i>Programme support costs</i>	\$2,145,000
Assessed Contributions	\$3,057,000	Assessed Contributions	\$2,991,000	Core Voluntary Contributions*	\$1,311,000
<i>Japan</i>	\$2,920,000	<i>Programme Support Costs</i>	\$1,446,000	USA	\$470,000
<i>European Commission</i>	\$1,700,000	<i>Australia</i>	\$769,000	<i>Thailand</i>	\$466,000
<i>Programme Support Costs</i>	\$991,000	<i>European Commission</i>	\$640,000	<i>Australia</i>	\$319,000
<i>Germany</i>	\$975,000	<i>Thailand</i>	\$531,000	<i>LEGO Foundation</i>	\$307,000
<i>Australia</i>	\$633,000	<i>Germany</i>	\$245,000	<i>Resolve to save lives</i>	\$228,000
<i>Thailand</i>	\$225,000	<i>Vital Strategies</i>	\$132,000	<i>UNEP</i>	\$171,000
<i>UK</i>	\$207,000	<i>Netherlands</i>	\$100,000	<i>Singapore</i>	\$116,000

³⁹ World Health Organization. Programme budget web portal (Thailand) [Internet]. Geneva: WHO; [cited 2025 Oct 31]. Available from: <https://open.who.int/2024-25/country/THA>

<i>UNOPS</i>	\$142,000	<i>Gates Foundation</i>	\$97,000	<i>UNOPs</i>	\$102,000
<i>UNFIP</i>	\$86,000	<i>Resolve to Save Lives</i>	\$97,000	<i>Finland</i>	\$66,000
<i>Gates Foundation</i>	\$66,000	<i>Luxembourg</i>	\$65,000	<i>MHCC</i>	\$50,000
<i>Saudi Arabia</i>	\$61,000	<i>Saudi Arabia</i>	\$49,000	<i>Germany</i>	\$45,000
<i>UNICEF</i>	\$35,000	<i>Sasakawa Foundation</i>	\$10,000	<i>UN Multi-Partner Trust</i>	\$43,000
<i>Vital Strategies</i>	\$31,000	<i>GSK</i>	\$3,000	<i>Zhongshan Ophthalmic Center</i>	\$40,000
<i>Russian Federation</i>	\$22,000			<i>Luxembourg</i>	\$22,000
<i>France</i>	\$20,000			<i>European Commission</i>	\$12,000
<i>World Organisation for Animal Health</i>	\$18,000			<i>Sasakawa Foundation</i>	\$10,000
<i>GFTAM</i>	\$16,000			<i>International Development Law Organisation</i>	\$9,000
<i>World Bank</i>	\$3,000			<i>Netherlands</i>	\$3,000
<i>FIA foundation</i>	\$2,000				
Total	\$22,551,000	Total	\$13,636,000	Total	\$10,589,000

* Core Voluntary contributions reflect the aggregation of contributions from multiple countries. This pooling introduces the possibility of data overlapping and double counting within the total presented.

Indonesia

As with India and Thailand, Indonesia's budget prioritises 'acute health emergencies' (especially in the 2020-21 biennium) and 'Improved access to quality essential health services'. Core Voluntary Contributions and Assessed Contributions make up around a third of the budget. However, between the 2020-21 and 2024-25 bienniums, the budget contracted from \$43.8 million to \$24.4 million (a 44% decline).

The Indonesian government itself also provide significant VCs (\$4.1 million in 2021, \$3.5 million in 2023, \$1.5 million in 2025). Other prominent sources of funding include the USA, Australia, and Gavi (\$3 million). But there is considerable diversity in the number of funders. Indonesia also receives modest contributions from transnational pharmaceutical companies, including GSK, Johnson & Johnson Foundation, Sanofi-Aventis, Merck KGAA, Eisai Co., Ltd., and Gilead Sciences.

Table 8. Indonesia Country Office source of funding⁴⁰

2020-21		2022-23		2024-25	
Contributor	Amount	Contributor	Amount	Contributor	Amount
<i>Japan</i>	\$9,257,000	<i>Australia</i>	\$6,348,000	Assessed Contributions	\$8,048,000
<i>Germany</i>	\$6,000,000	Core Voluntary Contributions*	\$6,225,000	<i>USA</i>	\$4,191,000
<i>Indonesia</i>	\$4,062,000	<i>USA</i>	\$5,537,000	<i>Programme Support Costs</i>	\$2,105,000

⁴⁰ World Health Organization. Programme budget web portal (Indonesia) [Internet]. Geneva: WHO; [cited 2025 Oct 31]. Available from: <https://open.who.int/2024-25/country/IDN>

Assessed Contributions	\$3,940,000	Assessed Contributions	\$3,912,611	<i>Gavi</i>	\$1,849,000
<i>USA</i>	\$3,883,000	<i>Indonesia</i>	\$3,477,000	<i>Indonesia</i>	\$1,544,000
Core Voluntary Contributions*	\$3,653,000	<i>GAVI</i>	\$2,358,000	<i>Australia</i>	\$1,309,000
<i>Australia</i>	\$3,505,000	<i>European Commission</i>	\$2,001,000	Core Voluntary Contributions*	\$1,023,000
<i>GAVI Alliance</i>	\$3,070,000	<i>Programme Support Costs</i>	\$1,600,000	<i>Saudi Arabia</i>	\$948,000
<i>European Commission</i>	\$1,666,000	<i>Japan</i>	\$1,458,000	<i>World Bank</i>	\$704,000
<i>Programme Support Costs</i>	\$1,582,000	<i>Saudi Arabia</i>	\$598,000	<i>European Commission</i>	\$592,000
<i>Bloomberg Family Foundation</i>	\$669,000	<i>Netherlands</i>	\$584,000	<i>UNFIP</i>	\$550,000
<i>Norway</i>	\$529,000	<i>PIP Framework Contributors</i>	\$453,000	<i>PIP Framework Contributors</i>	\$404,000
<i>Republic of Korea</i>	\$467,000	<i>Bloomberg Family Foundation</i>	\$404,000	<i>Bloomberg Family Foundation</i>	\$270,081
<i>CDC Foundation</i>	\$429,000	<i>UN MPTF</i>	\$340,000	<i>Sasakawa Health Foundation</i>	\$250,000
<i>New Zealand</i>	\$327,000	<i>Germany</i>	\$221,000	<i>Germany</i>	\$114,000
<i>PIP Framework</i>	\$295,000	<i>Sasakawa Health Foundation</i>	\$195,000	<i>Denmark</i>	\$70,000
<i>Sasakawa Health Foundation</i>	\$120,000	<i>CDC Foundation</i>	\$148,000	<i>GSK</i>	\$63,000
<i>UNDP</i>	\$115,000	<i>GlaxoSmitKline</i>	\$63,000	<i>UNAIDS</i>	\$56,000
<i>GSK</i>	\$91,000	<i>Johnson & Johnson Foundation</i>	\$25,000	<i>Zhongshan Ophthalmic Center</i>	\$50,000
<i>UK</i>	\$65,000	<i>Sanofi-Aventis</i>	\$25,000	<i>Luxembourg</i>	\$43,000
<i>Eisai Co., Ltd.</i>	\$60,000	<i>Sweden</i>	\$25,000	<i>Gates Foundation</i>	\$37,000
<i>Nippon Foundation</i>	\$20,000	<i>Merck KGAA</i>	\$20,000	<i>UNICEF</i>	\$34,000
		<i>Wellcome Trust</i>	\$10,000	<i>Food and Agriculture Organization</i>	\$30,000
		<i>Gates Foundation</i>	\$9,000	<i>International Development Law Organisation</i>	\$30,000
				<i>Netherlands</i>	\$25,000
				<i>Sweden</i>	\$25,000
				<i>UK</i>	\$23,000
				<i>UNOPS</i>	\$19,000
				<i>Bayer AG</i>	\$10,000
				<i>Finland</i>	\$6,000
				<i>Singapore</i>	\$2,000
				<i>Christoffel-Blindenmission</i>	\$1
Total	\$43,805,000	Total	\$36,036,611	Total	\$24,424,82

* Core Voluntary contributions reflect the aggregation of contributions from multiple countries. This pooling introduces the possibility of data overlapping and double counting within the total presented.

Malaysia

Malaysia's WHO country office budget is relatively small (\$3.7 million in 2024-25). In the 2021 biennium, funding for acute health emergencies was paramount. Funding was concentrated on 'acute health emergencies' during the peak COVID-19 years and subsequently on 'Improved access to quality essential health services' and 'strengthening foundational health systems'.

For the last two bienniums, ACs have been the primary funding source, making up 62% of the 2024-25 budget. Contributions in the form of VCs are relatively small and come from a range of government and non-governmental donors including Germany, Japan, the USA, the European Commission, China, the Republic of Korea, and various smaller contributors. A contribution from the Embassy of the Philippines in the current biennium (\$198,000) is a surprising finding, suggesting nascent South-South cooperation.

Table 9. Malaysia Country Office source of funding⁴¹

2020-21		2022-23		2024-25	
Contributor	Amount	Contributor	Amount	Contributor	Amount
COVID 19 solidarity fund	\$1,604,000	Assessed Contributions	\$1,403,000	Assessed Contributions	\$2,339,000
Assessed Contributions	\$1,489,799	Germany	\$995,000	FAO	\$110,000
Germany	\$1,300,000	Japan	\$968,000	Embassy of the Philippines	\$198,000
European Commission	\$961,283	USA	\$827,000	European Commission	\$173,000
Programme Support Costs	\$383,000	Programme Support Costs	\$530,000	UNICEF	\$146,000
Gates Foundation	\$102,000	CDC Foundation	\$289,000	Programme Support Costs	\$225,000
UK	\$97,000	Core Voluntary Contributions*	\$112,000	China	\$101,000
UNAIDS	\$72,000	Denmark	\$109,000	Republic of Korea	\$70,000
Vital strategies	\$65,000	European Commission	\$99,000	CDC Foundation	\$69,000
Japan	\$44,000	Vital Strategies	\$80,000	Core Voluntary Contributions*	\$63,000
USA	\$30,000	UNAIDS	\$78,000	Zhongshan Ophthalmic Center	\$50,000
UNITAID	\$11,000	Switzerland	\$48,000	Denmark	\$40,000
		Canada	\$45,000	USA	\$40,000
		Bloomberg Foundation	\$18,000	Luxembourg	\$27,000
		Russian federation	\$15,000	Japan	\$20,000
		Gates Foundation	\$5,000	Bloomberg Foundation	\$47,000
				UNFIP	\$19,000
				Norway	\$15,000

⁴¹ World Health Organization. Programme budget web portal (Malaysia) [Internet]. Geneva: WHO; [cited 2025 Nov 14]. Available from: <https://open.who.int/2024-25/country/MYS>

				UNAIDS	\$14,000
				Christoffel-Blindenmission	\$9,000
				Germany	\$8,000
Total	\$6,159,082	Total	\$5,621,000	Total	\$3,746,000

* Core Voluntary contributions reflect the aggregation of contributions from multiple countries. This pooling introduces the possibility of data overlapping and double counting within the total presented.

Philippines

The WHO Philippines budget for 2024-25 has decreased by almost half. This reflects broader normalization after emergency surge funding, with sharp declines in 'acute health emergencies' and 'Improved access to quality essential health services'. As with Thailand, the Philippines WHO country office seem relies heavily on funding from external partners. In 2024-25, the USA, Republic of Korea, and UNICEF provide the largest contributions, but Philippines' donor composition has changed significantly between 2020 and 2025. Unlike India or Indonesia, the government itself appears to make no direct VCs to its WHO country office, and unlike Malaysia, assessed and core contributions comprise only 22% of the budget (\$3.2 million assessed, \$467,000 core). As with other countries in the region, the donor list is highly diverse including UN agencies, bilateral partners and private foundations.

Table 10. Philippines Country Office source of funding⁴²

2020-21		2022-23		2024-25	
Contributor	Amount	Contributor	Amount	Contributor	Amount
Germany	\$4,710,000	USA	\$7,862,000	USA	\$3,265,000
Covid 19 Solidarity Fund	\$4,600,000	Republic of Korea	\$4,173,000	Assessed Contributions	\$3,178,000
USA	\$3,134,195	Assessed Contributions	\$2,225,000	Republic of Korea	\$2,244,000
Assessed Contributions	\$2,831,437	UNICEF	\$1,800,000	UNICEF	\$2,005,000
European Commission	\$2,728,361	European Commission	\$1,623,000	Programme Support Costs	\$1,120,000
Republic of Korea	\$1,631,000	Core Voluntary Contributions*	\$1,195,000	UNFPA	\$848,000
Rotary International	\$1,200,000	Australia	\$926,000	Resolve to Save Lives	\$838,000
National Philanthropic Trust	\$1,000,000	Vital Strategies	\$837,000	Core Voluntary Contributions*	\$467,000
Japan	\$998,000	Norway	\$807,000	European Commission	\$465,000
Australia	\$728,000	Programme Support Costs	\$743,000	Norway	\$366,000
Programme Support Costs	\$660,000	Pilipinas Shell Foundation	\$508,000	Japan	\$333,000
Vital Strategies	\$610,000	Korean foundation for healthcare	\$411,000	Lego Foundation	\$300,000

⁴² World Health Organization. Programme budget web portal (Philippines) [Internet]. Geneva: WHO; [cited 2025 Nov 14]. Available from: <https://open.who.int/2024-25/country/PHL>

<i>Pilipinas Shell Foundation</i>	\$379,000	<i>Germany</i>	\$398,000	<i>Switzerland</i>	\$224,000
<i>Korean Foundation for International Healthcare</i>	\$371,000	<i>UNICEF</i>	\$299,000	<i>Pandemic Influenza Preparedness Framework</i>	\$145,000
<i>Philippines Business for Social Progress</i>	\$316,000	<i>UNAIDS</i>	\$294,000	<i>UNAIDS</i>	\$125,000
Core Voluntary Contributions*	\$315,000	<i>UNFPA</i>	\$254,000	<i>GSK</i>	\$80,000
<i>UNAIDS</i>	\$262,000	<i>Canada</i>	\$243,000	<i>Germany</i>	\$60,000
<i>Norway</i>	\$228,000	<i>Switzerland</i>	\$204,000	<i>Spain</i>	\$50,000
<i>United Kingdom</i>	\$130,000	<i>Resolve to save lives</i>	\$180,000	<i>UNOPS</i>	\$41,000
<i>University Research Co, LLC</i>	\$117,000	<i>St Judes Children's Research Hospital</i>	\$156,000	<i>Gavi</i>	\$40,000
<i>St Judes Children's Research Hospital</i>	\$97,000	<i>Japan</i>	\$141,000	<i>Institute of Philanthropy</i>	\$35,000
<i>Sasakawa Foundation</i>	\$46,000	<i>Pandemic Influenza Preparedness Framework</i>	\$130,000	<i>Gates Foundation</i>	\$21,000
<i>WHO Contingency Fund for Emergencies</i>	\$40,000	<i>Luxembourg</i>	\$123,000	<i>Canada</i>	\$11,000
<i>Pandemic Influenza Preparedness Framework</i>	\$30,000	<i>Bloomberg Foundation</i>	\$119,000	<i>Zhongshan Ophthalmic Center</i>	\$10,000
<i>UNITAID</i>	\$29,000	<i>University Research Co, LLC</i>	\$113,000	<i>Australia</i>	\$8,000
<i>Switzerland</i>	\$26,000	<i>Sasakawa Health Foundation</i>	\$80,000	<i>London School of Tropical Medicine</i>	\$7,000
<i>Gavi</i>	\$21,000	<i>CDC Foundation</i>	\$70,000		
<i>The Global Fund to Fight AIDS, Tuberculosis and Malaria</i>	\$20,000	<i>UNOPS</i>	\$53,000		
<i>Netherlands</i>	\$20,000	<i>China</i>	\$50,000		
<i>Nippon Foundation</i>	\$20,000	<i>Gates Foundation</i>	\$47,000		
<i>Bloomberg Foundation</i>	\$13,000	<i>GAVI</i>	\$2,000		
<i>International Telecommunications Union</i>	\$12,000				
<i>Russian Federation</i>	\$11,000				
<i>UNICEF</i>	\$11,000				
<i>GSK</i>	\$7,000				
Total	\$27,351,993	Total	\$26,066,000	Total	\$16,286,000

* Core Voluntary contributions reflect the aggregation of contributions from multiple countries. This pooling introduces the possibility of data overlapping and double counting within the total presented.

Key points about WHO

WHO as a multilateral organisation

Countries across the world – including those in South and Southeast Asia - need to decide on the extent to which they support the future existence of WHO and its constitutional mandate, including its unique treaty-making powers and its authority around establishing global health standards and guidelines within a rights-based and equity-oriented framework.

Presently the countries of both SAARC and ASEAN provide relatively little financial commitment to WHO. SAARC nations, which account for nearly a quarter of the global population, only contribute 2.6% of WHO's total budget. Collectively, ASEAN nations, while comprising 8.5% of the world's population, contribute 2.1% of WHO's ACs and 0.49% of its total budget. Similarly, at a national level, we see India, representing nearly 18% of the world's population, contributing 1.04% of all ACs and 1.72% of WHO's overall budget.

Countries must also consider their commitment to funding WHO as an independent, specialized multilateral agency with a core budget as opposed to funding it through conditional VCs. Without a greater level of ACs, WHO's ability to function independently and normatively will be compromised and over-influenced by its biggest donors. While the 2025 WHA decision to increase ACs by 20% signals movement in a positive direction, there is an argument for countries in South and Southeast Asia to collectively commit greater financial support to WHO while also seeking greater influence over how WHO determines its priorities.

One of WHO's most important characteristics is its normative and inter-governmental role. With the risk of future global pandemics being high and with the global nature of many determinants of health (including climate change and globalised supply chains for critical health technologies and commodities), a functional and authoritative WHO should be viewed as a vital component of future global health security irrespective of WHO's budget cuts and the withdrawal of the US. A smaller, more focused and democratic WHO, concentrating on its normative functions could even result in it becoming more influential and impactful, especially if it is accompanied by a willingness to allow WHO to exert its normative and scientific authority into the domain of broader social and economic policy, so that it is not constrained by a narrow biomedical framework.

WHO at the regional and country level

WHO's regional structures are not particularly well configured from an Asian perspective. SEARO and WPRO divide Asia as a continent and are quite uneven in terms of size. Furthermore, the countries of South and Southeast Asia are split across different regional offices. There has been, however, little research conducted about how countries in the two sub-regions view and experience their interactions with WHO, and how they view WHO's role at both the regional and country level. What is notable however is that governments in both South and Southeast Asia tend to provide

relatively little funding to their regional and country WHO offices, with external public, private and philanthropic donors providing the bulk of funding. Country offices have multiple funding streams; and also appear to have budgets that can change in size and composition quite considerably from one biennium to the next.

**DEVELOPMENT BANKS
(WORLD BANK, ADB and AIIB)**

The World Bank's Governance and its Role in Global Health

The World Bank Group comprises five institutions, but only three directly channel resources to developing countries and governments: the IBRD, IDA, and IFC. The other two (MIGA and ICSID) serve primarily risk mitigation and dispute resolution functions. Originally focused on post-war reconstruction and later development financing for infrastructure and poverty reduction, the World Bank now plays a central role in global health.

The WB's governance structure links voting power to financial contributions. The United States is the WB's largest shareholder and traditionally appoints the Bank's president.⁴³ The other major shareholders are Japan, Germany, the UK, France, and increasingly China.⁴⁴

The International Development Association (IDA) is the World Bank's concessional arm, offering grants and low-interest, long-maturity loans to low-income, low-creditworthy countries, funded through periodic donor replenishments. The International Bank for Reconstruction and Development (IBRD) lend at or near market rates to middle-income and credit-worthy lower-income countries, financed by bond issuance in international capital markets. The International Finance Corporation (IFC), the Group's private sector arm, finances commercially viable private projects with development impact, including a modest but growing health portfolio, and some low-income countries receive "blend" financing from both IDA and IBRD.

The WB also acts as the fiduciary trustee and administrative host for several global health initiatives constituted as trust funds or Financial Intermediary Funds (FIFs) which typically pool voluntary, earmarked contributions from donors.^{45,46,47} The growth of WB trust funds accelerated in the 1990s and 2000s and as of 2024, it was the trustee of 26 FIFs holding \$37.2 billion in assets, with health-related FIFs accounting for approximately 51% of these assets.^{48,49,50} Among these are the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Coalition for Epidemic Preparedness Innovations (CEPI), International Finance Facility for Immunisation (IFFIm), and the Pandemic Fund.

⁴³ Toussaint E. Domination of the United States on the World Bank [Internet]. CADTM. 2024 Feb 28 [cited 2025 Aug 12]. Available from: <https://www.cadtm.org/Domination-of-the-United-States-on-the-World-Bank>

⁴⁴ World Bank Group. Voting powers [Internet]. Washington, DC: World Bank; [cited 2025 Nov 8]. Available from: <https://www.worldbank.org/en/about/leadership/votingpowers>

⁴⁵ World Bank Group. Financial intermediary funds (FIFs) [Internet]. Washington, DC: World Bank; [cited 2025 Nov 3]. Available from: <https://fiftrustee.worldbank.org/en/about/unit/dfi/fiftrustee/funds>

⁴⁶ Reinsberg B. Trust funds as a lever of influence at international development organizations. *Glob Policy*. 2017;8(55):85-95.

⁴⁷ World Bank Group. A guide for development partners: trust funds & partner relations – partnering with the World Bank through trust funds and umbrella 2.0 programs [Internet]. Washington, DC: World Bank; 2023 [cited 2026 Apr 23]. Available from: <https://thedocs.worldbank.org/en/doc/85936e023f875cd12c3d14ce844b6b33-0060072023/original/Partnering-with-the-World-Bank-through-Trust-Funds-and-Umbrella-2-Oct-2023.pdf>

⁴⁸ Heinzel M, Reinsberg B. Trust funds and the sub-national effectiveness of development aid: evidence from the World Bank. *World Dev*. 2024;179:106609.

⁴⁹ Winters J, Sridhar D. Earmarking for global health: benefits and perils of the World Bank's trust fund model. *BMJ*. 2017;358:j3394.

⁵⁰ World Bank Group. 2024 trust fund annual report: partnerships in action [Internet]. Washington, DC: World Bank; 2024 [cited 2026 Apr 23]. Available from: https://tfar.worldbank.org/assets/images/tf_report/pdf/WORLD%20BANK-Trust-Fund-report.pdf

The WB's role in global health has evolved. Originally founded as a financing agency, it has increasingly assumed a role in shaping health policy since the 1980s. This influence was initially exercised through the conditionalities embedded in loans and grants, most pronounced in developing countries during the era of Structural Adjustment Programs (SAPs).^{51,52,53}

World Bank Health Financing in South and Southeast Asia

Table 11 lists active IBRD and IDA-funded health projects in South and Southeast Asia in 2026. The total aggregate value of these WB funds amounts to a little over USD14.1 billion. A high number of the projects relate to large health systems and pandemic preparedness programmes concentrated in a few countries, namely Indonesia, India, Bangladesh and Pakistan, alongside smaller grant-financed projects in lower-income and fragile settings such as Afghanistan, Nepal, Laos and Myanmar. It is notable that some countries do not receive any grants or loans from the World Bank (e.g. Malaysia, Singapore and Vietnam).

In the first group, the size of WB funds, combined with their focus on core health system functions, gives the institution scope to shape the direction and sequencing of sector-wide reforms, whereas in other countries its influence is more limited to specific programmes, projects or emergency responses.⁵⁴ The financing modality affects a country's future fiscal space for health with non-concessional and mixed financing incurring debt repayments.

The type of financing modalities and project themes varies from country to country. Indonesia and the Philippines, for example, receive both 'non-concessional' and 'mixed' loans for health system and UHC reforms, including programs to strengthen and expand national health insurance and expand coverage, as well as COVID-19 recovery measures. Bangladesh, Pakistan and Sri Lanka, for example, receive concessional and mixed financing for primary care, health workforce and pandemic preparedness. In Afghanistan, Nepal and Myanmar, the current portfolio is mainly made up of grants and short-term emergency projects.

In general, grants and concessional loans are tied to detailed plans with performance indicators.^{55,56} Historically, World Bank loans and grants have been associated with neoliberal health sector reforms and the prioritization of external debt payments. At present, there is a significant reorganization at the World Bank with a shift in focus and a push to speed up lending. In a changing political context shaped by the new US approach to development financing, the WB has moved away from a focus on climate and global public goods toward job creation and growth. In efforts to bring

⁵¹ Ugalde A. The World Bank and international health policy: a critical review. *J Int Dev*. 1995;7(3).

⁵² Forster T, Kentikelenis AE, Stubbs TH, King LP. Globalization and health equity: the impact of structural adjustment programs on developing countries. *Soc Sci Med*. 2020;267:112496.

⁵³ The changing role of the World Bank in global health. *Am J Public Health*. 2005;95(1). doi:10.2105/AJPH.2004.042002

⁵⁴ Tichenor M, Winters J, Storeng KT, et al. Interrogating the World Bank's role in global health knowledge production, governance, and finance. *Global Health*. 2021;17:110.

⁵⁵ McIsaac M, Kutzin J, Dale E, Soucat A. Results-based financing in health: from evidence to implementation. *Bull World Health Organ*. 2018;96(11):730-730A.

⁵⁶ World Bank. Results-based financing for health: experience from Rwanda and other countries [Internet]. Washington, DC: World Bank; 2011 [cited 2026 Apr 23]. Available from: https://ieg.worldbankgroup.org/sites/default/files/Data/reports/chapters/health_finance_evaluation_w_appendix_updated_0.pdf

in more private investment, the World Bank proposes a greater merger of the IDA, IBRD and IFC, with greater alignment around the objective of attracting more finance capital into the development sector.^{57,58}

Table 11. Active World Bank health funding through IBRD and IDA in South and Southeast Asia⁵⁹

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
South Asia	Afghanistan	Afghanistan Health Emergency Response (HER) Project	Nutrition	2025	IDA / Trust Funds (ARTF, GFF)	Grant	241	N/A
South Asia	Afghanistan	Afghanistan Health Emergency Response (HER) Additional Financing	Nutrition	2023	Trust funds (ARTF, GFF)	Grant	267	N/A
South Asia	Afghanistan	Afghanistan Health Emergency Response (HER) Project	Nutrition	2022	IDA + Trust Funds (ARTF, GFF)	Grant	841	N/A
South Asia	Afghanistan	Afghanistan COVID-19 Emergency Response and Health Systems Preparedness Project	Health Emergency Preparedness and Response	2020	IDA	Grant	100	N/A
South Asia	Afghanistan	Afghanistan Sehatmandi Project	Community Health Programs	2018	IDA + Trust Funds (ARTF)	Grant	600	N/A
South Asia	Bangladesh	Health, Nutrition and Population Sector Development Program	Primary Health Care	2024	IDA + Trust Fund	Mixed (Concessional + Grant)	379	31 years, 6-year grace (IDA loan portion)
South Asia	Bangladesh	Inclusive Services and Opportunities for Host Communities and Displaced Rohingya Population	Migrant Health	2024	IDA	Mixed (Concessional + Grant)	350	31 years, 6-year grace (IDA loan portion)
South Asia	Bangladesh	Urban Health, Nutrition and Population Project	Primary Health Care	2023	IDA	Concessional	200	31 years, 6-year grace
South Asia	Bangladesh	Local Government COVID-19 Response & Recovery Project	Health Emergency Preparedness and Response	2022	IDA	Concessional	300	31 years, 6-year grace

⁵⁷ Saldinger A. In a changing world, where do World Bank reforms stand? [Internet]. Devex. 2025 Aug 26 [cited 2026 Apr 20]. Available from: <https://www.devex.com/news/sponsored/in-a-changing-world-where-do-world-bank-reforms-stand-110696>

⁵⁸ Edwards S. World Bank weighs consolidating its three accountability mechanisms [Internet]. Devex. 2026 Apr 14 [cited 2026 Apr 20]. Available from: <https://www.devex.com/news/sponsored/world-bank-weighs-consolidating-its-three-accountability-mechanisms-112271>

⁵⁹ World Bank Group. Projects & operations database: South and Southeast Asian countries; financing sources: IBRD and IDA; project status: active; sector filter: health [data set] [Internet]. Washington, DC: World Bank; [cited 2026 Mar 1]. Available from: <https://projects.worldbank.org/en/projects-operations/projects-list>

South Asia	Bangladesh	Additional Financing for and Restructuring of the COVID-19 Emergency Response and Pandemic Preparedness Project	Health Emergency Preparedness and Response	2021	IDA	Concessional	500	31 years, 6-year grace
South Asia	Bhutan	Accelerating Maternal & Child Health Outcomes Project	Maternal, Child, and Adolescent Health & Nutrition	2024	Trust Funds (JSDF)	Grant	2.8	N/A
South Asia	Bhutan	Additional Financing to Bhutan COVID-19 Emergency Response and Health Systems Preparedness Project	Health Emergency Preparedness and Response	2022	IDA	Concessional	10	31 years, 6-year grace
Southeast Asia	Cambodia	Health Equity and Quality Improvement Project - Phase 2	Primary Health Care	2024	Trust Funds (Unspecified)	Grant	4.8	N/A
Southeast Asia	Cambodia	Cambodia Nutrition Project II	Maternal, Child, and Adolescent Health & Nutrition	2022	Trust Funds (Cambodia Free-standing Trust Fund)	Grant	9.5	N/A
Southeast Asia	Cambodia	Cambodia Health Equity and Quality Improvement Project - Phase 2	Health Emergency Preparedness and Response	2022	IDA + Trust Funds (SDTF, GFF, MDTF)	Mixed (Concessional + Grant)	118	31 years, 6-year grace
Southeast Asia	Cambodia	Strengthening Pre-Service Education System for Health Professionals Project	Health Workforce	2020	IDA + Trust Funds (KfW SDTF)	Mixed (Concessional + Grant)	35	31 years, 6-year grace
Southeast Asia	Cambodia	Engaging Citizens to Improve Service Delivery Through Social Accountability	Healthcare Management	2020	Trust Funds (SASD-TF MDTF)	Grant	5.9	N/A
Southeast Asia	Cambodia	Cambodia Nutrition Project	Maternal, Child, and Adolescent Health & Nutrition	2019	IDA + Trust Funds (HEQIP, IDFHP, GFF, KfW)	Mixed (Concessional + Grant)	41	31 years, 6-year grace
South Asia	India	West Bengal Health System Reform Program Operation	Maternal, Child, and Adolescent Health	2026	IBRD	Non-concessional	286	~20-year avg., ~5-year grace
South Asia	India	Kerala Health Systems Improvement Program	Primary Health Care	2025	IBRD	Non-concessional	280	~20-year avg., ~5-year grace
South Asia	India	India - Enhancing Innovation among ICMR Institutions	Health Innovation	2025	Trust Funds (HEPRTF)	Grant	1	N/A
South Asia	India	Meghalaya Multisectoral Project for Adolescent Wellbeing,	Adolescent Health	2025	IBRD	Non-concessional	35	~20-year avg., ~5-year grace

		Empowerment and Resilience (MPOWER)						
South Asia	India	Assam State Secondary Healthcare Initiative for Service Delivery Transformation (ASSIST) Project	Secondary Health Care	2023	IBRD	Non-concessional	251	~20-year avg., ~5-year grace
South Asia	India	Systems Reform Endeavours for Transformed Health Achievement in Gujarat (SRESTHA-G)	Primary Health Care	2022	IBRD	Non-concessional	350	~20-year avg., ~5-year grace
South Asia	India	India's Enhanced Health Service Delivery Program	Primary Health Care	2022	IBRD	Non-concessional	500	~20-year avg., ~5-year grace
South Asia	India	PHSPP: Transforming India's Public Health Systems for Pandemic Preparedness and Response	Health Emergency Preparedness and Response	2022	IBRD	Non-concessional	500	~20-year avg., ~5-year grace
South Asia	India	Meghalaya Health Systems Strengthening Project	Health System Strengthening	2021	IBRD	Non-concessional	40	~20-year avg., ~5-year grace
South Asia	India	The Resilient Kerala Program	Disaster Management	2021	IBRD + Trust Fund/ Grants	Mixed	370	~20-year avg., ~5-year grace
South Asia	India	Mizoram Health Systems Strengthening Project	Health System Strengthening	2021	IBRD	Non-concessional	27	~20-year avg., ~5-year grace
South Asia	India	Jhelum and Tawi Flood Recovery Project	Disaster Management	2015	IDA	Concessional	250	31 years, 6-year grace
Southeast Asia	Indonesia	Indonesia Community-Based Childcare and Women's Empowerment Project	Primary Health Care	2025	Trust Funds (ELP MDTF + JSDF)	Grant	4.1	N/A
Southeast Asia	Indonesia	Indonesia Supporting Health Transformation Project (I-SeHat)	Primary Health Care and Digital Health	2024	Trust Funds (HT-MDTF)	Grant	9	N/A
Southeast Asia	Indonesia	Indonesia Health Systems Strengthening Project	Health System Strengthening	2023	IBRD	Non-concessional	1,485	~20-year avg., ~5-year grace
Southeast Asia	Indonesia	Investing In Nutrition & Early Years Phase 2 Program	Child Health and Nutrition	2023	IBRD + Trust Funds (MDTF)	Mixed (Non-concessional + Grant)	630.5	~20-year avg., ~5-year grace (IBRD loan portion)
Southeast Asia	Indonesia	Indonesia: Strengthening National Tuberculosis Response Program	Community Health Programs	2022	IBRD	Non-concessional	300	~20-year avg., ~5-year grace

Southeast Asia	Indonesia	National Health Insurance (JKN) Reforms and Results Program	Health System Strengthening	2021	IBRD + Trust Fund (MDTF)	Mixed (Non-concessional + Grant)	404	~20-year avg., ~5-year grace (IBRD loan portion)
Southeast Asia	Indonesia	Indonesia Emergency Response to COVID-19 Additional Financing	Health Emergency Preparedness and Response	2021	IBRD + Trust Funds (Indonesia-Australia Bank Umbrella Fund)	Mixed (Non-concessional + Grant)	507	~20-year avg., ~5-year grace (IBRD loan portion)
Southeast Asia	Laos	Improving Frontline Workers Performance in Education and Health Project	Health Workforce	2026	IDA	Concessional	35	31 years, 6-year grace
Southeast Asia	Laos	Lao Health and Nutrition Services Access Project II	Health Emergency	2024	IDA + Trust Funds (MDTF)	Mixed (Concessional + Grant)	62	31 years, 6-year grace (IDA loan portion)
Southeast Asia	Laos	Lao PDR COVID-19 Response Project - Additional Financing	Health Emergency Preparedness and Response	2021	IDA + Trust Funds (HEPRTF)	Mixed (Concessional + Grant)	15	31 years, 6-year grace (IDA loan portion)
Southeast Asia	Myanmar	Myanmar Health Assistance and Nutrition Support (HANS) Project	Maternal, Child, and Adolescent Health & Nutrition	2025	IDA	Grant	40	N/A
Southeast Asia	Myanmar	Additional Financing to Myanmar COVID-19 Emergency Response Project	Health Emergency Preparedness and Response	2020	Trust Funds (PEF)	Grant	7.7	N/A
South Asia	Nepal	Nepal Disaster Resilience Development Policy Credit with Cat DDO (NDRC)	Disaster Management	2024	IDA	Concessional	150	31 years, 6-year grace
South Asia	Nepal	Second Additional Financing to Nepal COVID-19 Emergency Response and Health Systems Preparedness Project	Health Emergency Preparedness and Response	2022	IDA	Concessional	18	31 years, 6-year grace
South Asia	Nepal	Additional Financing: Nepal COVID-19 Emergency Response and Health Systems Preparedness Project	Health Emergency Preparedness and Response	2021	IDA	Concessional	75	31 years, 6-year grace
South Asia	Pakistan	Punjab Family Planning Program	Community Health Programs	2023	IDA	Concessional	100	31 years, 6-year grace

South Asia	Pakistan	Khyber Pakhtunkhwa Citizen-Centered Service Delivery Project	Child Health	2023	IDA + Trust Funds (Unspecified)	Mixed (Concessional + Grant)	50	31 years, 6-year grace (IDA loan portion)
South Asia	Pakistan	Strengthening Social Protection Delivery System in Sindh	Child Health	2022	IDA	Concessional	200	31 years, 6-year grace
South Asia	Pakistan	Sindh Integrated Health and Population Project	Maternal, Child, and Adolescent Health & Nutrition	2022	IDA	Concessional	200	31 years, 6-year grace
South Asia	Pakistan	National Health Support Program	Primary Health Care	2022	IDA + Trust Funds (GFF)	Mixed (Concessional + Grant)	314	31 years, 6-year grace (IDA loan portion)
South Asia	Pakistan	KP- Spending Effectively for Enhanced Development	Primary Health Care	2022	IDA	Concessional	400	31 years, 6-year grace
South Asia	Pakistan	Khyber Pakhtunkhwa Human Capital Investment Project	Primary Health Care	2020	IDA + IDA Grant	Mixed (Concessional + Grant)	200	31 years, 6-year grace (IDA loan portion)
South Asia	Pakistan	Punjab Human Capital Investment Project	Primary Health Care	2020	IDA	Concessional	200	31 years, 6-year grace
Southeast Asia	Philippines	Philippines Health System Resilience Project	Health System Strengthening	2025	IBRD	Non-concessional	496	~20-year avg., ~5-year grace
Southeast Asia	Philippines	The Philippines Multisectoral Nutrition Project	Nutrition	2022	IBRD	Non-concessional	178	~20-year avg., ~5-year grace
Southeast Asia	Philippines	Philippines COVID-19 Emergency Response Project - Additional Financing 2	Health Emergency Preparedness and Response	2021	IBRD	Non-concessional	300	~20-year avg., ~5-year grace
Southeast Asia	Philippines	Philippines COVID-19 Emergency Response Project Additional Financing	Health Emergency Preparedness and Response	2021	IBRD	Non-concessional	500	~20-year avg., ~5-year grace
South Asia	South Asia	SAR Capacity Building for Pandemic Prevention, Preparedness, and Response (PPR) with One Health approach	Health Emergency Preparedness and Response	2025	Trust Funds (HEPRTF)	Grant	4	N/A
South Asia	Sri Lanka	Sri Lanka: Primary Healthcare System Enhancing Project (PHSEP)	Primary Health Care	2024	IDA	Concessional	150	31 years, 6-year grace

South Asia	Sri Lanka	Third Additional Financing for Sri Lanka COVID-19 Emergency Response and Health System Preparedness Project	Health Emergency Preparedness and Response	2021	IBRD	Non-concessional	100	~20-year avg., ~5-year grace
South Asia	Sri Lanka	Second Additional Financing for Sri Lanka COVID-19 Emergency Response and Health Systems Preparedness Project	Health Emergency Preparedness and Response	2021	IBRD+IDA	Mixed (Concessional + Non-concessional)	80.5	Indicative blend: ~20-year (IBRD), 31-year (IDA), 6-year grace
Southeast Asia	Thailand	Enhancing Psychosocial Services for Traumatized Persons in Conflict-Affected Areas in Thailand's Deep South	Mental Health	2024	Trust Funds (SPF)	Grant	1.1	N/A

- a. Financing Source distinguishes core WB windows (IBRD, IDA) from WB-administered trust funds. Specific facilities (e.g. ARTF, GFF, single- or multi-donor trust funds) are named where identified in project documents. In WB country-level data, projects are labelled according to broad financing types (eg. IDA, IBRD, Grants) and the split between IDA grants and WB-administered trust-fund grants is not visible. Thus, identifying the relative weight of trust-fund grants versus IDA grants would require cross-checking detailed project and financing documents rather than headline financial tables.
- b. 'Instrument' classifies the form of finance (loan, grant, or loan-grant blend). In general, IBRD loans are non-concessional; IDA credits are concessional; and pure grants are non-repayable. Operations combining IDA credits with grants or trust funds are 'mixed'. Several projects are co-financed with external partners (eg. AIB or bilateral donors) and governments. This table only reports the IBRD/IDA and WB-administered trust-fund portions and does not capture the full size of blended financing packages. Parallel financing from other partners that is not channeled through WB trust funds is excluded. Overall, the table should be read as an attempt to reconstruct the Bank's health portfolio, making explicit distinctions between multilateral finance and earmarked donor funding which are obscured in published aggregates.
- c. 'Typical maturity' and grace periods are drawn from standard term sheets rather than individual loan agreements. For IDA credits, this column reports the regular IDA schedule (31-year final maturity, 6-year grace), as set out in the current IDA terms table; this schedule is uniform across regular IDA credits. For IBRD loans, exact repayment profiles by project are not disclosed; the table therefore reports an indicative band ('~20-year average maturity, ~5-year grace') derived from the IBRD Flexible Loan's 20-year maximum average repayment maturity and 35-year maximum final maturity, combined with typical grace periods used in investment operations, and should not be read as the legal tenor of each loan. Exact loan terms may differ by operation and country but are not systematically reported in the Projects & Operations database.

ARTF = Afghanistan Reconstruction Trust Fund; GFF = Global Financing Facility for Women, Children and Adolescents; JSDF = Japan Social Development Fund; Cambodia Free-standing Trust Fund = Cambodia-specific free-standing trust fund; SDTF = Sector Development Trust Fund; MDTF = Multi-Donor Trust Fund; KfW SDTF = KfW-financed Sector Development Trust Fund; SASD-TF MDTF = South Asia Social Development Trust Fund (multi-donor); HEPRTF = Health Emergency Preparedness and Response Multi-Donor Trust Fund; PEF = Pandemic Emergency Financing Facility; SPF = State and Peace Building Fund.

The IFC also shapes health systems by providing loans to or investing in private healthcare and related industries. It also seeks to actively attract additional private financial investments. Table 12 shows that IFC health investments, amounting to USD68.65 million, in South and Southeast Asia are concentrated in a few countries, with India and Indonesia accounting for most projects and committed amounts. India's eleven projects span hospital care, dialysis networks, home care, primary care, health technology and pharmaceuticals, while Indonesia's portfolio (3 projects) focuses on medical equipment manufacturing and pharmaceutical distribution, financed through a mix of loans and equity. Pakistan (2 projects) and Thailand (1 project) have loans and equity investment into private hospital operators and platforms. Bangladesh and Sri Lanka have one loan each for pharmaceutical production, and in the Philippines has three loans to food services and

nutrition companies and a multi-sector corporate group with partial health and social infrastructure components. Singapore has equity invested in a regional healthtech platform financed.

Table 12. Active IFC Healthcare Investments in South and Southeast Asia

Country	Projects	Sector Focus	Total IFC Commitment (Million USD)	Investment Type	Notes
<i>Bangladesh</i>	1	Pharmaceutical manufacturing	810	Loan	Drug production capacity
<i>India</i>	11	Hospitals, dialysis networks, primary care, home healthcare, pharma, vision care, ed-tech	18,019	Loan, Equity	Largest portfolio; includes ed tech (\$8.7B), pure health services (\$7.3B)
<i>Indonesia</i>	3	Medical devices distribution, medical equipment manufacturing, pharmaceutical distribution	17,590	Loan, Equity	Manufacturing focus; local production capacity and supply chain resilience
<i>Malaysia</i>	2	Hospital network expansion, higher education (health workforce development)	3,415	Equity	Sunway 3,400+ bed target by 2032; ed tech for health workforce (\$3.4B)
<i>Pakistan</i>	2	Tertiary hospital systems, private hospital expansion	4,314	Loan	Infrastructure expansion: Shifa International (\$3.3B), Northwest Hospital (\$1.0B)
<i>Philippines</i>	3	Food services/nutrition, multi-sector corporate financing with partial health and social infrastructure support	20,374	Loan	Food services/nutrition: TCG Holdings (Cravings) loans (\$13.4B); multi-sector corporate: Ayala Corporation financing (\$10B)
<i>Singapore</i>	1	Medical claims administration platform (healthtech)	60	Equity	Regional healthtech platform serving Southeast Asia
<i>Sri Lanka</i>	1	Pharmaceutical manufacturing	1,056	Loan	Domestic pharmaceutical capacity
<i>Thailand</i>	1	Private hospital operator, healthcare platform	3,012	Equity	Hospital platform and network development
Total	25		68,650		

Notes: Data were compiled with assistance from Perplexity AI, from World Bank Group Finances One portal, IFC Investment Services Projects dataset (DS00499, <https://financesone.worldbank.org/ifc-investment-services-projects/DS00499>), and IFC project disclosure and press materials for infrastructure and manufacturing investments in health and health-related sectors in South and Southeast Asia (accessed March 30, 2026). Figures include projects with “active” status only and aggregate IFC commitments in healthcare services, healthcare infrastructure, and health-related manufacturing; classification is based on IFC sector coding and project documentation and assigns multi-sector operations to a single primary health-related category. Project-level disclosure pages for MiCare (Singapore), Renata PLC (Bangladesh) and Sunshine Healthcare Lanka (Sri Lanka) investments were inaccessible at the time of data extraction; status and sector classification are based on IFC press releases and secondary reporting.

The Asian Development Bank (ADB)

The ADB was established in 1966. It is owned by 69 member states, 50 of which are from Asia and the Pacific.⁶⁰ Its primary mandate is to promote economic growth and regional cooperation by financing development projects through loans and grants and providing technical assistance.⁶¹ Its voting power is directly proportional to capital subscriptions. Japan and the US have maintained their position as the largest shareholders (15.6% each), granting them the most influence.⁶² China (6.4%), India (6.3%) and Australia (5.8%) also hold substantial shares. There is an understanding that the President is always from Japan.

The ADB is synonymous with large-scale infrastructure projects.⁶³ Over the decades it has built long-standing development partnerships with Bangladesh, India, Indonesia, Malaysia, Nepal, the Philippines, Singapore, Sri Lanka, Thailand, and Vietnam.⁶⁴ However, in recent years it has moved towards a more holistic approach that includes a focus on climate change and social policy (including health).⁶⁵ The ADB now explicitly frames investments in health not as a social welfare cost, but as an investment in human capital that underpins economic growth and regional stability.

The ADB's investment in health is aimed at advancing UHC by strengthening core building blocks of health systems: governance, financing, service delivery, and the health workforce.⁶⁶ There is an intention to double the share of health in its total commitments to 6-10% by 2030.⁶⁷ A key focus is integrating digital health tools, such as telemedicine and electronic health records, across primary care systems. Additionally, the ADB links health objectives to development in complementary

⁶⁰ Asian Development Bank. About ADB [Internet]. Manila: ADB; [cited 2026 Apr 23]. Available from: <https://www.adb.org/who-we-are/about>

⁶¹ Asian Development Bank. Agreement establishing the Asian Development Bank (ADB Charter) [Internet]. Manila: ADB; 1965 [cited 2026 Apr 23]. Available from: <https://www.adb.org/documents/agreement-establishing-asian-development-bank-ADB-Charter>

⁶² Asian Development Bank. Credit fundamentals [Internet]. Manila: ADB; 2025 Jul 11 [cited 2026 Apr 23]. Available from: <https://www.adb.org/work-with-us/investors/credit-fundamentals>

⁶³ Economic Research Institute for ASEAN and East Asia. ADB at 50: is it ready to face the new challenges and stay relevant? [Internet]. Jakarta: ERIA; 2017 May 10 [cited 2026 Apr 23]. Available from: <https://www.eria.org>

⁶⁴ Asian Development Bank. ADB project documents [Internet]. Manila: ADB; 2026 Jun 30 [cited 2026 Apr 23]. Available from: <https://www.adb.org/projects/documents/country/bangladesh/country/india/country/indonesia/country/malaysia/country/nepal/country/philippines/country/singapore/country/sri-lanka/country/thailand/country/viet-nam>

⁶⁵ Asian Development Bank. Strategy 2030: achieving a prosperous, inclusive, resilient, and sustainable Asia and the Pacific [Internet]. Manila: ADB; 2018 Jul [cited 2026 Apr 23]. Available from: <https://www.adb.org/sites/default/files/institutional-document/435391/strategy-2030-main-document.pdf>

⁶⁶ Asian Development Bank. Strategy 2030 health sector directional guide: toward the achievement of universal health coverage in Asia and the Pacific [Internet]. Manila: ADB; 2022 Nov 30 [cited 2026 Apr 23]. Available from: <https://www.adb.org/sites/default/files/institutional-document/855216/strategy-2030-health-sector-directional-guide.pdf>

⁶⁷ Asian Infrastructure Investment Bank. AIIB health strategy: sector trends and analysis [Internet]. Beijing: AIIB; 2025 Feb [cited 2026 Apr 23]. Available from: https://www.aiib.org/en/policies-strategies/operational-policies/health-strategy/.content/_download/AIIB-Health-Strategy-web-publication.pdf

sectors like sanitation, education, and transport, and addresses cross-border regional challenges such as climate change, migration, and cross-border disease transmission.⁶⁸

The ADB utilizes a diverse toolkit for health, including policy-based lending (PBL) to support systemic reforms and investment projects to build infrastructure and digital health systems.⁶⁹ It finances hospitals and regional centres, upgrades health information systems, and integrates social protection measures such as conditional cash transfers and gender-responsive services to better protect women and marginalized groups, as seen in Bangladesh and Bhutan.

ADB’s Health Financing in South and Southeast Asia

ADB’s currently active health funding in South and South-East Asia is mostly of large operations that target whole health systems instead of isolated facilities. The loans and grants in Table 13 show substantial commitments in both regions for urban care, tertiary hospitals, provincial health systems, and local health-service development, along with major investments in vaccines and diagnostics manufacturing. The amounts of funding provided to these currently active projects amount to around USD5.82 billion.

Concessional loans and ‘loan-plus-grant’ packages are concentrated in lower-income countries such as Bangladesh, Bhutan, Lao PDR and Sri Lanka. Larger middle-income countries such as Indonesia, India and the Philippines make greater use of non-concessional loans. ADB’s loans are substantial and multi-year and can influence the trajectory of health systems development in terms of, for example, the balance between primary care and hospital services, and the roles and interactions of public and private providers in the system.

Table 13. Currently Active ADB Health Financing in South and Southeast Asia⁷⁰

Country	Project (short title)	Main focus	Instrument^a	Terms	Year	USD million^b
Bangladesh	Urban Primary Health Care Services	Urban primary care; systems	Project loan + grant	Concessional loan + grant	2012	160.4
Bangladesh	COVID-19 Response Emergency Project	COVID-19 response; systems	Project loan	Concessional loan	2020	100.0
Bangladesh	COVID-19 Vaccines for Recovery	Vaccines	Project loan	Concessional loan	2021	940.0
Bangladesh	Vaccines & Diagnostics Manufacturing	Health manufacturing; systems	Project loan	Concessional loan	2023	336.5

⁶⁸ Asian Development Bank. As climate change transforms migration, governments must act to ease restrictions [Internet]. Manila: ADB; [cited 2025 Nov 7]. Available from: <https://blogs.adb.org/blog/climate-change-transforms-migration-governments-must-act-ease-restrictions>

⁶⁹ Asian Development Bank. ADB’s work in Southeast Asia: Cambodia, Indonesia, Lao People’s Democratic Republic, Myanmar, Philippines, Thailand, Timor-Leste, Viet Nam [Internet]. Manila: ADB; [cited 2025 Nov 7]. Available from: <https://www.adb.org/where-we-work/southeast-asia/overview>

⁷⁰ Asian Development Bank. ADB sovereign projects dataset [data set] [Internet]. Manila: ADB; 2025 [cited 2026 Apr 23]. Available from: <https://www.adb.org/projects>

Bhutan	COVID-19 Vaccines for Recovery	Vaccines	Loan + grant	Concessional loan + grant	2022	10.0
Cambodia	Border Areas Health Project	Border health; NCDs; MCH; insurance	Project loan + grant	Concessional loan + grant	2022	32.6
Cambodia	Rapid Immunization Support	Vaccines	Project loan	Concessional loan	2022	95.0
Indonesia	Essential Health Actions & Transformation	Sector reforms	Program-type loan	Non-concessional loan	2023	350.0
Indonesia	Primary Care & Lab Strengthening	Primary care and labs	Project loan	Non-concessional loan	2023	650.2
Lao PDR	Border Areas Health Project	Border health; systems	Project loan + grant	Concessional loan + grant	2024	24.9
Lao PDR	Quality of Health Care Project	Service quality; hospitals	Project loan	Concessional loan	2023	45.0
Maldives	COVID-19 Vaccination for Recovery	Vaccines	Grant	Grant	2022	10.0
India	Urban Primary Health Care (PM-AB)	Urban primary care; infrastructure	Program / project	Non-concessional loan	2020	300.0
India	Early Childhood Development, Meghalaya	Child health; nutrition; systems	Project / program	Concessional loan	2023	40.5
India	Maharashtra Tertiary Care & Medical Education	Tertiary care; medical education	Sector program loan	Non-concessional loan	2023	500.0
Pakistan	KP Health Systems Strengthening Program	Provincial health systems	Program loan	Non-concessional loan	2022	100.0
Philippines	Health System Enhancement for COVID-19	COVID-19 response; systems	Project loan	Non-concessional loan	2020	125.0
Philippines	Build UHC Program – Subprogram 1	UHC reforms	Policy-based loan	Non-concessional loan	2021	600.0
Philippines	Build UHC Program – Subprogram 2	UHC reforms	Policy-based loan	Non-concessional loan	2023	450.0
Sri Lanka	Health System Enhancement Project	Communicable disease; system reform	Project loan + grant	Concessional loan + grant	2018	160.0
Sri Lanka	COVID-19 Vaccines for Recovery	Vaccines	Project loan	Non-concessional loan	2021	150.0
Viet Nam	Local Health Care for Disadvantaged Areas Program	Local health services; insurance; reform	Sector program	Concessional loan + grant	2018	100.6

a. Instrument refers to the lending modality used by the ADB. Policy-Based Loans (PBL) provide budget support linked to policy and institutional reforms; Results-Based Loans (RBL) disburse funds based on the achievement of predefined program results; and Project Loans finance specific investments such as health infrastructure, services, or system improvements.

b. The amount excludes additional co-financing provided by other development partners.

Asian Infrastructure Investment Bank (AIIB)

AIIB is a new MDB led by China which began operations in 2016 and tasked with supporting infrastructure development across Asia.⁷¹ It has more than 100 member countries from the region (but excluding Japan) and beyond.⁷² Initially, it was seen as an alternative to established institutions like the WB, which had faced criticism for its unfavourable terms and conditionalities.⁷³ More recently, AIIB has shifted to a more collaborative approach with the WB, including co-financing projects to combine strengths and reduce duplication.⁷⁴

Most of AIIB's health lending is non-concessional, priced at a variable reference rate plus a spread of 0.50% to 1%, with standard front-end and commitment fees. This positions AIIB as a provider of near-market capital for middle-income countries (MICs) rather than a traditional development bank. Its Special Fund Window (SFW) has been used only once for an interest-rate buydown in Cambodia,⁷⁵ indicating that concessionality is a marginal feature. Generally, its approach tilts towards commercially attractive projects and PPPs to attract private investors.

AIIB only recently entered the health sector and adopted its first health strategy in 2024,⁷⁶ mainly framing health as co-benefit of infrastructure financing. Its strategy includes using energy, transport and water projects to improve health, supporting UHC-relevant infrastructure, strengthening pandemic preparedness, greening health facilities, promoting digital tools such as AI and telemedicine, and mobilising private capital.

Table 14 lists AIIB's health-specific lending in South and Southeast Asia. All involve non-concessional loans, and several are co-financed with other development banks. Projects have been concentrated around a small number of pandemic and system-strengthening loans in Bangladesh, Cambodia, India, Indonesia and the Philippines. In South Asia, Bangladesh and India each received loans in the range of 100-500 million USD for COVID-19 emergency response and health-system preparedness. In Southeast Asia, Cambodia has a 50 million USD project for immunisation and resilient health infrastructure plus a 33 million USD loan for One Health livestock and value-chain investment. Indonesia has three major loans: a 250 million USD COVID-19

⁷¹ Asian Infrastructure Investment Bank. About AIIB [Internet]. Beijing: AIIB; [cited 2025 Oct 28]. Available from: <https://www.aiib.org/en/about-aiib/index.html>

⁷² Asian Infrastructure Investment Bank. Members of the Bank [Internet]. Beijing: AIIB; 2017 Oct 13 [cited 2025 Oct 28]. Available from: <https://www.aiib.org/en/about-aiib/governance/members-of-bank/index.html>

⁷³ Investopedia. Asian Infrastructure Investment Bank (AIIB): history and overview [Internet]. New York: Investopedia; [cited 2025 Oct 28]. Available from: <https://www.investopedia.com/terms/a/asian-infrastructure-investment-bank-aiib.asp>

⁷⁴ Asian Infrastructure Investment Bank. Partnerships: MOUs and related documents [Internet]. Beijing: AIIB; [cited 2025 Oct 28]. Available from: <https://www.aiib.org/en/about-aiib/who-we-are/partnership/index.html>

⁷⁵ Asian Infrastructure Investment Bank. AIIB special fund window for less developed members [Internet]. Beijing: AIIB; [cited 2025 Nov 17]. Available from: <https://www.aiib.org/en/what-we-do/special-funds/special-fund-window-for-less-developed-members/index.html>

⁷⁶ Asian Infrastructure Investment Bank. Health strategy: tomorrow's infrastructure for health [Internet]. Beijing: AIIB; 2024 Dec 12 [cited 2026 Apr 23]. Available from: https://www.aiib.org/en/policies-strategies/operational-policies/health-strategy/.content/_download/AIIB-Health-Strategy-web-publication.pdf

emergency response operation, 500 million USD in additional financing, and a 999 million USD health-system modernisation project, as well as a 226.4 million USD hospital construction and integration loan, mostly co-financed with the WB, ADB and the Islamic Development Bank (IsDB). The Philippines has a 300 million USD vaccine-focused project to support its COVID-19 health-system enhancement.

Table 14. Currently Active AIIB Health Financing in South and Southeast Asia⁷⁷

Region	Country	Sector	Project Name	Thematic Area	Approval Year	AIIB Financing (USD million)	Co-Financing Partners
South Asia	Bangladesh	Public Health	COVID-19 Emergency Response and Pandemic Preparedness Project	Pandemic Response	2020	100	WB
Southeast Asia	Cambodia	Public Health	Cambodia Rapid Immunization Support and Resilient Health Infrastructure Project	Health System Strengthening	2022	50	None
Southeast Asia	Cambodia	Health Infrastructure	Cross-border Livestock Health and Value-chain Infrastructure Improvement Project	One Health	2023	33	ADB
South Asia	India	Public Health	COVID-19 Emergency Response and Health Systems Preparedness Project	Pandemic Response	2020	500	None
South Asia	India	Public Health	Responsive COVID-19 Vaccines for Recovery Project	Pandemic Response (Vaccine)	2022	500	ADB
Southeast Asia	Indonesia	Public Health	Emergency Response to COVID-19 Program	Pandemic Response	2020	250	WB
Southeast Asia	Indonesia	Public Health	Emergency Response to COVID-19 Program - Additional Financing	Pandemic Response	2021	500	WB
Southeast Asia	Indonesia	Health Infrastructure	Modernization of the Health System	Health System Strengthening	2023	999	WB; ADB; IsDB
Southeast Asia	Indonesia	Health Infrastructure	RSAB Harapan Kita Construction and Integration of Three Diamond Hospitals Project	Health System Strengthening	2025	226.4	None
Southeast Asia	Philippines	Public Health	Second Health System Enhancement to Address and Limit COVID-19 under Asia Pacific Vaccine Access Facility Project (HEAL 2)	Pandemic Response (Vaccine)	2021	300	ADB

⁷⁷ Asian Infrastructure Investment Bank. Author's compilation from the Asian Infrastructure Investment Bank project database and PSI documents, filtered by sectors "Health Infrastructure" and "Public Health" and limited to projects with status "Approved" [data set]. Beijing: AIIB; [cited 2026 Mar 10]. Available from: https://www.aiib.org/en/projects/list/year/All/member/All/sector/Health%20Infrastructure/financing_type/All/status/All

Development Banks: Findings & Perspectives

Development Banks are central actors in shaping health systems in South and Southeast Asia. The WB, ADB and AIIB provide health financing through various modalities, terms and governance arrangements. The WB and ADB provide a broader mix of loans and grants for both social sector and infrastructure projects, while the AIIB has a sharper focus on non-concessional loans for infrastructure financing, and also seeks to mobilise private capital alongside its own lending. The IFC also channels growing volumes of private capital into the health sector.

Table 15: Comparative Lending and Grant Volumes in South and Southeast Asia

	World Bank	ADB	AIIB
South Asia			
Grants	\$2.06B	\$10.0M	-
Concessional	\$2.75B	\$1.42B	-
Non-Concessional	\$2.37B	\$1.05B	\$1.10B
Mixed	\$1.74B	\$330.4M	-
Total	\$8.92B	\$2.81B	\$1.10B
Southeast Asia			
Grants	\$82.1M	-	-
Concessional	\$35.0M	\$140.0M	-
Non-Concessional	\$3.26B	\$2.18B	\$2.36B
Mixed	\$1.81B	\$158.1M	-
Total	\$5.19B	\$2.47B	\$2.36B

Following the COVID-19 pandemic, MDBs have channelled larger volumes of health-related finance to South and Southeast Asia. World Bank documents show nearly \$12 billion mobilized for COVID-19 in South Asia, including \$2.5 billion for 15 health projects and support to over 23,000 facilities, part of a \$31 billion regional package that included about \$1 billion for vaccine purchase and deployment.⁷⁸ Between 2020 and 2023, ADB committed roughly \$6.9 billion for COVID-19 emergency and crisis response, effectively doubling its health portfolio in under four years,⁷⁹ while the AIIB financed 22 health projects totalling about \$4.87 billion within a year of launching its inaugural health strategy in December 2024.⁸⁰

The three banks also interact with each other. Co-financed operations, such as Indonesia's large health-system modernization loans and several pandemic response and vaccine projects exemplify cooperation and some alignment of reporting requirements and reform benchmarks. This can reduce transaction costs for governments and create a common reform package. For governments,

⁷⁸ World Bank Group. Achieving results in South Asia [Internet]. Washington, DC: World Bank; 2023 Feb 16 [cited 2026 Apr 23]. Available from: <https://www.worldbank.org/en/region/sar/brief/achieving-results-in-south-asia>

⁷⁹ Asian Development Bank. Independent Evaluation Department. Evaluation of ADB's support for health in Asia and the Pacific [Internet]. Manila: ADB; 2025 Sep 1 [cited 2026 Apr 23]. Available from: <https://www.adb.org/documents/evaluation-ADB-s-support-health-asia-and-pacific>

⁸⁰ Asian Infrastructure Investment Bank. AIIB launches its first health strategy to strengthen the resilience, inclusivity and sustainability of health systems [Internet]. Beijing: AIIB; 2025 [cited 2025 Oct 28]. Available from: <https://www.aiib.org/en/news-events/news/2025/aiib-launches-its-first-health-strategy-to-strengthen-the-resilience-inclusivity-and-sustainability-of-health-systems.html>

the key challenge is negotiating good terms and conditions and ensuring that projects are designed and managed to meet both health goals and financial or macro-fiscal targets.

A key question is whether stronger regional cooperation could help countries engage more strategically and efficiently with development banks. This could involve sharing information, co-developing health-sector standards to guide infrastructure investments, or jointly scrutinising new PPPs and financialisation models before they are scaled up. There is also scope for peer learning about what has and hasn't worked in areas such as UHC reforms, hospital PPPs or vaccine manufacturing which could help governments' negotiations with private investors and trans-national corporate actors.

GLOBAL PUBLIC PRIVATE PARTNERSHIPS (GPPPs)

Introduction

The literature defines PPPs as collaborative relationships between the public and private sectors aimed at providing infrastructure and public services in which risks and benefits are shared to achieve a common goal.⁸¹ These partnerships typically pool resources from major donors and provide grants to help expand access to vaccines and other priority health interventions. Global public-private partnerships (GPPPs) have become key actors in global health. Some have large budgets, bureaucracies and programmes operating across the world are also considered as influential actors in global health stewardship, and in the production of guidelines and policies.⁸²

While they generate positive benefits, their narrow focus on selected diseases and/or technologies have created ‘vertical’ and selective programmes that can undermine general health systems strengthening and divert attention away from other national priorities.^{83,84}

Here we look at Gavi, the Vaccine Alliance (GAVI), CEPI and the Global Fund as three prominent GPPPs in global health (Table 16). The World Bank-hosted Pandemic Fund is another new GPPP model worth noting. While LICs and lower-MICs in South and Southeast Asia have received funds from GPPPs, some lower-MICs and upper-MICs have also begun to make contributions to GPPPs.

Table 16. Key Global Public-Private Partnerships

GAVI	Founded in 2000, GAVI brings together governments, private and multilateral actors to source vaccines by pooling demand to negotiate lower vaccine prices with manufacturers and providing financing to support their purchase and delivery. GAVI also has an innovative financing arm, the International Finance Facility for Immunisation (IFFIm), which issues ‘vaccine bonds’ backed by sovereign pledges, essentially front-loading future aid so it can accelerate roll-out and support pandemic responses such as COVAX.
The Global Fund	Established in 2002, the GF pools public and private funds to finance programmes addressing HIV, tuberculosis, and malaria. It functions as a financing mechanism for pooling international resources to support country-owned programmes combating the three diseases.
Coalition for Epidemic Preparedness Innovations (CEPI)	CEPI, launched in 2017, mobilises public and private capital to accelerate vaccine development for epidemic-prone diseases.

⁸¹ Kopańska A, Osiński R, Korbus B. Private entities motivations to participate in public-private partnerships. *Socio-Econ Plann Sci.* 2024;92:101841.

⁸² Abu El Kheir-Mataria W, El-Fawal H, Chun S. Changing roles in global health governance following COVID-19. *East Mediterr Health J.* 2024;30(2):93-102.

⁸³ Maciocco G, Stefanini A. From Alma-Ata to the Global Fund: the history of international health policy. *Rev Bras Saúde Mater Infant.* 2007;7:479-486.

⁸⁴ Clinton C, Sridhar D. *Governing global health: who runs the world and why?* Oxford: Oxford University Press; 2017.

Global Fund

The Global Fund is one of the largest global health actors, having disbursed \$69 billion since 2002.¹⁰⁸ Its Board includes representation from donor and recipient countries, alongside representatives from civil society and affected communities.⁸⁵ Country Coordinating Mechanisms (CCMs) act as a mechanism for governments and domestic stakeholders to engage with the Global Fund and oversee implementation at the country level. In reality, the GF's biggest donors have a disproportionate influence over strategic decisions and funding priorities.⁸⁶

In Asia, Table 17 provides data from a sample of ten countries in South and Southeast Asia. It shows that some countries have begun to transition from being purely Global Fund recipients to being hybrid donor-recipients with Singapore only being a donor. India has been increasing its contributions across replenishment cycles (while also being one of the largest recipients of Global Fund disbursements globally).

The Global Fund's Indo-Pacific report indicates around \$2.2 billion allocated for 2024-2026.⁸⁷ The Indo-Pacific region covers Afghanistan, Bangladesh, Bhutan, Cambodia, Cook Islands, Fiji, India, Indonesia, Kiribati, Lao PDR, Malaysia, Marshall Islands, Micronesia, Mongolia, Myanmar, Nauru, Nepal, Niue, Pakistan, Palau, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Tonga, Tuvalu, Vanuatu and Viet Nam.

Table 17. Global Fund Recipients and Contributors from South and Southeast Asia⁸⁸

Country	Country-status	Total Funds Received (up to 2026)	Funds Contributed (up to 2026)	Pledges (8th replenishment, 2026–2028)
India	Donor and Recipient	US\$3.15 billion	US\$94 million	US\$30 million
Indonesia	Donor and Recipient	US\$1.71 billion	US\$10 million	Nil
Pakistan	Recipient	US\$1.65 billion	Nil	Nil
Bangladesh	Recipient	US\$998 million	Nil	Nil
Myanmar	Recipient	US\$910 million	Nil	Nil
Philippines	Recipient	US\$802 million	Nil	Nil
Vietnam	Recipient	US\$673 million	Nil	Nil
Thailand	Donor and Recipient	US\$633 million	US\$27 million	Nil
Afghanistan	Recipient	US\$380 million	Nil	Nil
Nepal	Recipient	US\$345 million	Nil	Nil

⁸⁵ The Global Fund. Board [Internet]. Geneva: The Global Fund; [cited 2026 Apr 23]. Available from: <https://www.theglobalfund.org/en/board/>

⁸⁶ Kavanagh MM, Chen S. Governance and health aid from the Global Fund: effects beyond fighting disease. *Ann Glob Health*. 2019;85(1):69.

⁸⁷ The Global Fund. Regional impact report: Indo-Pacific [Internet]. Geneva: The Global Fund; 2025 [cited 2026 Apr 23]. Available from: https://www.theglobalfund.org/media/wzflzdcg/impact_indo-pacific_report_en.pdf

⁸⁸ The Global Fund. Government and public donors [Internet]. Geneva: The Global Fund; 2026 Apr 20 [cited 2025 Nov 2]. Available from: <https://www.theglobalfund.org/en/government/>

Cambodia	Recipient	US\$295 million	Nil	Nil
Laos	Recipient	US\$190 million	Nil	Nil
Sri Lanka	Recipient	US\$129 million	Nil	Nil
Timor-Leste	Recipient	US\$38 million	Nil	Nil
Bhutan	Recipient	US\$31 million	Nil	Nil
Malaysia	Recipient	US\$20 million	US\$0.13 million	Nil
Singapore	Donor	Nil	US\$1.6 million	US\$0.4 million
Brunei	Non-Participant	Nil	Nil	Nil

In its current replenishment cycle, the Global Fund has so far raised US\$11.34 billion, well below its \$18 billion target as traditional donors like the US, UK and France reduce their contributions significantly.^{89,90,91} India on the other hand has continued to increase its commitments pledging \$30 million.⁹² However, Singapore has decreased its contributions while Thailand and Malaysia have not made any pledges for the 2026-2028 cycle.⁹³ India, Indonesia and Singapore are thus the only countries from South and Southeast Asia to have made pledges for the current cycle.^{94,95}

The declining funds have led to a revised allocation formula based on a country's GNI per capita and disease burden, as well as a "Co-Financing Policy" that requires recipient countries to increase their domestic health investments. This new approach is designed to encourage countries to gradually reduce reliance on external grants.⁹⁶ The Global Fund has also sought to move away from being a vertical disease funder in favour of providing more integrated support while also emphasizing greater domestic self-reliance.⁹⁷ A recent 2025 Memorandum of Understanding with the WB aims to move the Fund away from a donor-recipient model towards a "co-investment" model where Global Fund

⁸⁹ Global Fund partners demonstrate unity and resolve to sustain progress and strengthen global health security [Internet]. The Global Fund. 2025 Nov 21 [cited 2026 Jun 2]. Available from: <https://www.theglobalfund.org/en/news/2025/2025-11-21-global-fund-partners-demonstrate-unity-resolve-sustain-progress-strengthen-global-health-security/>

⁹⁰ The United States maintains its Global Fund commitment [Internet]. Think Global Health. 2025 Nov 26 [cited 2026 Jun 2]. Available from: <https://www.thinkglobalhealth.org/article/the-united-states-maintains-its-global-fund-commitment>

⁹¹ International Health Policies News. IHP News #856: M/multilateralism in the year 2025. 2025 Nov 28.

⁹² Government profiles: India [Internet]. The Global Fund. [cited 2026 Jun 2]. Available from: <https://www.theglobalfund.org/en/government/profiles/india/>

⁹³ Government profiles: Thailand [Internet]. The Global Fund. [cited 2026 Jun 2]. Available from: <https://www.theglobalfund.org/en/government/profiles/thailand/>

⁹⁴ Global Fund Indonesia US\$10 million commitment to eighth replenishment [Internet]. The Global Fund. 2026 May 27 [cited 2026 Jun 2]. Available from: <https://www.theglobalfund.org/en/updates/2026/2026-05-27-global-fund-indonesia-us10-million-commitment-eighth-replenishment/>

⁹⁵ The Global Fund. Data explorer [Internet]. Geneva: The Global Fund; [cited 2026 Apr 23]. Available from: <https://data.theglobalfund.org/>

⁹⁶ The Global Fund. Sustainability, transition and co-financing [Internet]. Geneva: The Global Fund; 2026 Apr 10 [cited 2026 Apr 23]. Available from: <https://www.theglobalfund.org/en/sustainability-transition-and-co-financing/>

⁹⁷ Health Policy Watch. \$9.42 billion for global health as US foreign aid bill passes [Internet]. 2026 Feb 4 [cited 2026 Apr 23]. Available from: <https://healthpolicy-watch.news/9-42-billion-for-global-health-as-us-foreign-aid-bill-passes/>

grants are strategically aligned with WB loans and national budgets to strengthen primary health care, laboratory services, supply chains and human resources for health.⁹⁸

GAVI, the Vaccine Alliance

The GAVI Board includes seats for 5 ‘implementing country governments’ and 5 for ‘donor country governments’ as well as seats for other constituencies. Countries rotate periodically based on ‘selected criteria and characteristics’.⁹⁹ Currently, amongst Asian states, Japan (donor country), South Korea (donor country), Indonesia (implementing country), Bhutan (implementing country) and Pakistan (implementing country) hold seats on the GAVI board as part of their constituency groupings.¹⁰⁰

Over the years, GAVI has disbursed US\$ 11bn (2000-2024) of grants in Asia and Pacific countries.¹⁰¹ Declining budgets have tightened eligibility criteria for receiving GAVI support. Since January 2026, only countries with a per capita Gross National Income (GNI) of less than US\$ 2,300 are eligible.¹⁰² These changes are relevant in South and Southeast Asia where several countries are transitioning from Gavi support while facing high burdens of vaccine-preventable diseases.¹⁰³ As it currently stands, in the region, Afghanistan (in the initial self-financing phase), Cambodia, Lao PDR, Myanmar, Pakistan, Nepal, Timor-Leste (in preparatory transition phase) remain eligible for GAVI aid and Bangladesh is in the accelerated transition phase.¹⁰² However some previous recipient countries like Indonesia and Viet Nam continue to receive targeted funding as part of a recent GAVI ‘middle-income country policy’ to prevent any backsliding on existing coverage.^{104,105} India receives Gavi support for specific health system strengthening initiatives.¹⁰⁶

⁹⁸ World Bank Group, The Global Fund. World Bank Group and Global Fund strengthen health care and fight HIV, tuberculosis, malaria [Internet]. Washington, DC: World Bank; 2025 Dec 8 [cited 2026 Apr 23]. Available from: <https://www.worldbank.org/en/news/press-release/2025/12/06/wbg-global-fund-strengthen-health-care-systems-sustainable-health-financing>

⁹⁹ Gavi. Board composition [Internet]. Geneva: Gavi; 2024 Oct 8 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/governance/gavi-board/composition>

¹⁰⁰ Gavi. Board members [Internet]. Geneva: Gavi; [cited 2026 Jun 2]. Available from: <https://www.gavi.org/governance/gavi-board/members>

¹⁰¹ Gavi. Gavi impact in Asia and the Pacific since 2000 [Internet]. Geneva: Gavi; 2025 Oct 9 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/vaccineswork/gavi-impact-asia-and-pacific-2000>

¹⁰² Gavi. Eligibility policy [Internet]. Geneva: Gavi; 2026 Apr 14 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/partner-countries/programmatic-policies/eligibility-policy>

¹⁰³ Gavi. Donor profiles [Internet]. Geneva: Gavi; 2025 Oct 31 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/investing-gavi/funding/donor-profiles>

¹⁰⁴ Gavi. Western Pacific [Internet]. Geneva: Gavi; 2026 Feb 12 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/partner-countries/western-pacific>

¹⁰⁵ MICs support mechanisms and Gavi 6.0 [Internet]. [cited 2026 Apr 23]. Available from: https://www.linkedinimmunisation.org/wp-content/uploads/2024/07/MICs-support-mechanisms-and-Gavi-6.0_01072024.pdf

¹⁰⁶ Ramakrishnan L. The potential impact of proposed Gavi funding cuts on global health security [Internet]. ORF Issue Brief No. 798. Observer Research Foundation; 2025 Apr [cited 2026 Jun 2]. Available from: <https://www.orfonline.org/research/the-potential-impact-of-proposed-gavi-funding-cuts-on-global-health-security>

While India is a legacy beneficiary of US\$3.15 billion in direct country-level disbursements, it represents Gavi's primary source of global vaccine inventory. Because Indian biopharma provides a dominant share of Gavi's volume, the Alliance acts as a major procurement revenue stream for the Indian industrial sector, making India a structural exporter of global immunization solutions.

The main donors of GAVI have historically been the United Kingdom, The Gates Foundation, and the United States of America and Norway.¹⁰⁷ However, the decline in funding from traditional donors has left GAVI with a projected US\$2.5 billion financing gap for its current replenishment cycle.⁹⁷ Interestingly, this has coincided with some countries pledging record amounts, including Australia, several African countries, India and Indonesia^{108,109} (see Table 18).

Table 18. Gavi Funding^{103,110}

Country	Cumulative contribution to date	Type	Pledges for GAVI 6.0 (2026)	Amount received to date
SAARC				
<i>Afghanistan</i>	Nil		Nil	US\$ 398 million
<i>Bangladesh</i>	Nil		Nil	US\$ 998 million
<i>Bhutan</i>	\$5,000 (2020)	COVAX	Nil	US\$ 34 million
<i>India</i>	\$17 million (2013-2025)	Direct Contribution	\$20 million	US\$ 3.15 billion
<i>Maldives</i>	Nil		Nil	Nil (Self-funding / Not eligible)
<i>Nepal</i>	Nil		Nil	US\$ 345 million
<i>Pakistan</i>	Nil		Nil	US\$ 3.42 billion
<i>Sri Lanka</i>	Nil		Nil	US\$ 129 million
ASEAN				
<i>Brunei</i>	Nil		Nil	Nil (High-Income Non-Participant)
<i>Cambodia</i>	Nil		Nil	US\$ 211 million
<i>Indonesia</i>	Nil		\$30 million	US\$ 1.71 billion
<i>Malaysia</i>	\$100,000 (2021-2025)	COVAX	Nil	US\$ 20 million (Ad-hoc emergency /COVAX)

¹⁰⁷ The U.S. government and Gavi, the Vaccine Alliance [Internet]. KFF. 2026 May 4 [cited 2026 Jun 2]. Available from: <https://www.kff.org/global-health-policy/the-u-s-government-gavi-the-vaccine-alliance/#b828bcc5-4d63-4a4b-a3b3-bdfbad378e72>

¹⁰⁸ Gavi. Gavi secures record number of pledges: now the hard work of immunising the world's children begins [Internet]. Geneva: Gavi; 2025 Jun 26 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/vaccineswork/gavi-secures-record-number-pledges-now-hard-work-immunising-worlds-children-begins>

¹⁰⁹ Gavi. Indonesia pledges US\$30 million to support global immunisation efforts through Gavi [Internet]. Geneva: Gavi; 2024 Dec 9 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/news/media-room/indonesia-pledges-us-30-million-dollars-support-global-immunisation-efforts-through-gavi>

¹¹⁰ Gavi. Global summit: health & prosperity through immunisation [Internet]. Geneva: Gavi; 2025 Jun 25 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/investing-gavi/resource-mobilisation-process/protecting-our-future>

<i>Laos</i>	Nil		Nil	US\$ 168 million
<i>Myanmar</i>	Nil		Nil	US\$ 491 million
<i>Philippines</i>	\$1.2 million (2021-2025)	COVAX	Nil	US\$ 802 million
<i>Singapore</i>	\$5 million (2021-2025)	COVAX	\$1 million	Nil (Donor Only)
<i>Thailand</i>	Nil		Nil	US\$ 633 million
<i>Timor Leste</i>	Nil		Nil	US\$ 41 million
<i>Viet Nam</i>	\$1 million (2021-2025)	COVAX	Nil	US\$ 673 million

The shortfall in funding has also prompted several reforms. Under the Gavi 6.0 strategy (2026–2030), the traditional vaccine-by-vaccine funding model will be replaced with multi-year “envelope financing”, allowing countries to allocate funds according to their priorities. The new strategy also aims to prioritise country ownership by allocating 90% of vaccine procurement budgets directly to country vaccine budgets. GAVI’s Secretariat is also targeting a 35% reduction in operating expenses (around US\$280 million) and streamlining the Partners’ Engagement Framework (PEF) to reduce overlaps with organisations like WHO and UNICEF.¹¹¹ GAVI is also partnering the ADB to expand its lending capacity by \$100 billion over the next decade to channel resources towards strengthening health systems, vaccination programs, and pandemic preparedness.¹¹²

The Coalition for Epidemic Preparedness Innovations (CEPI) and Pandemic Fund

CEPI is a non-profit GPPP focused on preventing and responding to epidemics and pandemics through vaccine and biologics development. It was founded and funded in 2017 following the Ebola epidemic by a coalition that included the governments of Norway and India, the Gates Foundation, the Wellcome Trust and the World Economic Forum. It now receives funding from many more governments including Indonesia, Malaysia, the Philippines and Singapore (Table 19).

Table 19. CEPI Fund Donations (Coalition for Epidemic Preparedness Innovations)¹¹³

Country	Cepi 1	Cepi 2	Total
SAARC			
<i>India</i>	Founding Donor & R&D Powerhouse	US\$ 3.1 million	Pending baseline approval
<i>Afghanistan</i>	Non-Donor	Nil	Nil
<i>Bangladesh</i>	Non-Donor / Trial Hub	Nil	Nil
<i>Bhutan</i>	Non-Donor	Nil	Nil

¹¹¹ Gavi. The Gavi Leap [Internet]. Geneva: Gavi; 2026 Mar 12 [cited 2026 Apr 23]. Available from: <https://www.gavi.org/our-work/gavi-leap>

¹¹² Gavi and ADB sign new partnership to boost health financing for immunisation [Internet]. ReliefWeb. 2025 Jun 12 [cited 2026 Apr 23]. Available from: <https://reliefweb.int/report/world/gavi-and-asian-development-bank-sign-new-partnership-boost-health-financing-immunisation>

¹¹³ Coalition for Epidemic Preparedness Innovations. Investors overview [Internet]. Oslo: CEPI; 2025 Sep 15 [cited 2026 Apr 23]. Available from: https://static.cepi.net/downloads/2025-09/2025_09_15%20CEPI%20-%20Investors%20Overview.pdf

<i>Maldives</i>	Non-Donor	Nil	Nil
<i>Nepal</i>	Non-Donor	Nil	Nil
<i>Pakistan</i>	Non-Donor	Nil	Nil
<i>Sri Lanka</i>	Non-Donor	Nil	Nil
ASEAN			
<i>Singapore</i>	Sovereign Donor & Strategic Hub	US\$ 4.5 million	US\$ 12 million (Committed for 2027–2030)
<i>Indonesia</i>	Sovereign Donor & Manufacturing Partner	US\$ 1.0 million	Pending matching cycle
<i>Malaysia</i>	Non-Donor	Nil	Nil
<i>Brunei</i>	Non-Participant	Nil	Nil
<i>Cambodia</i>	Non-Donor	Nil	Nil
<i>Laos</i>	Non-Donor	Nil	Nil
<i>Myanmar</i>	Non-Donor	Nil	Nil
<i>Philippines</i>	Non-Donor	Nil	Nil
<i>Thailand</i>	Institutional Collaborator	Nil	Nil
<i>Timor Leste</i>	Non-Participant	Nil	Nil
<i>Viet Nam</i>	Non-Donor	Nil	Nil

CEPI’s regional investments in South and Southeast Asia are comparatively small and include USD15 million in Indonesia’s Bio Farma¹¹⁴ and up to USD30 million on outbreak vaccine manufacturing at the Serum Institute of India.¹¹⁵

An important development during the Covid pandemic was the involvement of GAVI, GF, CEPI and other actors in creating the Access to COVID-19 Tools Accelerator (ACT-A). COVAX was established under ACT-A to help coordinate the purchase and supply of vaccines, the failure of which illuminated certain limitations inherent with both the COVAX model and the wider system of GHG.¹¹⁶

The Pandemic Fund has been set up as a multilateral global financing mechanism hosted by the WB and expected to work in coordination with the WHO, GAVI and other partners. The fund was endorsed by the G20 and launched in 2022 to provide grants and catalytic financing to strengthen countries’ health security systems. It also aims to encourage coordination between governments, multilateral development banks, UN agencies and regional health organisations.

¹¹⁴ Coalition for Epidemic Preparedness Innovations. CEPI and Bio Farma partnership boosts rapid response vaccine manufacturing for the Global South [Internet]. Oslo: CEPI; 2023 Sep 19 [cited 2026 Apr 1]. Available from: <https://cepi.net/cepi-and-bio-farma-partnership-boosts-rapid-response-vaccine-manufacturing-global-south>

¹¹⁵ Coalition for Epidemic Preparedness Innovations. Serum Institute of India joins CEPI global network to boost production of affordable outbreak vaccines [Internet]. Oslo: CEPI; 2024 Jan 23 [cited 2026 Apr 23]. Available from: <https://cepi.net/serum-institute-india-joins-cepi-global-network-boost-production-affordable-outbreak-vaccines>

¹¹⁶ Narayanan P, Pillai AV, Chattu VK. A critical analysis of COVAX alliance and corresponding global health governance and policy issues: a scoping review. *BMJ Glob Health*. 2023;8(10):e012168.

Table 20. Pandemic Fund Contributors¹¹⁷

Donor	Amount
Singapore	\$20 million
India	\$22 million
Indonesia	\$50 million

Key points about GPPPs

Since 2000, GPPPs have emerged as important global health actors. During this time some of them have become large bureaucracies. Some have also increased their autonomy by diversifying funding sources and introducing innovative financing mechanisms (eg. vaccine bonds) and broadened their mandates. Inter-GPPP cooperation has also helped increase their influence with Gavi, the Global Fund and CEPI, for example, increasingly working together. While providing important funds for health improvement in developing countries, concerns with GPPPs include: the vertical and top-down nature of GPPPs; their selective focus; their use of parallel systems that contribute to fragmenting health systems; their lack of democratic accountability; their heavy emphasis on technologies and commodities; and the strong influence of a small number of major donors like the UK and US.¹¹⁸ However, the retreat of traditional donors has prompted several important reforms with GAVI and the Global Fund. In particular, GAVI's shift toward "envelope financing" and the Global Fund/World Bank's "health compacts" suggest a wish to reconcile vertical funding with horizontal health system strengthening.⁹⁸

However, the relevance of GPPPs amongst the wealthier countries in South and Southeast Asia is waning.^{119,120} However, some middle-income countries in South and Southeast Asia potentially face a "transition trap" where they lose access to concessional GPPP pricing and grants before their domestic systems are ready to fill the gap.

As traditional donors from the Global North reduce their budgets, some countries in South and Southeast Asia like Indonesia and India have increased their contributions.¹²¹ India has been a long-standing donor to the Global Fund and Gavi but has increased its contributions in the most recent replenishment cycle for the GF, and is also a key contributor to the new Pandemic Fund. Indonesia

¹¹⁷ The Pandemic Fund. Contributors [Internet]. Washington, DC: World Bank; [cited 2025 Nov 2]. Available from: <https://www.thepandemicfund.org/contributors>

¹¹⁸ Hoffman SJ, Cole CB, Pearcey M. Global health governance: the major players in the field and their challenges. *Am J Public Health*. 2017;107(12):1848-1850. Available from: https://www.academia.edu/105342583/Global_Health_Governance_The_Major_Players_in_the_Field_and_Their_Challenges

¹¹⁹ Chen S, Zhang S, Bärnighausen T. Global health governance in the post-COVID-19 era: a network analysis of the Global Fund, WHO, and the World Bank. *Int J Environ Res Public Health*. 2022;19(20):13153.

¹²⁰ Madan Keller J, Bonnifield R, Baker P. A radically simplified Global Fund to meet the moment [Internet]. Washington, DC: Center for Global Development; 2026 Feb 5 [cited 2026 Apr 23]. Available from: <https://www.cgdev.org/publication/radically-simplified-global-fund-meet-moment>

¹²¹ The Lancet. The Global Fund and the future of global health. *Lancet*. 2025;406(10519):2509.

has also made substantial commitments to the Global Fund and CEPI and is the largest contributor from South and Southeast Asia to the Pandemic Fund. Singapore has also shown strong engagement in pandemic preparedness, with significant contributions and pledges to CEPI and the Pandemic Fund. Some countries in South and Southeast have an opportunity therefore to move being "passive recipients" or "symbolic donors" to become more active stewards of GPPPs and ensuring that the performance indicators of GPPPs are aligned to national health priorities.⁸²

**NON-REGIONAL PLATFORMS FOR INTERNATIONAL
HEALTH COOPERATION**

Introduction

In this section, we discuss three *non-geographic* and *non-health specific* platforms that have been playing a significant role in shaping international health cooperation and which are particularly relevant to countries in South and Southeast Asia. These are the G20, BRICS+ and G77.

G20

The G20 emerged from the 1997–1998 Asian financial crisis, which exposed the inadequacy of the G7’s narrow representation of advanced economies. The crisis revealed the deep interdependence of global markets and the need to include emerging economies in international financial decision-making. It was formally established in 1999 as an “informal forum for the Finance Ministers and Central Bank Governors,” designed to “bring together systemically important industrialised and developing economies.”¹²² By incorporating emerging markets such as Brazil, China, India, Indonesia, and South Africa, the G20 institutionalised a more inclusive framework for global economic governance - linking established powers with the Global South and creating a platform to anticipate and manage cross-border systemic risks.

The 2008 global financial crisis elevated the G20 from a ministerial forum to a leaders’ summit. Initially focused on macroeconomic stability, the G20’s agenda gradually broadened to include trade, climate change, sustainable development, and health. While some have characterised this expansion as “mandate creep,” others argue that economic stability cannot be separated from social, environmental, and health systems.¹²³ Health crises such as the COVID-19 pandemic, estimated to have generated global output losses of nearly US\$13.8 trillion through 2024, reinforced the understanding that health security and resilient health systems are foundational to economic resilience and global stability.¹²⁴

With 21 members, comprising 19 countries, the European Union and the African Union, the G20 remains an informal, non-treaty-based forum without a permanent secretariat.¹²⁵ This informality is said to allow it to respond quickly to global crises and generate high-level political consensus that can then catalyse action through formal institutions such as the World Bank, IMF, and WHO. The G20’s authority derives largely from the economic weight of its members: G20 countries account for about 85% of global GDP and more than 75% of world trade. Its countries also have important global

¹²² G20. About G20 [Internet]. Rio de Janeiro: G20 Brazil; [cited 19 April 2026]. Available from: <https://www.g20.rio/en/about>

¹²³ McBride B, Hawkes S, Buse K. Soft power and global health: the sustainable development goals (SDGs) era health agendas of the G7, G20 and BRICS. *BMC Public Health*. 2019;19:815.

¹²⁴ Yamey G, Schäferhoff M, et al. A finance and health collaboration to counter pandemic threats. *BMJ Glob Health*. 2024;9(Suppl 3):e015366.

¹²⁵ Szczepeński M, Bassot E. The Group of Twenty (G20): setting the global agenda [Internet]. Brussels: European Parliamentary Research Service, European Parliament; 2015 Jan [cited 2026 Apr 29]. Available from: [https://www.europarl.europa.eu/RegData/etudes/BRIE/2015/545712/EPRS_BRI\(2015\)545712_REV1_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/BRIE/2015/545712/EPRS_BRI(2015)545712_REV1_EN.pdf)

health relevance with, for example, 78% of the world's largest pharmaceutical companies headquartered in G20 countries.¹²⁶

A rotating annual presidency sets the agenda for G20 meetings each year, supported by a “Troika” of past, current, and incoming chairs to ensure continuity. The G20 works through two tracks: a Finance Track, led by Finance Ministers and Central Bank Governors, and a Sherpa Track, which addresses other issues including health. Stakeholder engagement also occurs through “Engagement Groups” including the B20 (business), C20 (civil society), L20 (labour), and T20 (think tanks), allowing non-state actors to influence policy debates.¹²⁷

Global Health was formally incorporated into the G20 agenda during Germany's 2017 presidency, which convened the first G20 Health Ministers' Meeting. The resulting Berlin Declaration identified three priority areas: (1) health emergencies and risk management, (2) antimicrobial resistance, and (3) health systems strengthening and universal health coverage.¹²⁸ The G20 does not set out to duplicate or usurp the role of existing global health institutions but seeks to mobilise high-level political support and coordination for initiatives led by organisations such as the WHO.¹²⁹ Scholars have described this as enabling ‘political acceleration’ and financing for global health priorities.¹³⁰ The forum's influence stems from the economic and political power of its members, which collectively dominate development assistance flows, pharmaceutical innovation, and global health financing.¹²³

The COVID-19 pandemic helped institutionalise the connection between economic governance and health security. Under Italy's 2021 presidency, a Joint Finance and Health Task Force (JFHTF) was created to strengthen coordination between finance and health ministries.¹³¹ The JFHTF also strengthened cooperation between political leadership, technical expertise from WHO, and financial resources from the World Bank, embedding health within the G20 Finance Track and reframing pandemic preparedness as an investment rather than a cost.

The G20 is particularly relevant for Asia because the region contains five G20 members (China, India, Indonesia, Japan and South Korea). Asian economies also play a central role in many global supply chains and in global health innovation and manufacturing. The region hosts several pharmaceutical

¹²⁶ Rahman MM, Kojima S, Saito Y, Kono K. The role of the G20 economies in global health. *Glob Health Med.* 2019 Oct 31;1(1):11-15.

¹²⁷ Lucas B. G7 and G20 commitments on health. K4D Helpdesk Report 673. Brighton, UK: Institute of Development Studies; 2019 Sep 27.

¹²⁸ G20 Information Centre. Berlin Declaration of the G20 Health Ministers: together today for a healthy tomorrow [Internet]. Toronto: University of Toronto; 2017 May 20 [cited 2026 Apr 29]. Available from: <https://www.g20.utoronto.ca/2017/170520-health-en.html>

¹²⁹ Kickbusch I, et al. The next step forward? *BMJ.* 2018 Feb 20;360:k788.

¹³⁰ Missoni E, Pacileo G, Tediosi F. *Global health governance and policy: an introduction.* 1st ed. London: Routledge; 2019. 328 p.

¹³¹ Italian G20 Presidency. The G20 established a Joint Finance-Health Task Force to strengthen pandemic prevention, preparedness and response [Internet]. 2021 Oct 29 [cited 2026 Apr 29]. Available from: <https://www.g20.utoronto.ca/2021/211029-finance-health-news.html>

production hubs and has been critical in vaccine manufacturing and distribution during global health emergencies.¹³² G20 Asian countries have thus exerted increasing influence, particularly on issues such as pandemic preparedness, digital health governance, and access to medicines. India and Indonesia, for example, have used their G20 presidencies to advance priorities linked to health equity, supply-chain resilience, and technology-enabled healthcare delivery.¹³³

For Asian countries navigating geopolitical tensions between major powers and fragmented global governance, the G20 is a platform for the pursuit of “poly-alignment”.¹³⁴ Indonesia’s 2022 G20 Presidency which took place during the phase of uneven global recovery from COVID-19, rising geopolitical tensions and widening global inequalities,¹³⁵ allowed it to position itself as a mediator between advanced and developing economies, while emphasising three global health priorities: strengthening global health system resilience, harmonising pandemic preparedness protocols, and expanding global manufacturing and research hubs for medical countermeasures. A major outcome of the presidency was the creation of the Pandemic Fund hosted by the World Bank.¹³⁶

India’s 2023 presidency built on this trajectory. A final Health Ministers’ communiqué prioritised pandemic preparedness, pharmaceutical cooperation to improve access to vaccines and therapeutics, and digital health innovation.¹³⁷ A key output was the launch of the Global Initiative on Digital Health (GIDH), a WHO-supported platform intended to harmonise digital health systems and improve interoperability of health data infrastructure globally.¹³⁸ India also emphasised equitable access to healthcare innovations and the need to address TB and non-communicable diseases.¹³³ Finally, India’s presidency marked a significant milestone with the admission of the African Union as a permanent member.¹³⁹

Brazil’s 2024 presidency emphasised health equity, climate and health, and the social determinants of health while South Africa’s 2025 presidency prioritised universal health coverage, local

¹³² Garg RK. The G20's vital role in global health. *Indian J Health Sci Biomed Res KLEU*. 2024 May-Aug;17(2):170-172.

¹³³ Hadda KB, Jain Y. India and G20: expectations from a public health perspective. Washington, D.C.: Center for Strategic and International Studies; 2023 Sep 12.

¹³⁴ Chodor T, Hameiri S. Global governance in the Second Cold War: the G20 and the political economy of polyalignment. *Third World Quarterly*. 2026;1-21.

¹³⁵ Liu Z. Briefing by the G20 Indonesian Presidency to the General Assembly [Internet]. New York: United Nations, Department of Economic and Social Affairs; 2022 Apr 1 [cited 2026 Apr 29]. Available from: <https://www.un.org/en/desa/briefing-g20-indonesian-presidency-general-assembly>

¹³⁶ The Pandemic Fund [Internet]. Washington, D.C.: The Pandemic Fund; [cited 2026 Apr 29]. Available from: <https://www.thepandemicfund.org>

¹³⁷ Government of India, Ministry of Information and Broadcasting. G20 Health Ministers' Meeting (Gandhinagar, Gujarat – August 18-19, 2023) [Internet]. New Delhi: Government of India; 2023 Aug 23 [cited 2026 Apr 29]. Available from: <https://static.pib.gov.in/WriteReadData/specificdocs/documents/2023/aug/doc2023823243401.pdf>

¹³⁸ World Health Organization. WHO launches a new Global Initiative on Digital Health supported by the G20 Presidency [Internet]. Geneva: World Health Organization; 2023 Aug 19 [cited 2026 Apr 29]. Available from: <https://www.who.int/news/item/19-08-2023-who-launches-a-new-global-initiative-on-digital-health-at-the-g20-summit-in-india>

¹³⁹ Kumar S. India's G20 Presidency as a voice of Global South. Discussion Paper #291. New Delhi: Research and Information System for Developing Countries; 2024 Feb. 34 p.

pharmaceutical manufacturing, and strengthening health system resilience in low- and middle-income countries. Together, these presidencies reflect a shift from a purely security-focused health agenda toward broader structural issues, including financing gaps, manufacturing capacity, digital infrastructure, and equitable access to medical technologies.

Indonesia (2022), India (2023) Brazil (2024) and South Africa (2025) initiated a sequence of Global South presidencies and provided a rare period of continuity for emerging economies to shape the G20 agenda.

BRICS+

BRICS+ is another forum for countries from the Global South. Initially comprised of Brazil, Russia, India, China and South Africa, it has since expanded to include six other countries: Saudi Arabia, Egypt, the United Arab Emirates, Ethiopia, Indonesia and Iran.¹⁴⁰ The expansion of the agenda and membership of BRICS, reflects an effort to transform a loosely defined economic grouping into a more structured geopolitical entity with the capacity to serve as a dedicated forum for South-South coordination.¹⁴¹

BRICS+ increasingly functions as a counterweight to global structures that are not inclusive or representative of the Global South.^{142,170} BRICS now enables dialogue on key international issues and contributes to a rebalancing of the West-centric international order.

Over the last two decades, the BRICS agenda has expanded to include new issues such as environment, energy, science and technology, and health, each falling into one of three basic pillars of cooperation: political and security, economic and financial, and cultural and people-to-people exchanges.¹⁶⁸ BRICS+ operates through consensus-based governance, with leaders' summits, annual ministerial meetings, and technical working groups. These platforms give effect to international cooperation, sustainable financing, and coordinated regulatory efforts.¹⁴³ The absence of a permanent secretariat, however, limits its role as an implementing agency and results in a lack of continuity.¹⁴⁴

¹⁴⁰ BRICS Brasil. About the BRICS [Internet]. Brasília: BRICS Brasil; 2025 Jan 20 [cited 2026 Apr 29]. Available from: <https://brics.br/en/about-the-brics>

¹⁴¹ Carvalho G de, Anand J, Naidu S. BRICS expansion: adaptive response or proactive restructuring of global governance? *S Afr J Int Aff.* 2025;32(1-2):9-32.

¹⁴² Patrick S, Hogan E, Stuenkel O, Gabuev A, Tellis AJ, Zhao T, et al. BRICS expansion and the future of world order: perspectives from member states, partners, and aspirants [Internet]. Washington, D.C.: Carnegie Endowment for International Peace; 2025 Mar 31 [cited 2026 Apr 29]. Available from: <https://carnegieendowment.org/russia- Eurasia/research/2025/03/brics-expansion-and-the-future-of-world-order-perspectives-from-member-states-partners-and-aspirants>

¹⁴³ Barbosa da Silva Junior J, Desiraju K, Matsoso P, Minghui R, Salagay O. BRICS cooperation in strategic health projects. *Bull World Health Organ.* 2014;92(6):388.

¹⁴⁴ Jütten M, Falkenberg D. Expansion of BRICS: a quest for greater global influence? [Internet]. Brussels: European Parliamentary Research Service; 2024 Mar [cited 2026 Apr 29]. Available from: [https://www.europarl.europa.eu/RegData/etudes/BRIE/2024/760368/EPRS_BRI\(2024\)760368_EN.pdf](https://www.europarl.europa.eu/RegData/etudes/BRIE/2024/760368/EPRS_BRI(2024)760368_EN.pdf)

The expansion of BRICS has increased Asian representation with the inclusion of Indonesia. The introduction of "partner country" status has further broadened participation, allowing nations such as Malaysia, Vietnam and Thailand to attend the summit and, with member consensus, join additional meetings. This allows these countries to gain from expanded diplomatic access, development cooperation, and participation in South–South knowledge networks. Several other countries have expressed an interest in joining the grouping, although BRICS policy is to only admit countries with strong economic standing and influence.¹⁴⁵

There is some asymmetry within BRICS, with some noting China as having strong influence especially with its China's Belt and Road Initiative (BRI).¹⁴⁶ Institutions such as the New Development Bank, the Shanghai Cooperation Organisation (SCO), and the Regional Comprehensive Economic Partnership (RCEP) also help embed BRI projects within other BRICS nations.¹⁴⁷ India's rivalry with China raises questions about the functionality of BRICS+ but thus far, the grouping is said to serve both their respective strategic interests.¹⁴⁸

Within the overarching framework of sustainable human and social development, health is a core area of cooperation. An annual health minister's meeting is indicative of this. The core pillars of BRICS health cooperation include the strengthening of surveillance systems, developing medical and health technologies for communicable diseases, and advancing universal health coverage.¹⁷¹ Current projects and achievements include: a Vaccine Development and Research Centre,¹⁴⁹ a BRICS TB Research Network,¹⁵⁰ and AI-focused digital health initiatives designed to create an interoperable framework for data sharing.¹⁵¹ BRICS Health Ministers' declarations emphasize equitable access to medicines and stronger health infrastructure. But leadership on these initiatives is inconsistent; it depends on each country's strengths and who holds the presidency, not on a unified regional plan.

At present, South and Southeast Asian representation in BRICS is limited, with only India and Indonesia as formal members. But there is increasing interest from other countries in joining the

¹⁴⁵ Papa M. BRICS and multilateralism: four dynamics to watch at the Kazan summit [Internet]. Berlin: ENSURED (European Nonproliferation and Disarmament Research Network); 2024 Oct 15 [cited 2026 Apr 29]. Available from: <https://www.ensuredeurope.eu/publications/brics-multilateralism-kazan-summit>

¹⁴⁶ Garcia-Herrero A. China continues to dominate an expanded BRICS [Internet]. East Asia Forum. 2024 Apr 12 [cited 2026 Apr 29]. Available from: <https://eastasiaforum.org/2024/04/12/china-continues-to-dominate-an-expanded-brics/>

¹⁴⁷ Singh AG. BRICS and BRI: China aims for strategic alignment. ORF Issue Brief No. 591. New Delhi: Observer Research Foundation; 2022 Nov. Available from: <https://www.orfonline.org/research/brics-and-bri-china-aims-for-strategic-alignment>

¹⁴⁸ Chaulia S. In spite of the spite: an Indian view of China and India in BRICS. *Glob Policy*. 2021;12(4):519-523.

¹⁴⁹ BRICS Think Tanks Council. BRICS Vaccine Research and Development Centre [Internet]. 2025 Sep 30 [cited 2026 Apr 29]. Available from: <https://bricsthinktankscouncil.org/mechanisms/brics-vaccine-research-and-development-centre/>

¹⁵⁰ BRICS TB Research Network. Homepage [Internet]. [cited 2026 Apr 29]. Available from: <https://bricstb.samrc.ac.za>

¹⁵¹ BRICS Brasil. Artificial Intelligence and Data Governance in Health Systems: Issue Note - BRICS 2025 [Internet]. Brasília: BRICS Brasil; 2025 [cited 2026 Apr 29]. Available from: <http://brics.br/pt-br/documentos/artificial-intelligence-and-data-governance-in-health-systems-issue-note-brics-2025.pdf/@@download/file>

grouping.¹⁵² For Southeast Asian countries, this reflects a strategy of joining overlapping institutions to diversify partnerships and hedge against great powers rivalry.¹⁵³

BRICS+ also engages with regional groupings such as the African Union. Specifically in the domain of health, BRICS has collaborated with the AU on a framework for cooperation on pandemic preparedness, prevention, and response,¹⁵⁴ along with specific commitments towards water and sanitation, in line with the African Union's 2026 priorities.¹⁵⁵ These efforts are further reinforced by synergies with the G20 and the G77.

BRICS+ presents a distinctive voice emerging from the Global South. While several factors impede a unified stand, it continues to evolve and be responsive to the changing geopolitical landscape.¹⁵⁶ Its engagements with other multilateral groupings, particularly the G20, but also in pushing for reforms in multilateral structures such as the UN Security Council, IMF and World Bank demonstrate efforts to align with other agendas beyond simply advancing the interests of the Global South.¹⁴²

BRICS also provides an alternative pathway to growth, particularly in response to the recent US withdrawal and the consequent cuts in development assistance for health. Joining and aligning with BRICS thus presents novel opportunities for a greater voice in priority-setting both regionally and globally. This is particularly relevant given its orientation as a counterbalancing forum to the Western institutional framework, which allows member states to leverage its South-South mandate.

BRICS primarily serves as a political coordination and convening platform. Its role is to ensure strategic alignment and promote coalition-building, enabling members to coordinate positions on global issues, amplify demands for multilateral institutional reform through collective bargaining power, and promote broader South-South cooperation. In practice, rather than producing a unified agenda or single developmental model for South-South cooperation, health cooperation within BRICS reflects a pluralistic engagement in the multilateral system.¹⁵⁷ While this pluralism encourages flexibility, it can also dilute collective bargaining power.¹⁵⁶

¹⁵² Deutsche Welle. Why are Southeast Asian countries looking to join BRICS? [Internet]. 2024 Jul 4 [cited 2026 Apr 29]. Available from: <https://www.dw.com/en/why-are-southeast-asian-countries-looking-to-join-brics/a-69547127>

¹⁵³ Son J. BRICS: Southeast Asian countries create options in a multipolar world [Internet]. Heinrich Böll Foundation | Southeast Asia. 2025 Aug 27 [cited 2026 Apr 29]. Available from: <https://th.boell.org/en/2025/08/27/brics-southeast-asian-countries-multipolar-world>

¹⁵⁴ Africa CDC. BRICS member states, Africa CDC and WHO commit to collaborate with business sector on pandemic prevention, preparedness and response [Internet]. 2023 Aug 28 [cited 2026 Apr 29]. Available from: <https://africacdc.org/news-item/brics-member-states-africa-cdc-and-who-commit-to-collaborate-with-business-sector-on-pandemic-prevention-preparedness-and-response/>

¹⁵⁵ Patel A. BRICS and Africa: a new era of multilateral partnerships for 2026 [Internet]. Institute for Global Dialogue. 2026 Feb 20 [cited 2026 Apr 29]. Available from: <https://igd.org.za/2026/02/20/brics-and-africa-a-new-era-of-multilateral-partnerships-for-2026/>

¹⁵⁶ Käkönen J. Global change: BRICS and the pluralist world order. *Third World Themat.* 2019;4(6):415-423.

¹⁵⁷ Hussain S. BRICS expansion: forging a new era of global pluralism [Internet]. CGTN News. 2023 Aug 25 [cited 2026 Apr 29]. Available from: <https://news.cgtn.com/news/2023-08-25/BRICS-expansion-Forging-a-new-era-of-global-pluralism-1mysQq4QzS/index.html>

G77

The Group of 77 (G77) developing countries, founded in 1964, emerged from a shared experience of past colonization and enduring global inequalities. It is often seen as representing the Global South and providing a “non-Western pole” in global politics although there are also power dynamics and differentials within the coalition.^{158,159,160} Historically, countries like Iran and Cuba have wielded disproportionate influence even though their economic weight and diplomatic standing in many external forums are more limited than those of larger emerging economies.¹⁶⁰ Their influence is said to help retain the anti-imperialist and non-aligned traditions of the G77 inherited from the Non-Aligned Movement (NAM).

In recent decades, China has increasingly aligned itself with the G77’s summits and joint statements, offering political and financial backing while remaining outside the G77’s membership. This “G77+China” configuration has amplified Global South voices, particularly when contesting the agendas of more powerful and wealthier states. In South and Southeast Asia, the G77 is still relevant by helping to create a common negotiating platform for member states on trade, finance, technology transfer and social policy. For example, through the G77, India has advocated for more equitable terms of trade, technology transfer and climate-finance for developing countries, thereby also reinforcing its role as a regional leader.¹⁶¹ Indonesia, Vietnam and the Philippines have used G77 and G77+China platforms to advocate for greater representation in global governance bodies and to push for a “fair and multipolar order”.¹⁶² The G77+China has also enabled South-South cooperation, including through high level summits and joint projects on infrastructure for health and education that build on the Bandung Conference and Non-Aligned Movement traditions.¹⁶³

In the field of health policy and governance, the G77 and China has articulated a shared Global South agenda on equitable access to health technology.¹⁶⁴ Through coordinated positions in UN General Assembly debates on global health and foreign policy, and in broader sustainable-development negotiations, it has consistently framed health as a human right, defended TRIPS flexibilities, and

¹⁵⁸ Braveboy-Wagner J. The NAM and the G77: the unexpected persistence of tricontinental multilateralism. Paper presented at: UACES (Academic Association for Contemporary European Studies); 2014 Sep 1-3; Cork, Ireland. Slightly updated for pre-publication, 2017. Available from: https://www.researchgate.net/publication/329440464_The_NAM_and_the_G77_The_Unexpected_Persistence_of_Tricontinental_Multilateralism

¹⁵⁹ World Economic Forum. What is the G77 and why does it matter? [Internet]. 2023 Sep 29 [cited 2026 Apr 29]. Available from: <https://www.weforum.org/stories/2023/09/g77-intergovernmental-developing-countries/>

¹⁶⁰ Baumann MO, Novoselova A, Surasky J, Schönrock P. The Group of 77 and global dialogue in the United Nations General Assembly. Discussion Paper 13/2024. Bonn: German Institute of Development and Sustainability (IDOS); 2024.

¹⁶¹ Arya R. India and the Global South: issues, engagement and challenges [Internet]. 2025 [cited 2026 Apr 29]. Available from: <https://swadeshishodh.org/india-and-the-global-south-issues-engagement-and-challenges/>

¹⁶² Al-Ghwel H. The rise of the Global South and what it means for the North [Internet]. Arab News Japan; 2024 Aug 4 [cited 2026 Apr 29]. Available from: https://www.arabnews.jp/en/uncategorized/article_127655/

¹⁶³ Lees N. The endurance of the G77 in international relations: South–South ideology and voting at the United Nations 1970–2015. *Jpn J Polit Sci.* 2023;24(3):310-330.

¹⁶⁴ Shashikant S. Divergence over IPR issues in technology transfer. Third World Network (TWN). 2008 Dec 19 [cited 2026 Apr 30]. Available from: https://twon.my/title2/intellectual_property/info.service/2008/twn.ipr.info.081203.htm

called for fair access to vaccines, medicines and diagnostics, as well as for strengthened health systems and workforces in developing countries.¹⁶⁵ The G77 this helps shapes the normative backdrop for global health governance by linking health to debt relief, development financing and science-and-technology cooperation across the South.^{166,167}

Compared to the G20 and BRICS+, the G77+China is the most numerically representative platform for advancing South-South voices and cooperation, but it operates with a broader and more diffuse agenda and with weaker institutional machinery. The G20 and BRICS+ forums have more limited membership but greater economic and political leverage, allowing them to influence financial flows, industrial policy and selected global health initiatives more directly. The G77+China's influence lies primarily in agenda-setting, norm-shaping and building cross-regional solidarity.

The G77+China continues to call for reforms of the international financial architecture, the UN Security Council and the climate-loss-and-damage fund.¹⁶⁸ In South and Southeast Asia, the effectiveness of these efforts will depend on whether governments can translate the coalition's shared positions into concrete regional initiatives, deepening South-South solidarity, strengthening coordination across overlapping forums, and securing a more consequential role in the institutions where rules on finance, trade, technology and health are actually made.

¹⁶⁵ United Nations. The historic importance of G-77 [Internet]. UN Chronicle. 2014 May 16 [cited 2026 Apr 30]. Available from: <https://www.un.org/en/chronicle/article/historic-importance-g-77>

¹⁶⁶ Group of 77 and China. Debt sustainability and socio-economic equality for all [Internet]. New York: United Nations; 2024 Apr 15 [cited 2026 Apr 30]. Available from: <https://www.g77.org/statement/getstatement.php?id=240415>

¹⁶⁷ United Nations Office for South-South Cooperation. G77 Havana Declaration focuses on science, technology, and innovation ahead of the UNGA [Internet]. 2023 Sep 28 [cited 2026 Apr 30]. Available from: <https://unsouthsouth.org/2023/09/28/g77-havana-declaration-focuses-on-science-technology-and-innovation/>

¹⁶⁸ Group of 77 and China. Third South Summit outcome document [Internet]. Kampala: Group of 77 and China; 2024 Jan 22 [cited 2026 Apr 29]. Available from: https://www.g77.org/doc/3southsummit_outcome.htm

REGIONAL GOVERNANCE ORGANISATIONS (ASEAN, SAARC and BIMSTEC)

ASEAN

ASEAN was not created as a health organisation. It emerged in 1967 out of post-Konfrontasi diplomacy among Indonesia, Malaysia, the Philippines, Singapore and Thailand, and the Bangkok Declaration which deliberately set out to establish a light, non-treaty form of regional cooperation. From the outset, ASEAN's overriding political purpose was to reduce interstate tensions and create a stable regional order in which functional cooperation could proceed; but without delegating a portion of sovereignty to a supranational body.^{169,170}

The first decade was institutionally thin and substantively modest. ASEAN's early structures centred on the foreign ministers, national secretariats and ad hoc committees, and contemporaries often described the organisation as slow or 'dormant'. Its first major institutional turn came at the 1976 Bali Summit, which produced the ASEAN Concord, the Treaty of Amity and Cooperation and the agreement establishing the ASEAN Secretariat. This did not create a supranational organisation, but it did give ASEAN a more solid diplomatic and administrative architecture.¹⁶⁹

A second phase followed the end of the Cold War. ASEAN turned more explicitly toward economic cooperation in the early 1990s, enlarged from five to ten members between 1984 and 1999, and then moved toward the language of 'community'. ASEAN Vision 2020, the 2003 Bali Concord II and, above all, the 2007 Charter (in force in 2008) recast ASEAN as a rules-based organisation structured around three pillars: the Political-Security Community, the Economic Community and the Socio-Cultural Community. Health now sits institutionally within the ASCC pillar rather than as an autonomous centre of authority.^{169,170}

Yet the Charter should not be overstated. It mostly codified existing practices without transforming ASEAN into a body with strong delegated powers. Consultation, consensus and non-interference stayed as core operating norms, sanctions remained weak, and the Secretariat continued to function mainly as a coordinating rather than a directing institution. In this sense, its evolution has been one of formalisation without a decisive transfer of authority away from member states.^{169,170}

This institutional design matters for health. The Secretariat and the Health Division can convene, coordinate and monitor, but they do not possess the fiscal or legal authority to compel implementation across highly diverse member states. The result is an implementation gap between ambitious regional declarations and uneven national follow-through, especially where issues are politically sensitive or resource-intensive.^{169,171}

¹⁶⁹ Weatherbee DE. ASEAN's half century: a political history of the Association of Southeast Asian Nations. Lanham (MD): Rowman & Littlefield; 2019.

¹⁷⁰ Cockerham GB. Regional integration in ASEAN: institutional design and the ASEAN way. *East Asia*. 2010;27(2):165-185.

¹⁷¹ Spencer J, Liverani M, Guinto R, Hanefeld J, Pang T, Tangcharoensathien V, et al. Governing complexity: the regional health architecture in Asia. In: Legido-Quigley H, Asgari-Jirhandeh N, editors. Resilient and people-centred health systems: progress, challenges and future directions in Asia. New Delhi: World Health Organization, Regional Office for Southeast Asia; 2018.

Health became a more visible ASEAN concern only after transboundary disease outbreaks demonstrated the economic and security consequences of inaction. SARS in 2003 and H5N1 in 2004 were pivotal in pushing health up the regional agenda and encouraging governments to view surveillance, preparedness and cross-border coordination as collective regional goods rather than purely domestic matters.^{171,172}

The post-2015 health architecture reflects this shift. Under the ASEAN Health Ministers' Meeting and the Senior Officials' Meeting on Health Development, ASEAN reorganised a previously disjointed set of projects into four health clusters: promoting healthy lifestyles, responding to hazards and emerging threats, strengthening health systems and access to care, and ensuring food safety. This was an important rationalisation of the health agenda, but it remains a non-binding and member-state-led framework.^{171,172}

ASEAN's strongest health cooperation has developed in areas where transboundary risks are obvious, and where interests converge, namely infectious disease surveillance, laboratory networking, emergency operations and public-health preparedness. By contrast, non-communicable diseases and broader health-systems strengthening have received less attention and fewer resources. The pattern is consistent with ASEAN's wider institutional logic: cooperation advances furthest in functional areas that do not seriously disturb national policy autonomy.^{170,171}

External partners have been central to this evolution. ASEAN Plus Three widened the regional health space by bringing China, Japan and South Korea into post-SARS cooperation, while dialogue partners have supplied finance, technical assistance and specialised platforms. During COVID-19, regional mechanisms included the Plus Three Field Epidemiology Training Network alongside newer ASEAN instruments such as the Response Fund, the Regional Reserve of Medical Supplies, and plans for vaccine security and self-reliance. This expanded ASEAN's functional reach, but it has also underlined how much regional health cooperation still depends on partner support.^{171,172}

Table 20 illustrates this partner-supported ecosystem of regional health governance. The key point is not that ASEAN has many partners, but that regional cooperation develops through a patchwork of ASEAN-led, Plus Three and donor-supported arrangements rather than through a single, well-financed regional authority. This helps explain why ASEAN can be institutionally central yet operationally uneven.^{171,172}

The central weakness, therefore, is not the absence of forums but the low level of institutionalisation behind them. Regional health cooperation remains underfunded, dependent on external support, and constrained by political diversity, economic inequality and consensus-based decision-making. While ASEAN's health architecture has become more coherent, it has not yet become strongly implementational.¹⁷¹

¹⁷² Rahman-Shepherd A, Cutter J, Hinjoy S, Ho ZJM, Huimin JC, Miranda I, et al. ASEAN and the COVID-19 pandemic: a scoping review on the role and response of a regional organisation in a global health emergency. *BMJ Glob Health*. 2025;10(9):e018342.

Table 21. ASEAN’s Health Cooperation with Development Partners

Partner	Focus Areas	Key milestones & outputs	Timeframe
China	<ul style="list-style-type: none"> - ID control & surveillance - Traditional medicine - Health systems strengthening - IP protection & benefit-sharing 	<ul style="list-style-type: none"> - Joint SARS & Emerging ID response - Annual ASEAN-China Health Minister Meetings - Material Transfer Agreements & equitable benefit-sharing 	2003 - ongoing
Japan	<ul style="list-style-type: none"> - ID control - Universal Health Coverage - Ageing populations - Digital health innovation - ACPHEED 	<ul style="list-style-type: none"> - ACPHEED established and funded (~\$50M) - ASEAN-Japan UHC Initiative focusing on aging populations 	2003 - ongoing
South Korea	<ul style="list-style-type: none"> - Digital health solutions and IT infrastructure - Aging populations - Emerging health threats - Health R&D partnerships 	<ul style="list-style-type: none"> - Joint statements on digital health cooperation 	2024 - ongoing
UK	<ul style="list-style-type: none"> - Health security and pandemic preparedness - Climate-related health risks - ASEAN One Health Plan 	<ul style="list-style-type: none"> - 5-year Health Security Partnership Programme announced in 2025 	2025 - 2030
US	<ul style="list-style-type: none"> - Health security, disease surveillance - Workforce training and PHC - Airborne Infection Defense Platform (TB and pandemics) 	<ul style="list-style-type: none"> - Permanent ASEAN-US Health Ministers Meeting established (2024) - Enhanced digital health collaboration 	2024 - ongoing
Australia	<ul style="list-style-type: none"> - Health security & pandemic preparedness - IDs & AMR - Health systems strengthening & UHC - Environmental & climate-related health risks 	<ul style="list-style-type: none"> - ASEAN-Australia Comprehensive Strategic Partnership (2025-2029) - Support for ASEAN Regional Reserve of Medical Supplies and ACPHEED 	2025 - 2029
India	<ul style="list-style-type: none"> - Pandemic preparedness and disease surveillance - Affordable medicines & pharmaceuticals - Traditional medicine & healthcare innovation - Digital health & UHC 	<ul style="list-style-type: none"> - ASEAN-India COVID-19 conference - \$1M contribution to ASEAN COVID-19 Response Fund - Plan of Action (2026-2030) 	2022 - 2030

COVID-19 both validated and exposed ASEAN’s model. Rahman-Shepherd et al identified 46 mechanisms that ASEAN leveraged during the pandemic across normative, functional and diplomatic roles (25 pre-existing and 21 newly created). These included the ASEAN COVID-19 Response Fund, the Regional Reserve of Medical Supplies for Health Emergencies, the Emergency Operations Centre Network for Public Health Emergencies, and ACPHEED. The pandemic thus

accelerated institutional accumulation around health security, especially in Cluster 2 on hazards and emerging threats.¹⁷² At the same time, the literature notes that ASEAN’s functional performance was weaker than its diplomatic and normative performance. Early regional coordination was often described as fragmented or minimal; and hindered by the Secretariat’s limited authority, the non-binding character of regional instruments, and the norms of national sovereignty, non-interference and consensus. The delays surrounding the ACPHEED establishment agreement are a particularly clear example of this implementation problem.¹⁷²

ASEAN’s health trajectory is thus best understood as a product of its broader political evolution. It has moved from a light security-oriented association to a denser, more rules-based and health-aware regional organisation, but without abandoning the sovereignty-preserving logic of the ‘ASEAN way’. That model has been sufficient to build trust, provide some convening power and facilitate the development of shared crisis instruments; but it has not been sufficient to guarantee rapid implementation, sustainable financing or strong cross-sectoral integration. Future strengthening is therefore likely to require more investment in the Secretariat’s capacity, greater integration of health, disaster-management and economic mechanisms, and widening the coalition for regional action beyond governments alone.^{170,171}

SAARC

Established in 1985, the South Asian Association for Regional Cooperation (SAARC)’s Charter aims to “promote the welfare of the peoples of South Asia” and “improve their quality of life”, identifying Health and Population Activities as one of five original areas of cooperation.¹⁷³

The organisation's highest decision-making forum is the Summit of Heads of State or Government, supported by a Council of Ministers and a permanent Secretariat based in Kathmandu, Nepal. SAARC has also created several technical specialised bodies, the most prominent in the health sector being the SAARC Tuberculosis Centre, established in Kathmandu in 1992. Its establishment was demanded by the region’s porous borders, dense populations and heavy TB prevalence.¹⁷⁴ Its mandate has subsequently been expanded and renamed the SAARC Tuberculosis and HIV/AIDS Centre (STAC). Regional cooperation has been seen in the form of SAARC and WHO/SEARO working together on TB and HIV/AIDS, with WHO designating STAC as a WHO Collaborating Centre until 16 May 2018. The Centre continues to produce epidemiological reports, training modules, and regional strategies, including guidance during COVID-19 on maintaining TB services.¹⁷⁵

¹⁷³ Ministry of Foreign Affairs, Nepal. Nepal and SAARC [Internet]. [cited 2025 Oct 31]. Available from: <https://mofa.gov.np/pages/nepal-and-saarc-5/>

¹⁷⁴ SAARC TB and HIV/AIDS Centre. About [Internet]. 2025 [cited 2026 Jun 2]. Available from: <https://www.saarctb.org/saarc-tb-and-hiv-aids-centre/>

¹⁷⁵ SAARC Tuberculosis & HIV/AIDS Centre (STAC). SAARC epidemiological response on tuberculosis 2021 [Internet]. Thimi, Bhaktapur, Nepal: STAC; 2021 [cited 2025 Oct 31]. Available from: <https://www.saarctb.org/wp-content/uploads/2022/03/SAARC-Epidemiological-response-on-TB-2021.pdf>

Other examples of regional health cooperation include the 2003 the Malé Declaration on SARS which aimed to create a regional response strategy through proposals for a “SAARC CDC” or “Rapid Deployment Health Response System”¹⁷⁶ though this did not materialize. And at the onset of the COVID-19 pandemic in March 2020, at the initiative of the Indian Prime Minister, a video conference of SAARC leaders was convened to discuss a coordinated regional response and the creation of a SAARC COVID-19 Emergency Fund.

However, despite a mandate for cooperation, SAARC has been undermined by political mistrust.¹⁷⁷ Persistent India-Pakistan tensions have rendered SAARC’s apex decision-making body, the Summit of Heads of State, inactive since 2016. However, while its political wing has been inactive, its technical arms, particularly STAC, have remained operational. STAC continues to host governing board meetings with participation from all member states, including India and Pakistan, as recently as October 2025.¹⁷⁸

The SAARC COVID-19 Emergency Fund exemplifies this. After it was proposed by India with an initial \$10 million pledge, Pakistan insistence that the Fund be managed by the SAARC Secretariat to ensure true multilateral control^{179,180} did not allow consensus to be reached. Proposals for a “common research platform”, information-sharing procedures and shared Pandemic Protocols¹⁷⁶ similarly stalled without consensus. SAARC’s paralysis can also be said to be due to its adoption of the unanimity principle - requiring complete agreement for all decisions – effectively giving each member veto power. As a result, SAARC has acted more as a forum for dialogue, rather than for developing regional policy or forging binding agreements.¹⁸¹ Moreover, the organisation is constrained by an underfunded secretariat and lacks the mechanisms to ensure that any agreements are monitored and implemented.¹⁸² Practical obstacles further hinder cooperation, such as restrictive visa regimes, even for medical patients and professionals.

That said, the geographic and epidemiological features of the region, with long and porous borders, similar climatic conditions, and a common vulnerability to vector-borne and infectious diseases, provide a strong incentive for collaboration. However, SAARC’s ability to enhance such collaboration would hinge on garnering political will and finding ways to improve the representation of smaller

¹⁷⁶ SAARC Secretariat. Social affairs [Internet]. Kathmandu: SAARC Secretariat; [cited 2025 Oct 31]. Available from: <https://www.saarc-sec.org/index.php/areas-of-cooperation/social-affairs>

¹⁷⁷ Adil JZ, Sohail M, Farid S. Pak-India War Crisis: a historical and strategic analysis. *The Critical Review of Social Sciences Studies*. 2025;3(3):131-144.

¹⁷⁸ SAARC TB and HIV/AIDS Centre (STAC). Homepage [Internet]. Thimi, Bhaktapur, Nepal: STAC; [cited 2025 Oct 31]. Available from: <https://www.saarctb.org/>

¹⁷⁹ Dawn. Pakistan seeks clarity about Saarc's Covid-19 fund [Internet]. 2020 Mar 20 [cited 2025 Oct 31]. Available from: <https://www.dawn.com/news/1543499>

¹⁸⁰ Embassy of India, Doha. Video conference of SAARC leaders on combatting COVID-19 [Internet]. [cited 2025 Oct 31]. Available from: <https://www.indianembassyqatar.gov.in/press?id=MjJlO>

¹⁸¹ Bhattarai P. The achievements and failures of the South Asian Association for Regional Cooperation (SAARC). *Political Science Journal*. 2025 Apr;3(1):68-75. doi:10.3126/psj.v3i1.77455.

¹⁸² The Business Standard. From Saarc to Bimstec: the failure of regional cooperation in South Asia [Internet]. 2025 Mar 23 [cited 2025 Oct 31]. Available from: <https://www.tbsnews.net/features/panorama/saarc-bimstec-failure-regional-cooperation-south-asia-1099896>

states.¹⁸³ In the absence of formal mechanisms for multilateral regional health cooperation, India has inevitably become the dominant health player. India's "Neighbourhood First" policy also positions it as the region's humanitarian first responder,¹⁸⁴ a role reinforced during COVID-19.¹⁸⁵

BIMSTEC

Established in June 1997, the Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation (BIMSTEC) is a unique grouping of seven nations: Bangladesh, Bhutan, India, Nepal, Sri Lanka, Myanmar and Thailand. For decades, its progress was minimal, mirroring SAARC's challenges of limited political will and capacity. However, since the suspension of SAARC summits in 2016, it was revitalised as an alternative option for regionalism. This led to a significant reorganisation at the 2022 Summit in Colombo when 14 unwieldy priority sectors were consolidated into seven pillars.

In this restructuring, "Public Health" was reframed. Previously a standalone sector, it was deprioritised as a sub-sector and made a part of the "Science, Technology & Innovation" sector, separate from other social sectors, and effectively framing health as a technological issue.

Historically, health cooperation within BIMSTEC has been limited, with a notable focus on traditional medicine, though the agenda now incorporates an emphasis on modern medicine, public health and technology. A technocratic model is exemplified by the India-funded JIPMER-BIMSTEC Telemedicine Network (JBTN), launched in 2017 to enable medical institutions to provide tele-consultations and share specialised medical knowledge,¹⁸⁶ and directly merging health with technology and communication. This digital health agenda is synergistic with the BIMSTEC Master Plan for Transport Connectivity.¹⁸⁷ Adopted in 2022, this plan's infrastructure corridors are seen as enablers for the rapid movement of medical supplies and personnel during health emergencies,¹⁸⁸ creating a dual high-tech and high-logistics approach to health security.

BIMSTEC's successes have been limited: It took 25 years to adopt a formal Charter, and the 2004 Free Trade Agreement remains unimplemented. Importantly, its demonstrable successes tend to focus on high-visibility projects like JBTN, which arguably risk diverting attention away from the region's fundamental health challenges of scarcity of reliable data, weak primary healthcare systems, and lack of trained human resources.

¹⁸³ Centre for Social and Economic Progress. What next for SAARC? [Internet]. 2016 Nov 7 [cited 2025 Oct 31]. Available from: <https://csep.org/event/what-next-for-saarc/>

¹⁸⁴ Ravi S. SAARC and India's healthcare opportunities [Internet]. Brookings Institution; 2014 Nov 20 [cited 2025 Oct 31]. Available from: <https://www.brookings.edu/articles/saarc-and-indias-healthcare-opportunities/>

¹⁸⁵ Centre for Public Policy Research. SAARC response to COVID: a silver lining in regional cooperation [Internet]. [cited 2025 Oct 31]. Available from: <https://www.cpvr.in/articles/saarc-response-to-covid-a-silver-lining-in-regional-cooperation>

¹⁸⁶ Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation (BIMSTEC). Sectors of cooperation [Internet]. [cited 2025 Oct 31]. Available from: <https://bimstec.org/pages/sectors-of-cooperation>

¹⁸⁷ Medical Dialogues. Telemedicine network launched at JIPMER [Internet]. 2017 Jul 14 [cited 2025 Oct 31]. Available from: <https://medicaldialogues.in/telemedicine-network-to-be-launched>

¹⁸⁸ Ministry of Health and Family Welfare, Government of India. E-governance & telemedicine [Internet]. [cited 2025 Oct 31]. Available from: <https://www.mohfw.gov.in/sites/default/files/20%20ChapterAN2018-19.pdf>

Summary

Table 22. Comparison of Regional Institutions for GHG

Feature	SAARC	BIMSTEC	ASEAN	Relationship to WHO ROs
<i>Geographic Composition</i>	<ol style="list-style-type: none"> Afghanistan Bangladesh Bhutan India Maldives Nepal Pakistan Sri Lanka 	<ol style="list-style-type: none"> Bangladesh Bhutan India Nepal Sri Lanka Myanmar Thailand 	<ol style="list-style-type: none"> Brunei Cambodia Indonesia Laos Malaysia Myanmar Philippines Singapore Thailand Vietnam Timor Leste 	<p>SEARO WPRO EMRO</p>
<i>Year of Inception</i>	1985	1997	1967	<p>SEARO - 1949 WPRO - 1952 EMRO - 1949</p>
<i>Mandate</i>	Promote economic growth, social progress, and cultural development in the region.	Foster economic growth, social progress, and technical/scientific collaboration in the Bay of Bengal region.	Accelerate economic growth, social progress, and cultural development, while promoting regional peace via three pillars (Political, Economic, Socio-Cultural).	
<i>Governance Structure (Health)</i>	Multi-tiered structure (Summit, Council of Ministers, Standing Committee, Technical Committees) plus Regional Centres (e.g., STAC).	Tiered structure (Summit, Ministerial Meetings, Senior Officials' Meeting).	Mature 3-level structure: Political (Health Ministers' Meeting), Bureaucratic (Senior Officials' Meeting), and Technical (Health Clusters).	
<i>Framing of Health</i>	Health as Social Welfare.	Health as a Technological Problem (solved by innovation, telemedicine, tech transfer). Health is a sub-sector under Science & Technology.	Health as Regional Security & Socio-Cultural Development (a human development goal framed as a security issue).	
<i>Key Health Initiatives</i>	COVID Emergency Fund, TB & HIV Centre.	Focuses on technocratic projects: JIPMER - BIMSTEC Telemedicine networks, transport connectivity, and	Institutional focus: ASEAN Centre for Public Health Emergencies (ACPHEED), ASEAN Health Clusters, and	WHO SEARO has been a collaborator on several projects (see section on SAARC).

		proposed centres for Tropical/Traditional Medicine.	a Regional Reserve of Medical Supplies.	
<i>Primary Drivers</i>	Shared epidemiological vulnerabilities and land borders.	Geopolitical imperative to create a viable alternative to the paralyzed SAARC.	Shared cross-border threats (pandemics), crisis-driven catalysis (SARS, COVID-19), and strong external partner support.	
<i>Primary Challenges</i>	Paralyzed by India-Pakistan conflict, institutional veto power (unanimity rule), and regional power asymmetries.	Institutional weakness (replicating SAARC's failures) and a misaligned focus on "winnable" tech projects over foundational health.	Sovereignty sensitivities (the "ASEAN Way") limit enforcement; high dependency on external donors; significant development disparities.	

DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)

Development Assistance for Health (DAH)

Over the past three decades, Development Assistance for Health (DAH), defined as all forms of financial assistance provided by donors or concessional lenders to eligible countries, has expanded dramatically.¹⁸⁹ During this time, it has also undergone a substantial shift in funding patterns, with an increasing proportion coming from private sources, and a greater proportion of DAH channelled through GPPPs like the Global Fund and GAVI.

Much DAH has been primarily directed at HIV/AIDS, tuberculosis, malaria, and reproductive, maternal, newborn, and child health (RMNCH), leading to a mismatch between disease burden and resource allocation.¹⁸⁹ For instance, as of 2019, HIV/AIDS has received 18% of the total DAH but accounted for only 5% of the preventable disease burden in LICs and 3% in LMICs. Similarly, Non-Communicable Diseases (NCDs) receive only 2–3 per cent of global DAH, even though they account for nearly 40% of the avoidable disease burden in these countries.¹⁸⁹ Interestingly, there has been a shift in the share of DAH disbursed to LICs vs LMICs from 2000 to 2019: LICs' share fell from 61% to 36%, while lower-MICs like India, Indonesia, and Viet Nam saw their share increase from 23% to 49%.

Today the system of DAH is at a turning point with a dramatic decline in the volume of Official Development Assistance (ODA) from donor countries and with the USA pulling out of multilateral systems and seeking to use aid more explicitly as an instrument of foreign policy. Meanwhile, new donors, especially from China and the Middle East, although their contributions are still relatively small.

Southeast Asia

Official Development Finance (ODF) to countries in Southeast Asia was US\$29 billion in 2023, up from US\$26.5 billion in 2022.¹⁹⁰ Most DAH is directed at individual countries but there has been some DAH allocated regionally, especially in relation to public health emergencies and ASEAN's recent health-sector strategy which has explicitly prioritized health system resilience for pandemics or other emergencies.¹⁹¹ For example, the WHO and the ASEAN–UK Health Security Partnership launched in 2025 is a 5-year programme to boost health security across the region.¹⁹²

¹⁸⁹ Center for Healthy Development (CHD). Taking stock of Development Assistance for Health (DAH) in the 21st Century: renewing our commitment [Internet]. 2025 Apr [cited 2026 Jun 2]. Available from: https://www.centerforhealthydevelopment.org/uploads/4/2/0/2/42028609/taking_stock_of_development_assistance_for_health_in_the_21st_century_april_2025.pdf

¹⁹⁰ Lowy Institute. Southeast Asia Aid Map: 2025 key findings [Internet]. 2025 Jul 22 [cited 2026 Jun 2]. Available from: <https://seamap.lowyinstitute.org/analysis/2025/key-findings/>

¹⁹¹ ASEAN Secretariat. Building a resilient health system to strengthen regional health security in the ASEAN region. Trend Report No. 2. ASCC Knowledge Hub; 2024 Apr 10 [cited 2026 Jun 2]. Available from: <https://knowascc.asean.org/publication/trend-report-no-2-2024-building-a-resilient-health-system-to-strengthen-regional-health-security-in-the-asean-region/>

¹⁹² World Health Organization. Update: countries in Southeast Asia Region, partners pledge over USD 345 million, including in-kind contributions, at special WHO Investment Round Event [Internet]. 2024 Oct 9 [cited 2026 Jun 2].

ASEAN member states are also funding each other, though it remains a very small share of total ODF. Thailand is the largest intra-ASEAN donor, followed by Vietnam.¹⁹⁰ This trend reflects a growing “south–south solidarity”.¹⁹³ In another development, at a high-level event co-convened with Gavi in 2024, ASEAN health ministers agreed to set a regional target for increased domestic immunization and health system spending.¹⁹⁴

Table 23. DAH Recipients in Southeast Asia

Country	DAH Status & Trends	Key Focus Areas of DAH	Major Donors/Partners
<i>Cambodia</i>	High recipient, but gradually declining due to transition to LMIC status. Historically reliant on external funding.	Major health programs: HIV, malaria, MCH, immunisation. Pressure to increase domestic spending.	Global Fund, Gavi, USAID, JICA, ADB.
<i>Lao PDR</i>	High dependency on external health aid. Debt distress limits use of concessional loans.	Communicable diseases, PHC strengthening, nutrition, maternal/child health.	World Bank, ADB, Global Fund, Gavi, France, Japan, UN agencies.
<i>Myanmar</i>	Bilateral aid suspended/restructured away from government since 2021. DAH flows through non-state channels.	Mainly humanitarian and emergency-focused due to severe deterioration of the health system.	UN agencies, local NGOs, cross-border health networks.
<i>Vietnam</i>	DAH has declined due to rapid economic growth; donors are transitioning out (e.g., Gavi exit, reduced PEPFAR).	Transition support for tuberculosis, HIV, AMR, laboratory systems, pandemic preparedness.	USAID (reduced), Gavi (exiting/exited), others focusing on transition.
<i>Philippines</i>	Medium-level recipient. Receives significant loan-based financing (e.g., COVID-19 emergency loans). Shifting from vertical programs to system reforms.	UHC reforms, primary care networks, digital health, pandemic preparedness.	USAID, JICA, ADB, Korea, Global Fund, World Bank.
<i>Indonesia</i>	Largest total DAH recipient in the region, but low DAH per capita. External grants are declining, shifting to multilateral loans.	PHC, emergency response, pandemic preparedness, AMR, climate–health projects.	ADB, World Bank (loans), OECD.
<i>Thailand</i>	Very low DAH; essentially a net donor. Provides intraregional assistance.	Niche, project-based support (e.g., migrant health, surveillance networks). Major role in regional health security.	TICA (Thailand International Cooperation Agency).

Available from: <https://www.who.int/southeastasia/news/detail/09-10-2024-update-countries-in-southeast-asia-region-partners-pledge-over-usd-345-million-including-in-kind-contribution-at-special-who-investment-round-event>

¹⁹³ Stanhope G. South-South solidarity in Southeast Asia [Internet]. Lowy Institute. 2024 [cited 2026 Jun 2]. Available from: <https://www.loyyinstitute.org/publications/south-south-solidarity-southeast-asia>

¹⁹⁴ Gavi, The Vaccine Alliance. ASEAN health ministers pledge boldly to boost immunization in the region [Internet]. DevelopmentAid. 2024 [cited 2026 Jun 2]. Available from: <https://www.developmentaid.org/news-stream/post/183635/asean-boost-immunization-in-the-region>

<i>Malaysia</i>	Limited DAH inflow.	Improving migrant health access, addressing NCD burdens, digital health, AMR, preparedness.	WHO, JICA.
<i>Singapore</i>	Does not receive DAH; a major funder and technical contributor within ASEAN.	Supports regional programs on health security, AI/digital health, infectious disease research, and training.	Hosts regional centres.
<i>Brunei Darussalam</i>	No significant DAH inflow; fully domestically funded.	Only technical assistance for specialised areas (AMR, surveillance, digital health).	(Technical partners only).
<i>Timor Leste</i>	DAH as a share of health spending is declining but remains relatively high.	General health system support, formerly key programs.	Australia, Global Fund, World Bank, Cuba (medical workforce).

Key Trends in DAH in SAARC Countries

Across South Asia, DAH has followed a common trajectory in which LICs and LMICs remain heavily dependent on external assistance while middle-income countries navigate a more complex transition. India has also moved from dependence on donor-financed disease programmes to taking on a greater share of health spending.

LICs and LMICs in South Asia have benefited from the general growth of DAH, particularly in health-program funding directed toward communicable diseases, maternal and child health, and human resources for health.¹⁹⁵ There was also a pronounced spike in DAH during the COVID-19 pandemic, followed by a decline.¹⁹⁶ The bulk of health ODA to SAARC countries comes from traditional donors. But there is increasing South–South cooperation in health, notably from regional actors like *India* to Afghanistan, Bangladesh, Bhutan, Nepal, Sri Lanka.¹⁹⁷ The Institute for Health Metrics and Evaluation

¹⁹⁵ GBD Health Financing Collaborator Network. Financing global health 2018: annual report. Seattle, WA: Institute for Health Metrics and Evaluation; 2019. Available from: https://www.healthdata.org/sites/default/files/files/policy_report/FGH/2019/FGH_2018_full-report.pdf

¹⁹⁶ Apeageyi AE, Bisignano C, Elliott H, Hay SI, Lidral-Porter B, Nam S, et al. Tracking development assistance for health, 1990–2030: historical trends, recent cuts, and outlook. *Recent Cuts, and Outlook*. 2025.

¹⁹⁷ oitra M, Patel NK, Cogswell I, Chanana DI, Maddison E, Simpson K, Stutzman H, Zhao Y, Tsakalos G, Dieleman J, Micah AE. Tracking development assistance for health from India to low- and middle-income countries, 2009–2020. *PLoS ONE*. 2022;17(12):e0277799.

(IHME) provides a DAH database covering 1990–2022,¹⁹⁸ with data that is disaggregated by **recipient country**, and by **source, channel, health focus area**, and **program area**.¹⁹⁹

Table 24. DAH Recipients in South Asia

Country	DAH Status & Trends	Key Focus Areas of DAH	Major Donors/Partners
<i>Afghanistan</i>	Afghanistan remains among the largest humanitarian health recipients, with development aid collapsing since August 2021. WHO and UNICEF note that the system is almost entirely donor-funded and heavily reliant on emergency humanitarian financing.	Basic service delivery, emergency/trauma care, nutrition, disease outbreaks, maternal–child health, service delivery in non-government-controlled areas.	WHO, UNICEF, WFP, OCHA, Global Fund (targeted programs), World Bank (support routed via UN agencies), major INGOs.
<i>India</i>	India receives the largest share of DAH among SAARC countries by virtue of its size and the number of donors engaged. But less than 1% of its health expenditure comes from external sources, and it is also a donor itself.	Polio, TB, AMR, climate-health, and digital health.	WHO, Global Fund, Gavi, USAID, World Bank, and the Gates Foundation.
<i>Pakistan</i>	Pakistan receives high DAH volumes, especially for vertical programs (polio, TB, HIV) and large health-systems projects via loans/grants. DAH is stable but significant in overall public health spending.	Polio eradication, TB/HIV, MCH, PHC strengthening, health financing reforms, digital health, health systems resilience.	World Bank, Asian Development Bank (ADB), USAID, Global Fund, Gavi.
<i>Sri Lanka</i>	Sri Lanka historically had low DAH dependency, but following the 2022–24 economic crisis, concessional financing and technical assistance increased. Donor engagement focuses on UHC-oriented reforms.	UHC implementation, PHC strengthening, NCDs, essential medicines, service-delivery efficiency, digital health.	World Bank, ADB, WHO, UNICEF; IMF.
<i>Bangladesh</i>	Continue to rely on external donors for funding and investments.	HIV/TB/malaria and selective health system projects.	Global Fund and World Bank
<i>Bhutan</i>	Bhutan receives modest DAH, mostly technical assistance and IDA financing.	PHC strengthening, NCDs, digital health, human capital & workforce resilience, health financing sustainability, elimination of malaria/TB.	World Bank (IDA), Global Fund (malaria/TB elimination), Government of Japan (JICA), WHO, UNICEF.

¹⁹⁸ Institute for Health Metrics and Evaluation (IHME). Development assistance for health database 1990–2022 [data set]. Global Health Data Exchange. 2023 [cited 2026 Jun 2]. Available from: <https://ghdx.healthdata.org/record/ihme-data/development-assistance-health-database-1990-2022>

¹⁹⁹ GBD Health Financing Collaborator Network. Financing global health 2023: methods annex. Seattle, WA: Institute for Health Metrics and Evaluation; 2023. Available from: https://www.healthdata.org/sites/default/files/files/policy_report/FGH/2023/Methods%20Annex.pdf

<i>Maldives</i>	Maldives has low DAH dependence.	PHC revitalization, NCDs, digital health, migrant health, health workforce development, IHR compliance, AMR.	WHO, UNICEF, World Bank, India (via Lines of Credit and technical support), UNFPA.
<i>Nepal</i>	Continue to rely on external donors for funding and investments.	HIV/TB/malaria and selective health system projects.	Global Fund and World Bank

Note: Research data compilation assisted by ChatGPT with verification against primary sources including: (1) UNICEF and WHO Country Assessments, (2) Global Fund and World Bank Reports, and (3) complementary DAH-related news sources.

NON-GOVERNMENTAL NETWORKS AND PLATFORMS

Non-governmental networks and platforms

Effective and equitable global and regional health governance requires not just formal systems of cooperation and collaboration between governments, but also cooperation and collaboration between non-governmental, professional, business and civil society actors. International health cooperation can progress substantially through networks and partnerships between academic and research institutions, think tanks, civil society organizations, patient and consumer groups, local businesses and journalists and media organizations.

Both South and Southeast Asia already have an ecosystem of networks and partnerships focused on fostering synergies and improving health. Examples include the South Asian Public Health Forum (SAPHF), the One Health Alliance South Asia (OHASA), the One Health Network Southeast Asia for zoonotic diseases, the South Asia Forum for Health Research, the Southeast Asia Tobacco Control Alliance (SEATCA), Dragon Net, the Southeast Asia Collaborative for Health (SEARCH), the Asia Pacific Observatory on Health Systems and Policies (APO), the Asia Pacific Action Alliance on HRH (AAAH), the International Association of National Public Health Institutes (IANPHI), the Asia Regional Network, the Asia Pacific Health Economics Network (APHEN), the Asia Pacific Academic Consortium for Public Health (APACPH), the R4D Accelerator, the South Asia Infant Feeding Research Network (SAIFRN), the South Asia Food and Nutrition Security Initiative (SAFANSI), the Asian Collective on Health Systems Strengthening (TACHS) and the Asia-Pacific Cardiovascular Disease Alliance.

These networks and alliances vary in terms of their geographic span, issues and activities. Many are focused on knowledge sharing, advocacy and capacity building (Table 25). With varied approaches, the networks have made contributions to fostering partnerships, producing knowledge and informing national policies, although many also face funding constraints and challenges in securing active participation from policymakers and state representatives.

Table 25. Range of Issues explored by Issue-based and Thematic networks

Theme	Issues	Networks
Health Security	Health system resilience, Pandemic Preparedness	Joint Learning Network, ASEAN, Alliance for Health Policy and Systems Research, Global Learning Collaborative on Health Systems Resilience (GLC4HSR)
Health Systems Strengthening	Primary Health Care (PHC)	WHO PHC Forum, The Southeast Asia Collaborative for Health (SEARCH), ASEAN
Gender	Sexual and reproductive health, maternal care, adolescent health	Sexual and Reproductive Health Matters Regional Hub, Global Health Strategies
Non-Communicable Diseases (NCDs)	Cardiovascular health, tobacco control	Asia-Pacific Cardiovascular Disease Alliance (APAC CVD Alliance), Southeast Asia Tobacco Control Alliance

Demographic and Epidemiological Challenges	Ageing population, demographic shifts, epidemiological transitions, disease burden, population health trends	Dragon Net, Japan, Global Health Strategies, Southeast Asia Infectious Disease Clinical Research Network
Nutrition and Food Security	Food safety, nutrition, food and nutrition security	ASEAN, South Asia Food and Nutrition Security Initiative (SAFANSI), SEA-PHN
Infectious and Emerging Diseases	Infectious diseases, emerging challenges, COVID-19	Southeast Asia Infectious Disease Clinical Research Network, Global Health Strategies
Climate and Health	Climate-health intersection, One Health approach	One Health Alliance South Asia, Global Heat Health Information Network - SEA Health Hub, One Health Network Southeast Asia, Southeast Asia One Health University Network
Digital Health and Innovation	Digital health, information systems	Asia E-Health Information Network (AeHIN)
Equity and Social Protection	Social protection, equity, gender intersectionality	CONNECT, EQUITAP, Alliance for Health Policy and Systems Research
Workforce Development	Human resources for health	Asia Pacific Action Alliance on HRH (AAAH)
Health Financing and Sustainability	Fiscal sustainability, provider payment, access to medicines, strategic health purchasing	Asia Regional Joint Network on Fiscal Sustainability of Health Systems, P4H Asia Network, Asia Pacific Network on Access to Medicines under UHC, The Southeast Asia Collaborative for Health (SEARCH)
Public Health	Health promotion, healthy lifestyles	ASEAN University Network - Health Promotion Network (AUN-HPN), Global Health Strategies
Data and Monitoring	National health accounts, health data systems, evidence synthesis, embedded research, systems thinking	Asia Pacific Network for Health Systems Strengthening (ANHSS), Asia Pacific Health Economics Network (APHEN), Asia-Pacific NHA Network (APNHAN), Alliance for Health Policy and Systems Research
Mental Health	Mental health, advocacy, and research	South Asian Hub for Advocacy, Research & Education on Mental Health (SHARE)

The Prince Mahidol Award Conference (PMAC), held annually in Thailand, is also an example of a global health conference held in Asia that helps to facilitate academic and research cooperation within the region while elevating those voices in global discussions about global health.

A plethora of civil society organizations engage in global health advocacy across UN agencies, including the Third World Network (TWN), the People's Health Movement (PHM) and the WHO-Watch who stand out as long-standing players with sustained institutional memory of global health and its changes. TWN operates not only within the WHO but also at the WTO, WIPO, and other multilateral venues, bringing decades of independent technical expertise on trade, intellectual property, and development policy to challenge incoherence between global health mandates and commercial interests. PHM and the WHO-Watch deploys grassroots activists and scholars to monitor WHO governance meetings in real time, while newer networks like the Geneva Global Health Hub (G2H2) convene diverse civil society actors to coordinate advocacy and democratize access to policy

spaces that have historically been dominated by states, Northern-based academic institutions and professionalised NGOs. Countless other CSOs strengthen this ecosystem through rights-based approaches to primary health care and health systems strengthening. Yet TWN and PHM's longevity gives them a distinctive capacity to track institutional drift, expose recurring patterns of corporate capture, and hold the WHO accountable across changing political climates, whilst amplifying systematically marginalized voices from the Global South and preventing accountability from being reduced to technocratic audit or diplomatic performance. Crucially, these civic networks help ensure that international health cooperation is fostered and conducted in ways that are just and democratic.

Professional and more technocratic networks also have a particularly important niche in terms of helping improve the quality of healthcare and public health programmes through the exchange of information, expertise and knowledge. Additionally, professional and epistemic relationships can be forged in parallel to inter-national and political tensions or economic competition between countries. Through such networks, practical steps can be taken regardless of the degree of formal cooperation between governments and sometimes, in spite of actual conflict between countries.

Key Takeaways and Questions

The case for improving regional health governance and cooperation

The global and regional health landscape is complex, multi-layered and shaped by multiple actors and institutions with different mandates, goals and agendas. Additionally global and regional health institutions are currently being subjected to considerable financial cutbacks and increasing geopolitical tensions and conflicts whilst also facing several growing public health threats that can only be fully managed through international cooperation. One response to this complex and challenging situation is to strengthen international cooperation at the regional level. This does not substitute the need for global cooperation or for global rules and standards that are applicable to all countries, but it may compensate for some of the weaknesses in the current system of GHG. In fact, regional health cooperation and governance may generate benefits through several pathways:

1. Strengthening the ability to manage cross-border health threats and risks
2. Reducing costs through the pooling of purchasing power and creation of economies of scale for research and development; training and capacity development, etc
3. Expanding capacity through the sharing or exchange of scarce specialized expertise
4. Generating efficiency through shared functions such as for quality assurance and regulatory approval of new medicines, vaccines, diagnostics
5. Improving health and health security equitably by creating opportunities for intra-regional financial and technical assistance
6. Strengthening the voice and bargaining power of countries in the region vis-à-vis: global organizations (eg. WHO and World Bank), global negotiations (eg. pandemic treaty); powerful nation states (eg. USA, China); and powerful private actors (eg. trans-national corporations and private foundations)

The potential for South and Southeast Asia to shape the future of global health is significant, not just because of the power vacuum created by the withdrawal of the US, but also because both regions have grown in terms of economic weight, political influence and technical expertise. India, Malaysia, Indonesia, Thailand and Singapore already engage quite prominently in international processes and debates on vaccine equity, intellectual property and digital public goods, and are now significant components of global supply chains, pandemic response capacities and digital health innovations.

However, while there are many potential benefits to be derived from better regional health governance and cooperation, there are also obstacles in the form of intra-regional conflicts, different national perspectives on regional cooperation, political, economic, social, demographic and epidemiological heterogeneity (see Table 26), as well as variable institutional capacity which may limit the two regions' ability to cooperate and govern collectively. A structured SWOT analysis could be conducted to assess current strengths and weaknesses and examine opportunities for enhancing and improving mutually beneficial regional health governance cooperation and governance in both South and Southeast Asia.

Table 26. Characteristics and features of South and Southeast Asian Countries

	Population	Average age	GDP per capita (2023/2024)	GINI	HDI (2023)	IMR (2024 estimates)	Doctor: population ratio	MMR (2023 estimates)	Financial contribution to WHO (AC & VC for 2024-25)
SAARC Members									
<i>Afghanistan</i>	42.6 million	17.4	414	No data	0.496 (Low) Rank ~181	48	0.3 (2023)	521	AC \$71,300 VC \$526,745
<i>Bangladesh</i>	173.6 million	26.3	2,593	30.9 (2022)	0.685 (Medium) Rank ~130	24	0.7 (2023)	115	AC \$114,830 VC \$1,923,000
<i>Bhutan</i>	0.8 million	31.0	3,831	28.5 (2022)	0.698 (Medium) Rank ~125	14	0.6 (2022)	47	AC \$11,880 VC \$N/A
<i>India</i>	1,451 million	29.2	2,695	25.5 (2022)	0.685 (Medium) Rank ~130	23	0.7 (2020)	80	AC \$11,989,000 VC \$105,275,000
<i>Maldives</i>	0.5 million	33.4	13,379	29.3 (2019)	0.766 (High) Rank ~93	5	2.2 (2019)	32	AC \$47,540 VC \$N/A
<i>Nepal</i>	29.7 million	25.7	1,447	30.0 (2022)	0.622 (Medium) Rank ~145	22	1.0 (2023)	142	AC \$114,840 VC \$10,121
<i>Pakistan</i>	251.3 million	20.8	1,488	33.5 (2024)	0.544 (Low) Rank ~168	48	1.2 (2021)	155	AC \$1,354,750 VC \$55,900,000
<i>Sri Lanka</i>	22.0 million	33.6	4,516	37.7 (2019)	0.776 (High) Rank ~89	5	1.1 (2023)	18	AC \$516,770 VC \$158,230
ASEAN Members									
<i>Brunei</i>	0.5 million	33.2	33,154	No data	0.837 (Very High) Rank ~60	9	1.9 (2021)	36	AC \$249,560 VC \$N/A
<i>Cambodia</i>	17.6 million	26.4	2,6289	No data	0.606 (Medium) Rank ~151	16	0.2 (2019)	59	AC \$83,190 VC \$353,982
<i>Indonesia</i>	283.5 million	30.7	4,925	34.4 (2025)	0.728 (High) Rank ~113	15	0.5 (2023)	140	AC \$6,305,000 VC \$1,364,000
<i>Laos</i>	7.8 million	25.3	2,124	34.7 (2024)	0.617 (Medium) Rank ~147	27	0.3 (2022)	112	AC \$83,190 VC \$207,811
<i>Malaysia</i>	35.6 million	31.4	11,874	40.7 (2021)	0.819 (Very High) Rank ~67	7	2.3 (2023)	26	AC \$3,996,000 VC \$18,066
<i>Myanmar</i>	54.5 million	30.4	1,359	30.7 (2017)	0.609 (Medium) Rank ~150	33	0.8 (2019)	185	AC \$118,830 VC \$N/A
<i>Philippines</i>	115.9 million	26.6	3,985	39.3 (2023)	0.720 (High) Rank ~117	22	0.8 (2021)	84	AC \$2,435,000 VC \$1,319,694
<i>Singapore</i>	6.0 million	36.8	90,674	No data	0.946 (Very High) Rank ~13	2	2.8 (2022)	6	AC \$5,788,000 VC \$3,298,200
<i>Thailand</i>	71.7 million	41.0	7,347	33.3 (2024)	0.798 (High) Rank ~76	8	0.5 (2021)	34	AC \$4,226,000 VC \$524,687
<i>Timor Leste</i>	1.4 million	22.1	1,332	28.7 (2014)	0.634 (Medium) Rank ~142	35	0.8 (2020)	192	AC \$11,880 VC \$1,703,000
<i>Vietnam</i>	101.0 million	33.9	4,717	36.1 (2022)	0.766 (High) Rank ~93	12	1.1 (2021)	48	AC \$1,068,000 VC \$196,924

Governance is about more than architecture

Many recent discussions about the future of global health have tended to focus on the architecture of the global health system and on need to reduce competition, overlaps and duplication of mandates and activities of the many global health organizations that now exist, whilst calling for greater self-reliance amongst LICs and MICs. However, often missing from these discussions are questions about structural power imbalances and a global political economy that has deepened inequalities, accelerated ecological breakdown and enabled an ever-increasing concentration of wealth and power in the hands of a small number of companies and individuals, many rooted in the Global North. Any discussions about the future of global health must thus also address the wider politics and economics of equitable and ecologically sustainable development.

The global health system

What next for WHO?

For decades, WHO has been hamstrung and debilitated by:

- international politics and national self-interest
- the lack of a core budget and excessive reliance on VCs which leads to the instrumentalisation of WHO by dominant donor states and private foundations.
- the rise in influence of other global health organisations
- insufficient coherence between the head office and regional offices

Presently, WHO faces an existential crisis. An important question is whether this crisis also presents an opportunity for countries from South and Southeast Asia to institute the reforms required for WHO and the global health system to function more effectively. It is not clear to what extent there are common views across South and Southeast Asia about the future of WHO. Views may range from thinking that WHO should be abolished (and reborn), to viewing WHO as vital and needing protection and revitalization. Those in the latter camp tend to emphasise WHO's scientific and technical mandate and authority to set international norms, standards and guidelines, negotiate international treaties and provide an inter-governmental platform for the management of global cross-border threats.

However, this would require addressing WHO's heavy over-reliance on VCs which undermines its autonomy and agency and gives an undue degree of influence to its biggest donors. It also requires at least a discussion about the contribution made by SAARC and ASEAN member states to WHO. Presently, the financial contribution of South Asian and Southeast Asian nations to WHO remain modest relative to their population size: SAARC nations account for 24.2% of the global population but only 2.6% of WHO's budget while ASEAN nations account for 8.5% of the world's population but only 0.49% of WHO's total budget.

The global health complex beyond WHO

Many other actors wield influence across the global health landscape and impact on health policy and health outcomes in South and Southeast Asia. These include development banks, GPPPs like

the Global Fund, Gavi and CEPI and private foundations. By and large, these actors operate bilaterally with individual countries and their relevance in South and Southeast Asia can vary considerably from one country to another.

Since 2000, GPPPs have been an important source of grant-based funding. While such grants have helped expand access to healthcare, it has also tended to reinforce vertical, selective, disease and biomedically focused programmes. However, the retreat of traditional donors has prompted several important reforms with GAVI and the Global Fund that suggest a move towards greater national ownership and more horizontal health system strengthening. DAH budget cuts have also shrunk the relevance of GPPPs like Gavi and the Global Fund amongst the MICs in South and Southeast Asia. Some countries like Indonesia and India have even increased their contributions to the Global Fund, Gavi, Pandemic Fund and CEPI, potentially marking the start a possible transition from being "passive recipients" or "symbolic donors" to becoming more active stewards of GPPPs.

Perhaps the most influential group of other actors are the Development Banks (WB, ADB and AIIB) who provide health financing through various modalities, terms and governance arrangements and who are influential in LICs, LMICs and UMICs alike. The WB and ADB provide a broader mix of loans and grants for both social sector and infrastructure projects, while the AIIB has a sharper focus on non-concessional loans for infrastructure development and on mobilising greater private capital investments in the health sector as does the IFC. The aggregate value of IBRD and IDA-funded health projects in South and Southeast Asia in 2026 was over USD14.1 billion; while IFC health investments amounted to USD68.65 million. ADB funding for 'currently active projects' amounts to around USD5.82 billion, while AIIB's mostly non-concessional lending for health amounts to 3.46billion.

A key question is whether stronger regional cooperation could help countries engage more strategically and efficiently with development banks. This could involve sharing information, co-developing health-sector standards to guide infrastructure investments, or jointly scrutinising new PPPs and financialisation models before they are scaled up. There is also scope for peer learning about what has and hasn't worked in areas such as UHC reforms, hospital PPPs or vaccine manufacturing which could help governments' negotiations with private investors and trans-national corporate actors.

Development Assistance for Health (DAH)

Various bilateral official aid programmes funded and delivered by the USA (eg. USAID, PEPFAR and PMI), the UK, Germany, Japan and several other high-income states are part of the global health system. Today however the system of DAH is at a turning point with a dramatic decline in the volume of ODA from traditional donor countries. Countries in South and Southeast Asia, especially the poorer countries, must navigate this decline in DAH as well as the growing influence of non-traditional donors from China and the Middle East.

Another challenge for countries in South and Southeast Asia is the USA's new and more aggressive America-first approach to foreign policy and development assistance illustrated by its defunding of

global health organisations and USAID and its more explicit use of bilateral aid as an instrument of US economic and foreign policy.

Importantly within both South and Southeast Asia there are examples of development assistance with, for example, Thailand and Vietnam acting as donors in Southeast Asia; and India in South Asia.

Regional structures and platforms

Multiple regional configurations

South and Southeast Asia have multiple, poorly aligned regional platforms for international health cooperation. The two WHO ROs that cover Asia have some geographic rationale but have some misalignment with the more political and economic groupings of ASEAN, BIMSTEC and SAARC.

Presently SEARO and WPRO budgets are relatively small, and the financial contribution made to them by South and Southeast Asian countries is small. A structured, independent and neutral SWOT analysis of SEARO and WPRO could help provide countries formulate plans to make WHO's regional layers work more effectively and efficiently South and Southeast Asian countries.

Of the groupings of ASEAN, BIMSTEC and SAARC, ASEAN appears to have the biggest potential to develop a coherent and potentially effective regional health infrastructure. ASEAN has developed provisions for regional stockpiling, pooled procurement of vaccines, and cross-border management of disease outbreaks. The existence of multilateral and bilateral development financing that is channelled through ASEAN is recognition of this. But maximizing the full potential of ASEAN may require the strengthening of its institutional capacity and a willingness to delegate more authority to ASEAN. ASEAN would also need to consider how it can preserve positive synergies with WPRO and SEARO.

SAARC, on the other hand, has been constrained by political conflicts between two key member countries. BIMSTEC, in contrast, has provided the basis for some emerging regional health cooperation.

Regional health governance and cooperation through non-governmental channels

While governance is often understood in terms of governmental or official structures and systems, good governance also relies on non-governmental, informal, professional and technical mechanisms and processes. This can involve different groups and actors including universities and research institutions; civil society organisations; and health professional associations. Issue-based groupings may offer greater agility and responsiveness than formal intergovernmental platforms.

Regional cooperation between universities, research institutions, civil society organisations and health professional associations can also help such actors engage more effectively with the multiple and distant institutions and processes of GHG that are mostly located in expensive cities in the Global North.

G20, BRICS and G77

The G20, BRICS Plus and G77 groupings also offer alternative and parallel mechanisms by which global health governance and cooperation is advanced.

Since the incorporation of sustainable development and health into its agenda, the G20 has helped institutionalise the connection between economic governance and health security and played an important catalytic role in advancing certain health issues on the international stage. By linking economic stability, pandemic preparedness, and health system resilience, the G20 increasingly positions health as a core pillar of GHG. Currently six G20 members are from Asia (China, India, Indonesia, Japan and South Korea). India and Indonesia thus represent important countries through which South and Southeast Asian perspectives may be reflected in G20 processes.

BRICS+ is an important forum for countries from the Global South. Initially comprised of Brazil, Russia, India, China and South Africa, it has expanded to include Saudi Arabia, Egypt, the UAE, Ethiopia, Indonesia and Iran. The introduction of "partner country" status has further broadened participation, allowing nations such as Malaysia, Vietnam and Thailand to attend the summit and additional meetings, and participate in extended South–South knowledge networks. Crucially, the last two decades have seen the BRICS agenda expand to include issues such as environment and health.

Finally, the G77 and the G77+China groupings provide another platform for amplifying Global South voices onto the global stage. For South and Southeast Asia, the G77 appears to be especially relevant in creating a common negotiating platform for member states on equitable access to vaccines, medicines, diagnostics and other health technologies.

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The UNU International Institute for Global Health (UNU-IIGH) in Kuala Lumpur, Malaysia, operates as the designated UN think tank specialising in global health. With a mandate to facilitate the translation of research evidence into policies and tangible actions, UNU-IIGH serves as a hub connecting UN member states, academia, agencies, and programmes.

Established through a statute adopted by the United Nations University Council in December 2005, the institute plays a pivotal role in addressing inequalities in global health. UNU-IIGH contributes to the formulation, implementation, and assessment of health programmes.

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