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South and Southeast Asia in Global Health Governance

A Regional Perspective

Sandhya Venkateswaran

Nadine Monteiro

Diya Chaudhry

David McCoy

Dian Maria Blandina



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Centre for Social and Economic Progress (CSEP)
CSEP Research Foundation
6, Dr Jose P. Rizal Marg, Chanakyapuri,
New Delhi - 110021, India

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Sandhya Venkateswaran

Senior Visiting Fellow
Centre for Social and Economic Progress
New Delhi, India

Nadine Monteiro

Research Analyst
Centre for Social and Economic Progress
New Delhi, India

Diya Chaudhry

Research Assistant
Centre for Social and Economic Progress
New Delhi, India

David McCoy

Policy Research Lead
United Nations University International Institute for
Global Health Kuala Lumpur, Malaysia

Dian Maria Blandina

Policy Associate
United Nations University International Institute for
Global Health Kuala Lumpur, Malaysia

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Abbreviations

AAAH	Asia Pacific Action Alliance on Human Resources for Health
AC	Assessed Contribution
ACPHEED	ASEAN Centre For Public Health Emergencies and Emerging Diseases
ACT-A	Access To COVID-19 Tools Accelerator
ADB	Asian Development Bank
ADB IED	Asian Development Bank, Independent Evaluation Department
AEHIN	Asia E-Health Information Network
AFRO	Regional Office for Africa
Africa CDC	Africa Centres for Disease Control and Prevention
AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
AIIB	Asian Infrastructure Investment Bank
AMR	Antimicrobial Resistance
AMRO	Regional Office for the Americas
ANHSS	Asia Pacific Network for Health Systems Strengthening
APAC	Asia-Pacific
APHEN	Asia Pacific Health Economics Network
ARTF	Afghanistan Reconstruction Trust Fund
ASCC	ASEAN Socio-Cultural Community
ASEAN	Association Of Southeast Asian Nations
ASSIST	Assam State Secondary Healthcare Initiative for Service Delivery Transformation
AUN-HPN	ASEAN University Network–Health Promotion Network
BIMSTEC	Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation
BRICS	Brazil, Russia, India, China, And South Africa
CAD-DDO	Catastrophe Deferred Drawdown Option
CCM	Country Coordinating Mechanism
CEPI	Coalition For Epidemic Preparedness Innovations
COVAX	COVID-19 Vaccines Global Access
CSO	Civil Society Organisation
CVC	Core Voluntary Contribution
CVD	Cardiovascular Disease
DAH	Development Assistance for Health
DG	Director-General
EB	Executive Board
EC	European Commission

ELP	Early Learning Partnership
EMRO	Regional Office for the Eastern Mediterranean
EQITAP	Equity in Asia-Pacific Health Systems
ERIA	Economic Research Institute for ASEAN and East Asia
EURO	Regional Office for Europe
FCTC	Framework Convention on Tobacco Control
FIF	Financial Intermediary Fund
G20	Group of 20
G77	Group of 77
GDP	Gross Domestic Product
GFF	Global Financing Facility for Women, Children and Adolescents
GHG	Global Health Governance
GHP	Global Health Partnership
GIDH	Global Initiative on Digital Health
GLC4HSR	Global Learning Collaborative on Health Systems Resilience
GLOBAL FUND	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GPPP	Global Public–Private Partnership
GPW 14	Fourteenth General Programme of Work
HANS	Health Assistance and Nutrition Support
HEAL	Health System Enhancement to Address and Limit COVID-19
HEPRTF	Health Emergency Preparedness and Response Multi-Donor Trust Fund
HEQUIP	Health Equity and Quality Improvement Project
HER	Health Emergency Response
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HQ	Headquarters
HRH	Human Resources for Health
HRP	Special Programme of Research, Development and Research Training In Human Reproduction
HT-MDTF	Health Transformation Multi-Donor Trust Fund
IBRD	International Bank for Reconstruction and Development
ICMR	Indian Council of Medical Research
ICSID	International Centre for Settlement of Investment Disputes
ID	Infectious Disease
IDA	International Development Association
IDFHP	Integrating Donor-Financed Health Programs
IED	Independent Evaluation Department

IFC	International Finance Corporation
IFFIM	International Finance Facility for Immunisation
IGO	Intergovernmental Organisation
IHR	International Health Regulations
IMF	International Monetary Fund
IP	Intellectual Property
ISDB	Islamic Development Bank
IT	Information Technology
JBTN	Jipmer-Bimstec Telemedicine Network
JIPMER	Jawaharlal Institute of Postgraduate Medical Education and Research
JKN	Jaminan Kesehatan Nasional
JSDF	Japan Social Development Fund
KFW	Kreditanstalt Für Wiederaufbau
KP	Khyber Pakhtunkhwa
LAO PDR	Lao People's Democratic Republic
LIC	Low-Income Country
LMIC	Lower- and Middle-Income Country
MCH	Maternal and Child Health
MDB	Multilateral Development Bank
MDTF	Multi-Donor Trust Fund
MIC	Middle-Income Country
MIGA	Multilateral Investment Guarantee Agency
MOHFW	Ministry of Health and Family Welfare
MPOWER	Meghalaya Multisectoral Project for Adolescent Wellbeing, Empowerment and Resilience
N/A	Not Available
NCD	Non-Communicable Disease
NDRC	Nepal Disaster Resilience Development Policy Credit
NGO	Non-Governmental Organisation
NHA	National Health Account
P4H	Providing For Health
PAHO	Pan American Health Organization
PB-AM	Pradhan Mantri-Ayushman Bharat
PEF	Pandemic Emergency Financing Facility
PHC	Primary Healthcare
PHSEP	Primary Healthcare System Enhancing Project
PHSPP	Transforming India's Public Health Systems for Pandemic Preparedness Program
PIP	Pandemic Influenza Preparedness
PLC	Public Limited Company

PMAC	Prince Mahidol Award Conference
PPP	Public–Private Partnership
PPR	Pandemic Prevention, Preparedness, And Response
R&D	Research And Development
RBL	Results-Based Loan
RO	Regional Office
RSAB	Rumah Sakit Anak dan Bunda
SAARC	South Asian Association for Regional Cooperation
SAFANSI	South Asia Food and Nutrition Security Initiative
SAP	Structural Adjustment Programme
SAR	South Asia Region
SARS	Severe Acute Respiratory Syndrome
SASD-TF	South Asia Social Development Trust Fund
SDTF	Sector Development Trust Fund
SEA	Southeast Asia
SEA-PHN	Southeast Asia Public Health Nutrition Network
SEARCH	Southeast Asia Collaborative for Health
SEARO	Regional Office for South-East Asia
SFW	Special Fund Window
SHARE	South Asian Hub for Advocacy, Research and Education on Mental Health
SPF	State and Peacebuilding Fund
SRESTHA-G	Systems Reform Endeavours for Transformed Health Achievement in Gujarat
STAC	SAARC Tuberculosis and HIV/AIDS Centre
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TCG	The Cravings Group
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children’s Fund
UNOSSC	United Nations Office for South–South Cooperation
VC	Voluntary Contribution
WB	World Bank
WBG	World Bank Group
WHA	World Health Assembly
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Executive Summary

Global health governance (GHG) is undergoing a significant transformation. Over the past three decades, the institutional architecture underpinning global health has shifted from a predominantly intergovernmental model (for example, the World Health Organization [WHO]) to a dense and multi-layered web of actors including multilateral development banks (MDBs), global public–private partnerships (GPPPs), philanthropic organisations, regional institutions, and informal multistakeholder platforms. This proliferation of actors has brought about certain benefits, such as a significant mobilisation of health financing and resources, an expansion in technical cooperation, and initiatives to combat infectious diseases. However, this has simultaneously led to the production of a fragmented ecosystem of overlapping mandates, complex institutional relationships, skewed power dynamics, and blurred lines of accountability. This ever-evolving interplay of actors marked by evident power asymmetries has critical implications for equity, as agenda-setting, financing capacity, and decision-making power remain concentrated among a relatively small group of states, donors, and private actors. In turn, this limits the influence of lower- and middle-income countries (LMICs) despite their demographic significance.

Contemporary geopolitical and economic churnings have exacerbated these challenges. The recent COVID-19 pandemic exposed both strengths of and fractures in the current governance structure. Similarly, declining development assistance for health (DAH), the withdrawal of the United States (US) from the WHO, rising debt burdens faced by LMICs, and the emergence of polyalignments have called into question the future of GHG. Given this context, South and Southeast Asia—regions that collectively host a third of the world’s population—have high stakes in and the potential to shape the landscape of GHG (World Bank Group [WBG], 2025).¹ Yet, despite the growing manufacturing, pharmaceutical, and technical capacities coupled with the expanding geopolitical influence of countries within the regions, South and Southeast Asia’s representation in GHG discourse remains constrained by uneven institutional capacity. This study looks at how the major institutions of GHG engage with countries of the region (including Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka, Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand, Timor-Leste, and Vietnam) and explores pathways to strengthen its collective representation in GHG.

World Health Organization

The WHO is the central normative authority in global health, with a constitutional mandate to direct and coordinate international health. Its comparative advantage remains in its institutional legitimacy, standard-setting function, technical capacity,

¹ Data as per World Bank population figures, 2025. Southeast Asia here refers to Indonesia, The Philippines, Vietnam, Thailand, Myanmar, Malaysia, Cambodia, Laos, Singapore, Timor-Leste, and Brunei. South Asia refers to India, Pakistan, Afghanistan, Nepal, Sri Lanka, Bhutan, and the Maldives.

and ability to set internationally binding policy. However, there are serious concerns regarding its financing structure, marked by a heavy reliance on voluntary funding, and constrained accountability and independence. In Asia, the WHO's regional functions are divided primarily between the two regional offices (ROs): the Western Pacific Regional Office (WPRO) and the South-East Asia Regional Office (SEARO). This bifurcation, which follows historical and political groupings rather than shared conditions, does not necessarily match with current contextual realities or epidemiological profiles. This fragmentation is compounded by the fact that the ROs receive some of the most modest funding within WHO (despite serving a demographically significant population). Preserving the roles that make WHO a unique body with considerable legitimacy requires reforming the financing structure to maintain autonomy while clarifying its relationship to the broadening ecosystem of actors and partners.

Multilateral Development Banks

MDBs have become pivotal players in global health and have come to actively shape global governance systems. Beyond financing infrastructure projects, the MDBs have expanded their role in health systems strengthening, pandemic preparedness, digital health, and universal health coverage (UHC). By providing loans and stipulating policy conditionalities, institutions like the World Bank (WB) increasingly influence domestic health systems and the policy contexts in which they operate. Players like the Asian Development Bank (ADB) and the Asian Infrastructure Investment Bank (AIIB) have emerged as regional alternatives; however, they encounter their own set of challenges. This group of banks has clearly expanded health financing across South and Southeast Asia, but important questions remain about growing debt burdens, fragmented and vertical financing that favours vertical programmes over holistic health systems development, private sector investment, and balancing macroeconomic objectives and public health priorities. Countries in the region, particularly those with limited resources and capacity, would likely be in a stronger position to negotiate effectively with the MDBs if they focus on coordinating more closely with one another.

Global Public–Private Partnerships

The GPPPs for health refer to institutions such as the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). These serve as financing mechanisms to provide countries with support for health-related goals such as vaccination, and disease prevention and control. Over the past decades, GPPPs have emerged as influential transnational organisations that shape global health priorities, financing structures, and development priorities. With an increase in DAH, many GPPPs are undergoing internal reform processes that promote greater domestic ownership, co-financing mechanisms, and stronger integration between vertical programmes and broader health system needs. Some common critiques of

the GPPPs include the influence of donors over strategic priorities, the expansion of GPPPs in areas that have historically been WHO's mandate to lead, and the blurring of institutional roles and boundaries. Simultaneously, some LMICs in South and Southeast Asia are transitioning from aid recipients to contributors. Other middle-income countries (MICs) continue to receive support from the GPPPs and contribute modestly. These issues underscore the need for better coordination and stronger country ownership.

Regional Governance Organisations

Against this backdrop, the importance of regional health governance is even more evident. Regional institutions are well placed to coordinate country responses to shared health challenges, elevate country needs by consolidating collective bargaining capacity with global actors, and amplify a regional voice within the fragmented global governance landscape.

The current picture of regional health governance shows a stark divergence between South and Southeast Asia. The institutional infrastructure of the Association of Southeast Asian Nations (ASEAN) is more established than that of many other regional bodies, particularly in surveillance systems, emergency coordination mechanisms, and health security arrangements. However, ASEAN's consensus-based decision-making slows down processes, and much of the organisation's work is highly dependent on external funding. The South Asian Association for Regional Cooperation (SAARC), on the other hand, has been constrained by a high-level political stalemate, despite technical operations on health retaining some momentum. The Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation (BIMSTEC), an alternative to SAARC, has approached health from technological and innovation frameworks, but efforts remain uneven, and capacity limited. Across both subregions, formal governmental channels do not neatly overlap with the WHO ROs, and regional governance is fragmented, under-resourced, and limited by the region's ability to articulate collective positions on shared challenges in a common forum. Strengthening institutional coordination, political commitment, and regional ownership will be essential to building more effective regional health governance.

Non-Regional Platforms

Apart from the formal global and regional structures, broader geopolitical fora like the Group of 20 (G20), Group of 77 (G77), and Brazil, Russia, India, China, and South Africa (BRICS) and BRICS+ (an expansion of BRICS) have also been emerging as sites of GHG. While these lack the normative and decision-making authority of the WHO and the financing capacity of the MDBs and the GPPPs, they play a key role in catalysing political consensus, agenda-setting, health diplomacy, and setting priorities for development financing. For South and Southeast Asia,

they play an important role in strengthening South–South cooperation, shaping multilateral reforms, and platforming countries like India and Indonesia as global health stewards.

Overall, the analysis concludes that South and Southeast Asia face both long-term structural vulnerabilities and notable gains from the current GHG architecture. GPPPs, regional cooperation mechanisms, and the growth of MDBs have mobilised previously unheard-of health resources, bolstered targeted disease control initiatives, increased pandemic preparedness, and allowed emerging economies to participate more actively in GHG. At the same time, the architecture has grown more dispersed due to a strong reliance on donors and enduring power disparities that continue to influence finance priorities and agenda-setting. As a result, the region becomes a crucial level of collaboration.

The region nevertheless possesses significant opportunities through countries' growing technical expertise, manufacturing capacity, and diplomatic influence. Stronger regional coordination could amplify the collective voice of South and Southeast Asia in global decision-making.

These opportunities also carry risks. Commercial and economic interests are expected to weigh more heavily on global health priorities if WHO and regional health governance institutions are not strengthened. That would further dilute public health goals and reinforce existing disparities. Stronger regionalism will be necessary to protect public health interests and effectively bridge the gap between national priorities and global governance at a time when bilateralism is increasingly replacing multilateral collaboration.

While the growing capabilities and ownership of countries across South and Southeast Asia provide an opportunity to strengthen regional cooperation and exercise greater collective influence, realising this potential will depend upon navigating an increasingly complex geopolitical landscape marked by declining development assistance, shifting donor priorities, rising nationalism, and the growing influence of development finance institutions and private actors.

Pathways Forward

The analysis points to several areas through which South and Southeast Asian countries could strengthen their collective role in global health governance. Academics, civil society organisations (CSOs), and policymakers could further explore these pathways to assess their feasibility in improving regional coordination, ownership, and engagement with global institutions.

- **Reaffirm WHO's normative and coordinating role** while strengthening its institutional independence. This includes reducing reliance on earmarked voluntary contributions and clarifying the separation between norm-setting and financing functions.

- **Strengthen the region's collective negotiating capacity** to engage strategically with MDBs and GPPPs, ensuring that external financing better reflects regional priorities and does not dilute WHO's normative leadership.
- **Build a regional bridge across South and Southeast Asia** by strengthening coordination across existing institutions and exploring flexible, consensus-based mechanisms that can provide a coherent regional voice in GHG.
- **Strengthen regional governance around functions that require collective action**, including cross-border health threats, pooled resources, expertise and procurement, regulatory cooperation, research and development (R&D), capacity building, and collective bargaining with global institutions.
- **Expand regional cooperation beyond governments** by leveraging academic, civil society, and professional networks to strengthen knowledge generation, implementation, accountability, and dialogue on the geopolitical dimensions of health.
- **Position regionalism as a necessary complement to multilateralism**, enabling South and Southeast Asia to safeguard public health priorities amidst growing bilateralism while becoming active architects of a more equitable and representative GHG system.

1. Global Health Governance: Evolution and Expansion

The term GHG refers to the formal and informal structures, systems, and institutions through which actors i) make decisions about global health standards, policies, and priorities; ii) finance, organise, 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 thus 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.

Global governance has generally been based on a system of intergovernmental organisations (IGOs) that emerged after the Second World War, including the United Nations (UN) and the Bretton Woods institutions. Various international treaties and agreements also represent agreed principles and standards for the conduct of international and national affairs. Global governance has faced various limitations and constraints. International rivalry, national self-interest, and power asymmetries among nation-states work against the multilateral system operating as it should. With the lack of direct democracy at the global level, democratic deficits at the national level are easily transposed to the global level of governance, especially given the distance and remoteness of global governance structures from ordinary communities and the sprawling nature of the UN, with its multiple structures with overlapping mandates. However, international and transnational communities of civil society actors play a key role in advocating for processes and practices of global governance that are equitable and accountable.

The deepening of globalisation precipitated important geopolitical developments and broad shifts in power from governments and state-based institutions towards global institutions and increasingly powerful transnational private actors. The deregulation of the financial sector and the increased commercialisation and privatisation of national and global economic systems shifted global governance processes towards increasingly hidden negotiations conducted through an array of bilateral, plurilateral, and multilateral trade and investment agreements. The emergence of multi-stakeholder forums and public–private partnerships (PPPs) further transformed global governance.

These changes have been mirrored in the sphere of GHG, with a relative weakening of the WHO and a corresponding shift of power and influence to the WB and a range of global health partnerships (GHPs). Since 2000, an increasing percentage

of the DAH has flowed through multi-stakeholder partnerships, with the combined expenditure of the Global Fund and Gavi eclipsing that of both WHO and the WB. Although WHO retains its mandate to act as the “directing and coordinating authority on international health work”, its increasing dependence on conditional grants has eroded its independence and autonomy, placing it more under the influence of major governmental and private funders. The rapid growth in the number and type of global health organisations, partnerships, and initiatives has also made GHG more complex, with less clarity about where responsibilities lie and how lines of accountability operate.

The past five years, however, have seen additional changes and new challenges to the system of GHG, precipitated by the COVID-19 pandemic and its impacts, and the later turmoil caused by the US’s defunding of DAH and its withdrawal from the WHO. This has been accompanied by additional cuts to DAH made by other countries, the emergence of a major debt crisis affecting many countries in the Global South, and increasing calls for international financial capital to help fill public financing gaps in the quest to attain UHC.

DAH has, in fact, undergone profound changes including in the form of structural shifts in funding and recipients, a resource allocation mismatch, and headwinds on account of geopolitical shifts. Between 1990 and 2020, DAH grew about fivefold, accompanied by an increase in funding from private sources and funding channelled through the GPPPs (such as Gavi and the Global Fund). The distribution of funds across countries has seen a considerable reallocation, with the share of DAH going to low-income countries (LICs) dropping from 61% to 36%, and the share of LMICs increasing from 23% to 49%, between 2000 and 2019 (Centre for Healthy Development, 2025). A large amount of DAH has been focused on communicable diseases despite the growing burden of non-communicable diseases (NCDs). With a mere 5% and 3% of the preventable disease burden in LICs and LMICs, respectively, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) consumed 18% of total DAH in 2019. NCDs received 2% to 3% of global DAH, while responsible for nearly 40% of the avoidable disease burden in these same countries (Center for Healthy Development, 2025).

The US withdrawing from multilateral frameworks and increasingly leveraging foreign aid as a tool for geopolitical strategy has disrupted the global health financing system, along with the retreat of traditional Western donors. Aid to Southeast Asia is likely to drop by USD 2 billion by 2026 (Lowy Institute, 2025). In this changed context, both South and Southeast Asia are witnessing a growth, albeit limited, in “South–South” funding.

All this has created an impetus for a reappraisal of the systems of GHG and the role of regional health governance and cooperation. In addition, there is a particular appetite for seeing how the current turmoil in the system can provide an opportunity for countries and regions in the Global South to build a system of global and regional health governance that better suits their needs and priorities.

Asia's role in GHG is becoming increasingly significant as the region grows in economic weight, political influence, and technical expertise. Countries such as India, China, Indonesia, Japan, South Korea, Thailand, and Singapore are now central to global supply chains, pandemic response capacities, digital health innovations, and South–South cooperation. Asian countries have engaged actively in G20 processes, debates on vaccine equity, intellectual property (IP), digital public goods, and traditional medicine, signalling a stronger interest in shaping global health norms. Yet this influence remains uneven and under-realised: Geopolitical tensions, concerns about sovereignty, variable institutional capacity, and fragmented regional platforms limit the region's ability to project a coherent voice. Existing sub-regional bodies (ASEAN, SAARC, and BIMSTEC) and numerous non-governmental networks contribute to cooperation, but thematic inconsistencies, geographical silos, and weak evidence-to-policy pathways constrain collective action. The Asian region, encompassing both South and Southeast Asia, thus occupies a distinctive space within the Global South's positioning, one that sets it apart from other regional groupings. From an institutional standpoint, the absence of a consolidated stance stands contrary to efforts of African solidarity emerging from the African Union and Africa Centres for Disease Control and Prevention (Africa CDC), and Latin American consensus expressed through the Pan American Health Organization (PAHO). It instead signals a lack of 'collective' Asian engagement globally and the limited potency of the 'Asian voice'.

There is a strong acknowledgement within the region of the necessity of health cooperation, particularly post-pandemic. Civil society as well as governmental actors have recently spoken to this need: The Union Health Minister of India, speaking at the WHO SEARO office in New Delhi (December 2025), described the newly inaugurated building as a symbol of the region's shared aspirations and collective resolve. He stressed India's ongoing commitment to strengthening regional and global health cooperation, noting that shared public health challenges call for coordinated action across nations (Press Information Bureau, 2025). This sentiment has been echoed by key stakeholders in the South and Southeast Asian region. At the 48th ASEAN Summit (Cebu, the Philippines, May 8, 2026), the 11 ASEAN leaders reaffirmed their commitment to strengthening regional healthcare cooperation and building more resilient public health systems amid growing health and pandemic threats across Southeast Asia (ASEAN, 2026).

Given Asia's growing relevance and the diversity of health system expertise across the region, stronger regional governance mechanisms could enable more effective pooling of resources, clearer articulation of shared priorities, and a more sustained and coordinated contribution to the global health architecture.

Nonetheless, the South and Southeast Asian regions exhibit different characteristics when contextualised within their historical and institutional trajectories. They present sharply contrasting political economies that shape their regional health governance. Southeast Asia, which is institutionally centred on ASEAN, has relatively balanced power dynamics despite the strain of regional competition between the US and China,

carrying significant implications for Indo-Pacific geopolitics (Global-Is-Asian Staff, 2026). That, along with higher average incomes and export-led growth, creates a situation of genuine interdependence that can translate itself into firmer regional commitments towards human capital development, including education and health (WB, 2019). South Asia, by contrast, is dominated by India, which accounts for roughly 80% of the region's gross domestic product (GDP). However, intra-regional trade within South Asia accounts for just under 6% as a share of its total global trade. (WB, 2018). As a result, the region remains the least economically integrated (J. Singh, 2025). Acute economic asymmetries and an inward-looking perspective over fears of national sovereignty tilt the region towards an individualistic, rather than a communitarian approach towards health. These variations contribute to the level of trust embedded within their regional institutions and how cooperation is catalysed as a collective endeavour vis-à-vis the region.

Yet, when it comes to engaging with the same set of institutions (the WHO, WB, ADB, etc.) and bargaining power, both regions occupy structurally similar positions in the GHG landscape, especially at an aggregate level. While there exists internal heterogeneity within the region, with countries like Singapore, Thailand, and India having stronger negotiation capacities, that is not true for all the constituent units within the region.

Taken together, South and Southeast Asia are not merely adjacent but structurally linked—predominantly a mix of donor-dependent and transitioning middle-income states. Shared patterns of epidemiological and demographic transitions, marked by overlapping trade and labour migration corridors, zoonotic spillover zones, and unfinished infectious disease agendas blur the neat distinction between the two regions. From an institutional perspective, cross-cutting bodies like BIMSTEC and an overlap in the WHO ROs mean that weak institutionalisation in one will also become a vulnerability for the other. Uneven institutionalisation as a gap in governance is thus worth studying as a single problem—to showcase how interconnected the risk landscape is.

Formal health governance requires not just systems of formal governance rooted in governmental and intergovernmental structures, but also non-governmental and informal systems of cross-border communication and collaboration through academic and research institutions, think tanks, CSOs, patient and consumer groups, local and regional businesses and manufacturers, and journalistic and media organisations.

Such intra-regional networks do exist across South and Southeast Asia. Not surprisingly, however, considerable variation exists in the scope, thematic focus, geographic coverage, and overall impact of existing networks. Geographically, these are spread across South Asia, Southeast Asia, and Asia Pacific. Table A-1 illustrates the range of non-governmental platforms in the region along with their thematic focus. Apart from the sub-regional platforms, Asia-wide platforms such as the Prince Mahidol Award Conference (PMAC) are issue-agnostic platforms for

countries across Asia. The variation in their thematic focus spans those that are agnostic to health issues but focus on system strengthening, and those focused on addressing specific health challenges or multiple health issues. The functional focus varies across knowledge sharing, advocacy, and capacity building.

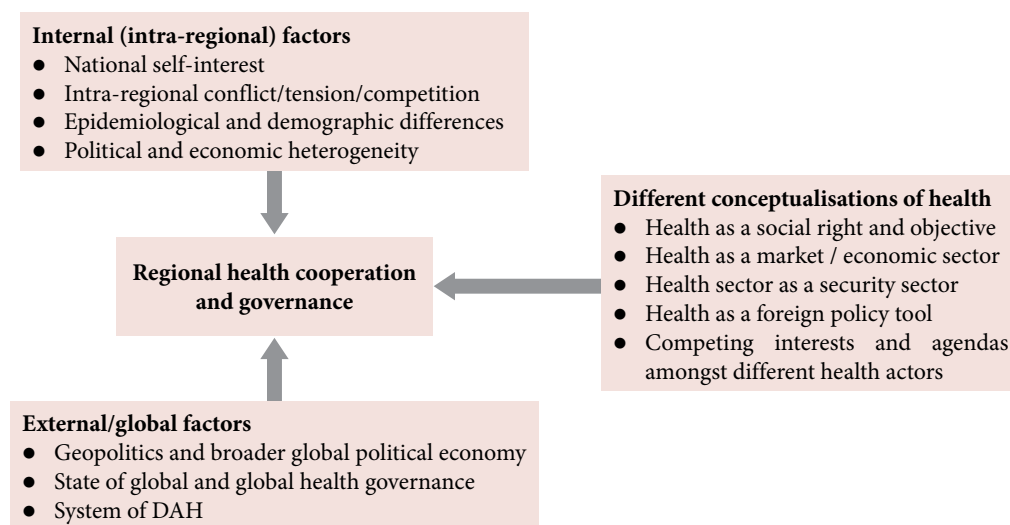
There are few that are large enough to meaningfully represent the region, or sub-regions such as South and Southeast Asia. Fragmentation across geographic scope, membership, and thematic focus has constrained their ability to engage with the overarching issue of how the region as a whole engages with institutions of GHG. This highlights the need to strengthen these networks.

1.1 Framework for Conceptualising and Assessing Regional Health Governance

Assessing current or future forms of global and regional health governance is not straightforward. Regional health governance, for example, is shaped by multiple factors that are both internal to the region and external or exogenous. In terms of the former, these factors include national perspectives on regional cooperation, the degree and nature of political, economic, social, and epidemiological heterogeneity across a region, and the presence of political tensions or even conflict between nations within a region. External factors include shifting geopolitics and changes to the wider architecture of global governance and development financing.

Finally, as shown below, any assessment of the effectiveness of regional health governance will also depend on how the health sector is conceptualised as a public policy domain, and on how the different functions of a health sector are valued relative to each other.

Figure 1: Framework for Assessing Regional Health Governance



Source: Authors' compilation.

Note: DAH = development assistance for health.

This paper examines regional health governance and GHG from the perspective of countries in South and Southeast Asia. It aims to inform discussions on how stronger regional health governance could allow countries in the region to better contribute to and improve the system of GHG; ensure that South and Southeast Asian needs and perspectives are better represented within GHG mechanisms; reduce reliance on external funding and expertise; enable more effective pooling of regional resources and expertise; promote intra-regional health equity; and contribute to building trust, shared prosperity, and peaceful coexistence among nations.

The paper is structured as follows: Section 2 explores the governance, structure, and financing of the WHO and its ROs. Section 3 looks at the expanding mandate and financing modalities of development banks (WB, ADB, and AIIB). Section 4 analyses the nature of engagement between the GPPPs (Global Fund, Gavi, and CEPI) and countries in South and Southeast Asia. Section 5 unpacks the role of regional governance mechanisms in the region (ASEAN, SAARC, and BIMSTEC) and in health. Section 6 highlights the growing relevance of non-regional platforms for international health cooperation, including the G77, G20, and BRICS+. Section 7 concludes the paper with a Strengths, Weaknesses, Opportunities, and Threats analysis of the overall architecture.

2. World Health Organization

2.1 WHO Mandate and Structural Constraints

WHO occupies a unique position in global governance, serving as the principal normative and standard-setting authority in global health while enjoying a certain level of legitimacy. Moreover, its intergovernmental structure, which grants all Member States equal voting rights in decision-making processes, distinguishes it from many of the institutions that have emerged in GHG. Its Constitution establishes WHO 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.

Within this framework, WHO has used its treaty-making powers to establish treaties and regulations such as the International Health Regulations (IHR) and the Framework Convention on Tobacco Control (FCTC). As the first legally binding global health treaty, the FCTC has been widely credited with accelerating regulatory reforms and contributing to declines in tobacco use, particularly where domestic law was initially weak (Puska, 2018). Following that, in 2005, the revised IHR created binding legal duties for States Parties that voluntarily sign on to the treaty. While the IHR are binding under international law, WHO's enforcement relies mainly on normative tools, such as peer reporting, public naming, technical assistance, and diplomatic pressure, rather than coercive measures. Nevertheless, the unanimous adoption of the IHR (2005), catalysed by the severe acute respiratory syndrome

(SARS) epidemic, is said to have sparked a renaissance in global health lawmaking, uniting nations through global health diplomacy (Puska, 2018).

WHO also has the capacity to influence so-called “soft laws” (Ruger & Yach, 2009). The Model List of Essential Medicines (WHO, 2025e) functions, for example, as a global reference for national medicines policy and influences procurement and price negotiations in LMICs. The International Code of Marketing of Breast-Milk Substitutes (WHO, 1981), adopted by the World Health Assembly (WHA) in 1981 (Wood et al., 2022), similarly sets standards that many states have then incorporated into domestic law.

Yet this unique mandate of WHO exists alongside significant political and economic constraints, leaving a gap between its mandate and its resources and autonomy. There is also a disconnect between its formal principle of one state one vote and decision-making and the reality of being highly influenced by a small number of powerful donors (Kickbusch & Reddy, 2015). The proliferation of global health institutions, development banks, vertical funds, philanthropic foundations, and PPPs has further diluted the WHO’s mandate, even though they lack the WHO’s formal authority and broad remit.

2.2 Organisational Structure and Governance

At the apex of formal governance is the WHA, composed of delegates from all 194 Member States operating on a ‘one-country, one-vote’ principle. Its key functions include setting policy and strategic direction; approving the biennial Programme Budget; appointing the Director-General (DG); and supervising financial policies. Agenda-setting power resides substantially with a 34-member Executive Board (EB), whose technically qualified members are designated by elected Member States for three-year terms. The DG, appointed by the WHA upon nomination by the EB, is the chief technical and administrative officer of WHO. There is an informal ‘gentleman’s agreement’ of rotating leadership between regions, but this has periodically been disrupted by great-power intervention, while the DG’s effective autonomy is constrained by financial dependencies.

WHO’s constitutional regional architecture is distinctive among UN agencies. The six ROs—the Regional Office for Africa (AFRO), the Regional Office for the Americas (AMRO/PAHO), the Regional Office for the Eastern Mediterranean (EMRO), the Regional Office for Europe (EURO), SEARO, and WPRO—exercise substantial autonomy and are highly responsive to the member states of their region. Regional Directors are elected by regional committees of member states’ representatives (WHO, 2025a), creating accountability flows that run horizontally to regional member states rather than vertically to Geneva (Clift, 2015). This structure creates responsiveness to regional specificities and protects against centralised imposition of policies and priorities. At the same time, it also fragments global-level governance, with ROs competing for resources and attention and developing separate technical capacities.

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 play a role as well. Pakistan, for example, is part of EMRO rather than SEARO and North Korea and South Korea are in different ROs.

SEARO comprises 10 member states as of early 2026 (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 (WHO, n.d.-a). Indonesia's transfer to WPRO (WHO, 2025) left India as the dominant member state (Tandon et al., 2021), followed by Thailand. WPRO's membership currently comprises 38 countries, areas, and territories, covering nearly 1.9 billion people (WHO, n.d.-b) with substantial diversity of high-income (Australia, New Zealand, Japan, South Korea, Brunei, Singapore), middle-income (China, Mongolia, Malaysia, Indonesia, Laos, the Philippines, Vietnam), and small island developing states, all with distinct health system challenges. The diverse membership presents WPRO with a unique set of challenges and opportunities (WHO, n.d.-k). While high-income countries with advanced health systems, such as Japan, necessitate a focus on innovation, sophisticated data governance, NCDs, and ageing populations, LMICs, including small island states, require dedicated efforts to address foundational public health issues such as isolation, resource gaps, and high vulnerability to NCDs (Ridlo, 2025).

Therefore, while the key challenge for SEARO is to scale up provision for UHC in diverse and often low-resource settings, WPRO membership continues to grapple with a complex array of issues, including rapid demographic shifts and climate-related health risks, particularly affecting small island nations (WPRO, 2025).

The exercise of influence in the region is more than just hierarchical. It is wielded through three subtle mechanisms (Clift, 2013): financial leverage (Bevan, 1998), global representation, and policy articulation (WHO, 2025c). In SEARO, India, owing to the scale of its population, acts as the principal gravitational force (Tandon et al., 2021), while Thailand leverages its domestically successful and lauded UHC system as soft power (Pechmee, 2025). In WPRO, China—through its geopolitical and economic weight—alongside Japan and Australia exerted control by providing large voluntary contributions (VCs) to the WHO. The earmarked nature of these contributions has a direct impact on the regional operational priorities (KFF, 2025). On top of that, by acquiring seats on the global WHO EB, these larger nations further ground their control in shaping organisational mandates (WHO, 2025d). The regional agenda is thus highly influenced by the financial and political gravity of a few key states.

WHO's Country Offices provide operational presence in member states, with variable presence and size across countries. Country Office heads are appointed by the WHO Director-General following consultation with the Regional Directors and host governments, procedures that create multiple lines of accountability but diffused authority. In practice, Country Offices operate primarily under Regional

Office oversight, with Geneva maintaining strategic and donor relationships (WHO, n.d.-j, 2005). Nonetheless, Country Offices may find themselves balancing regional and headquarters priorities against national health needs.

2.3 Funding and Budgets

WHO is financed through two primary mechanisms: assessed contributions (ACs) and VCs. ACs are mandatory membership fees paid by all member states and currently constitute less than 20% of the Organization's total budget (WHO, n.d.-c).

ACs are determined using a formula based primarily on each nation's gross national income (GNI), with adjustments for factors like debt burden and population size. By design, ACs give WHO the independence and financial stability to fulfil its mandate. Yet the level of ACs has been effectively frozen in nominal terms for decades, even though global health challenges have multiplied. The result is that WHO's core budget has shrunk in real terms and relative to global health spending, while resources have shifted to voluntary funding channels. The current pattern of funding reflects a major transformation in the last 3–4 decades, when 80% of funding came from ACs.

Since 2020, there have been concerted efforts to increase member state ACs. The 20% AC increase approved for 2024–2025 (WHO, n.d.-e), and the second 20% increase (WHO, 2025b) coinciding with the January 2025 US withdrawal, are moves in this direction, but given the low baseline, even doubled, ACs remain below levels that would restore genuine multilateral control over strategic direction.

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

- **Core voluntary contributions** (CVCs) are unconditional and account for 6.6% of all VCs.
- **Thematic contributions** are earmarked for broad, WHO-defined strategic areas (e.g., UHC, health emergencies) and account for 6% of all VCs.
- **Specified contributions** are earmarked to a specific project, geographic area, and timeframe, and represent 87% of all VCs.

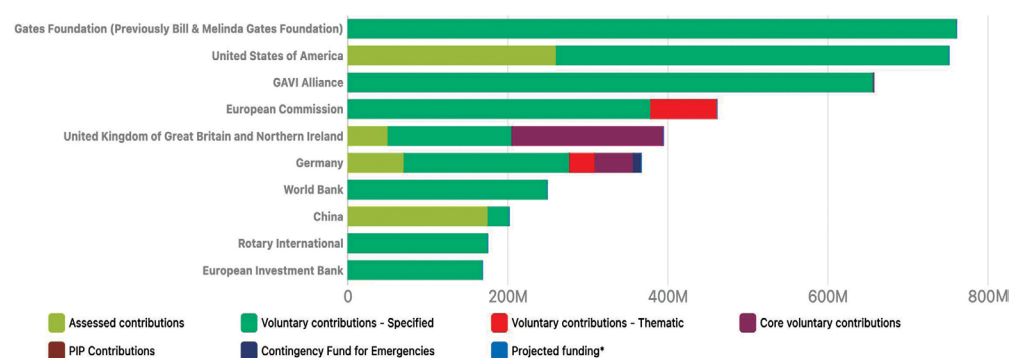
Notably, this structure is not merely a funding mechanism but rather a governance instrument. When 87% of voluntary funding carries specified conditions, WHO's strategic and independent planning capacity is constrained, and it risks functioning, in effect, as a project implementation agency for its major donors.

Furthermore, WHO's funding exhibits a significant donor concentration, with a small number of funders accounting for a large share of resources. For the 2024–2025 biennium, five funders (Gates Foundation, US, Gavi, the European Commission

[EC], and the United Kingdom [UK]) accounted for approximately 35% of total resources (Figure 2) (WHO, n.d.-i). The withdrawal of the US in January 2025, which had provided roughly 15% of total resources, prompted immediate 25% budget cuts across the organisation, highlighting the fragility of the current financing structure and the limited cushion provided by ACs. The 2024–2025 AC increases, while welcome, remain too modest and too late to overcome this dependency on the US.

The concentration visible in Figure 2 has significant systemic implications. Donor preferences, shaped by domestic political constraints, philanthropic strategy, or corporate partnership interests, can exert considerable influence over programmatic priorities, at times diverging from epidemiological burden or member state expressed needs. Issues such as health equity, health systems strengthening, and social determinants, where the WHO holds comparative advantage and constitutional mandate, tend to receive less funding relative to disease-specific interventions that are more amenable to metric-driven, time-limited projectisation.

Figure 2: Top Ten Funders for the 2024–2025 Biennium



Source: World Health Organization (n.d.-i).

Note: Currency in USD. PIP = Pandemic Influenza Preparedness.

WHO's budget itself is split into three main sections (see Table 1). The largest component is the Base Budget, which is allocated in accordance with the strategic goals of the current Fourteenth General Programme of Work (GPW 14). This component has the broadest participation of contributors within 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), typically structured as partnerships with other funders. The third component is Emergency Operations and Appeals, which caters to responses to disasters and outbreaks. Although this area has grown, it remains episodic and unpredictable in nature. This segmented budgetary structure has implications for how WHO pursues its mandate. The Base Budget supports comprehensive, sustained work, yet faces constraints from its financing mix. Emergency operations address immediate needs but can shift attention toward shorter-term priorities. Special Programmes maintain technical capacity through partnership arrangements that involve additional governance structures.

Table 1: WHO 2024–2025 Programme Budget: Components, Financing Sources, and Governance Arrangements^a

Budget Component	Approved Budget 2024–2025 (USD)	Main Financing Source(s)	Governance/ Budgetary Effect
Base budget^b	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.
Special programmes	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	1,000 million (14.6%)	Mainly specified VCs and appeals	Appeal-based financing is highly contingent and reactive.

Source: World Health Organization (2026, 2025).

Note:

^a WHO’s 2024–2025 budgetary documentation includes four segments: base budget, polio eradication, special programmes, and emergency operations. For clarity of analysis, this table excludes the polio component (USD 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.

^b 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).

AC = assessed contribution; VC = voluntary contribution; WHO = World Health Organization.

In the case of WHO’s ROs, the financial contribution of South and Southeast Asian nations to the WHO remains 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. Except for Bhutan, the Maldives, Brunei, and Myanmar, all countries provide VCs of varied sizes/in varied amounts in addition to their ACs, although none offer unrestricted VCs.

The disparities are striking. India, representing nearly 18% of the world’s population, contributes 1.04% of the total AC and 1.72% of the WHO’s overall budget, only

a fraction of its demographic weight. Collectively, SAARC nations account for nearly a quarter of the global population (24.2%) but contribute only 2.6% of the WHO's budget. ASEAN presents a more varied picture: for example, Singapore demonstrates contribution ratios that exceed its proportional demographic weight, while populous Indonesia and the Philippines maintain modest proportional engagement. Timor-Leste presents an interesting case: minimal AC paired with disproportionately elevated VC (USD 1.7 million), suggesting a preference for a targeted approach. Collectively, ASEAN nations, while comprising 8.5% of the world's population, contribute 2.1% of the WHO's ACs and 0.49% of its total budget.

This pattern suggests both strategic calculation and institutional caution. Beyond shaping issue prioritisation, 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 channelling of these contributions reveals varying models of engagement. India and Indonesia direct most VCs to their own country offices, embedding WHO operations within national health systems—a form of deep operational partnership, albeit one that keeps resources under national oversight. The Philippines directs most to the WPRO regional office, signalling a preference for regional proximity. Malaysia sends over 90% to the WHO headquarters, suggesting a focus on engagement at the centre. Thailand splits contributions between the country offices and ROs, reflecting a diversified approach. The cumulative effect is that significant resources flow outside WHO's centralised allocation mechanisms, which can complicate governance and constrain the organisation's ability to distribute funding based on equity or need. There is, of course, a trade-off between the flexibility, oversight, and country ownership offered by voluntary funding to countries like India and Indonesia, and the risk that earmarking by big donors influences institutional priorities. However, the logic and incentives for funding patterns vary across countries, and therefore we do not see a uniform preference.

Budget allocations to regions are made through a complex process of negotiation that takes into account multiple factors, including population size, health needs, and the preferences of donors as expressed through their VCs. Often, budgets submitted by ROs to the WHO headquarters are not fully funded. 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.

Finally, at the level of the country offices, the structural separation across SEARO and WPRO affects the ability of these countries to coordinate and engage with WHO. The institutional division creates practical challenges in financing, policy coordination, and health delivery for individual member states. Data from five countries (India, Thailand, Indonesia, Malaysia, and the Philippines) illustrate different dimensions of the challenge (see specific country data in the unabridged report). Crucially, all the countries show a long list of donors providing VCs of

varying amounts that are tied to particular themes or projects (Blandina et al., 2026; WHO, n.d.-g).

The financing landscape in these countries is one of multiple, diverse donors. Each donor has its own priorities and requirements, needing significant administrative capacity to align with national health planning. As well, national governments contribute varying amounts to the WHO country office, making some more dependent on headquarters or external funding. Managing this complexity without domestic financing buffers or regional risk-sharing mechanisms leaves some countries (such as the Philippines, for example) particularly exposed to donor priority shifts. Regional pooling would be especially valuable here: collective negotiation with common donors, shared administrative platforms to reduce transaction costs, and mutual support arrangements that buffer sudden funding transitions. Experience from Malaysia points to different trade-offs in funding models: stability through assessed contributions versus scale and flexibility through diverse external partnerships. Optional regional mechanisms, such as formalised South–South funding platforms or shared technical assistance pools, could supplement core funding without disrupting the predictability that assessed contributions provide.

Table 2: Assessed and Voluntary Contributions of SAARC and ASEAN countries in 2024–2025^a

Country	Country's AC 2024–2025 (USD) ^b	Country's VC 2024–2025 (USD)	Total WHO ACs for 2024–2025 (USD)	Total WHO Budget 2024– 2025 (ACs and VCs) (USD)	Percentage of Country AC to Total WHO's ACs (%)	Percentage of Country Total Contributions to WHO's Total Budget (%)	Percentage of World Population (2025) (%) ^c
SAARC			1,14,83,00,000	6,83,40,00,000			
Afghanistan	71,300	5,26,745			0.01	0.01	0.54
Bangladesh	1,14,830	19,23,000			0.01	0.03	2.13
Bhutan	11,880	N/A			0.00	0.00	0.0097
India	1,19,89,000	10,52,75,000			1.04	1.72	17.78
Maldives	47,540	N/A			0.00	0.00	0.0064
Nepal	1,14,840	10,121			0.01	0.00	0.36
Pakistan	13,54,750	5,59,00,000			0.12	0.84	3.12
Sri Lanka	5,16,770	1,58,230			0.05	0.01	0.28
ASEAN							
Brunei	2,49,560	N/A			0.02	0.00	0.0057
Cambodia	83,190	3,53,982			0.01	0.01	0.22
Indonesia	63,05,000	13,64,000			0.55	0.11	3.47
Laos	83,190	2,07,811			0.01	0.00	0.096
Malaysia	39,96,000	18,066	0.35	0.06	0.44		
Myanmar	1,18,830	N/A	0.01	0.00	0.66		
The Philippines	24,35,000	13,19,694	0.21	0.05	1.42		
Singapore	57,88,000	32,98,200	0.50	0.13	0.07		
Thailand	42,26,000	5,24,687	0.37	0.07	0.87		
Timor-Leste	11,880	17,03,000	0.00	0.03	0.017		
Vietnam	10,68,000	1,96,924	0.09	0.02	1.23		

Source: World Health Organization (n.d.-h, 2024a); Worldometer (n.d.).

Note:

^a WHO's funding portal categorises 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 harmonised real-time country-level account.

^b Data from the World Health Organization (2024).

^c Population data from Worldometer (n.d.).

AC = assessed contribution; ASEAN = Association of Southeast Asian Nations; SAARC = South Asian Association for Regional Cooperation; VC = voluntary contribution; WHO = World Health Organization; N/A = Not Available.

Table 3: Regional Office and Headquarters Budgets for 2024–2025^a

Biennium	RO	Total Population	Total Regional Budget (USD)	Total WHO Budget (USD)	Share of Regional Budget over Total Budget (%)	Per Capita Budget (USD)
2024–2025	AFRO	~1,29,89,16,859	1,60,06,00,000	6,83,40,00,000	23.42	1.23
	PAHO	~1,04,62,53,866	30,86,00,000		4.52	0.29
	EMRO	~93,77,76,131	95,24,00,000		13.94	1.02
	EURO	~92,00,00,000	40,96,00,000		5.99	0.45
	HQ	N/A (Global Secretariat)	1,67,86,00,000		24.56	N/A
	SEARO	~1,84,69,84,672	59,23,00,000		8.67	0.32
	WPRO	~1,91,71,68,353	42,60,70,000		6.23	0.22

Source: World Health Organization (n.d.-f).

Note:

^a The total WHO budget aligns with figures published in the Budget Portal. The sum of regional budgets presented here is USD 5.97 billion, leaving USD 865.9 million (12.67%) unallocated, likely reflecting cross-cutting programmes, contingency funds, or other central allocations not included in this table. 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.

AFRO = Regional Office for Africa; EMRO = Regional Office for the Eastern Mediterranean; EURO = Regional Office for Europe; HQ = headquarters; PAHO = Pan American Health Organization; RO = regional office; SEARO = Regional Office for South-East Asia; WHO = World Health Organization; WPRO = Western Pacific Regional Office; N/A = Not Available.

2.4 What’s Next for WHO?

Three broad trends emerge from the above analysis. One, the fragility of the WHO’s financing architecture and its implications. Two, the effectiveness of the WHO’s regional structures. Three, WHO’s role and comparative advantage.

Financing Architecture and Its Implications

Presently, the countries of both SAARC and ASEAN provide relatively little financial commitment to the WHO. SAARC nations, which account for nearly a quarter of the global population, contribute a mere 2.6% of the WHO’s total budget. Collectively, ASEAN nations, while comprising 8.5% of the world’s population, contribute 2.1% of the 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 the WHO’s overall budget.

The financing architecture reveals systemic fragility. Globally, the 80% reliance on VCs (87% tightly specified) constrains strategic planning. When 87% of voluntary revenue is tightly earmarked, it dictates organisational policy. This operational constraint limits the WHO’s strategic independence, potentially reducing it to a project delivery arm for major donors. The US withdrawal prompted immediate 25% budget cuts, exposing limited resilience. Regionally, the SEARO/WPRO

division fragments Asia's collective weight: serving 3.8 billion people (47% of the world population) yet receiving only 14.9% of the WHO's budget combined. Nationally, country offices face operational fragility: India's 25-plus donor complexity, Thailand's 52% post-pandemic budget contraction, the Philippines' sudden 40% decline, and Indonesia's pharmaceutical industry funding all illustrate how external dependency creates sustainability risks. The absence of domestic government contributions in the Philippines (0%) and minimal contributions in Thailand (<5%) contrast sharply with India's 50% self-financing, revealing uneven national ownership across the region. With extensive external funding, donor political and corporate interests often dictate global health funding, potentially at the cost of actual local needs. This dilutes the WHO's core mission—strengthening health systems and promoting equity—while overfunding narrow, disease-specific projects that offer quick, measurable metrics.

Regional Structures

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 ROs. 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.

The pattern of differential AC and VC financing, relative to population figures, discussed above, suggests both strategic calculation and institutional caution. Beyond shaping issue prioritisation, 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 channelling 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 offices and ROs (Blandina et al., 2026) (see specific country case studies in the unabridged report).

Significant resources thus flow outside WHO's centralised allocation mechanisms, which can complicate governance and constrain the organisation's ability to distribute funding based on equity or need.

Role and Comparative Advantage

Thus, the WHO's ability to function has long been affected by divergent state interests, the rise in influence of other global health organisations, and the heavy reliance on specified VCs. This leads to a patchwork of donor-aligned projects and programmes

coexisting with critically underfunded core activities, creating imbalances across the organisation's mandate. It also signals the clear influence of the major donors over the way priorities and plans are translated into actual funded activities, an issue affecting all levels of the WHO's organisational structure. Decentralised resource flows outside the WHO's allocation framework compromise institutional oversight and restrict equitable, needs-based funding distribution.

Despite these constraints, WHO retains unique constitutional powers: binding legal instruments, global health standards, and technical expertise across 194 member states. The case studies confirm that WHO country offices serve as essential channels for international health resources, delivering USD 146 million in India and USD 67 million in Bangladesh, which would be difficult to replicate bilaterally. The 2025 WHA decision to increase assessed contributions by 20% signals enduring member state confidence, even amid US withdrawal. However, without further intervention, current trends threaten effectiveness. Donor fragmentation may accelerate as major powers pursue bilateral health diplomacy outside multilateral frameworks. The case studies show this could already operate at the country level.

In this crowded landscape, WHO's comparative advantage lies in its standard-setting role and its capacity to embed rights-based, equity-oriented norms into global health law and policy. The central question is whether ongoing reforms will reinforce this distinctive authority or further subsume WHO into a donor-driven architecture that increasingly weakens its role as custodian of the right to health. WHO's increasingly close cooperation with the International Monetary Fund (IMF) and WB sharpens this tension (WHO, 2024b). Alignment with macrofiscal surveillance and health financing agendas offers policy coherence and access to resources, potentially extending the WHO's norms on UHC and equity through loan conditionalities and country programmes. But it also risks entrenching a narrow, technocratic vision of "fiscally sustainable" health that subordinates the right to health to macroeconomic stability and investor confidence, especially in LMICs facing debt distress and austerity ("Financing Pandemic Recovery, Prevention, Preparedness and Response", n.d.). How these relationships are structured will help determine whether WHO projects its normative authority into economic decision-making, or whether its legitimacy is instead used to endorse policy packages that constrain the very fiscal space needed for its member states to realise the rights WHO is mandated to uphold (Cullinan, 2025).

Yet these opportunities remain speculative. At this stage, it is unclear how countries from South and Southeast Asia view the WHO's future, whether they will pursue regional cooperation through existing structures, develop extra-WHO mechanisms, or continue fragmented bilateral engagement. Any efforts to strengthen regional health governance would need to consider how such efforts could simultaneously improve global-level governance, particularly for functions that cannot be accomplished regionally.

3. Development Banks (World Bank, Asian Development Bank, and Asian Infrastructure Investment Bank)

Development Banks are becoming increasingly influential actors in shaping health systems in South and Southeast Asia, with the WB, ADB, and AIIB providing health financing through various modalities, terms, and governance arrangements in the region.

3.1 Institutional Origins and Role in Global Health

Although each institution has followed a different trajectory, all three have expanded their engagement with health beyond their original mandates. Originally focused on post-war reconstruction and later development financing for infrastructure and poverty reduction, the WB is now a pivotal player in GHG. The WB's role in global health has evolved from that of a financing agency to increasingly 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) (Forster et al., 2020; Ruger, 2005; Ugalde, 1995).

ADB, in operationalising its engagement with health, has been gradually moving away from its enduring focus on large-scale infrastructure projects (Economic Research Institute for ASEAN and East Asia [ERIA], 2017). Over the decades, it has built long-standing development partnerships with Bangladesh, India, Indonesia, Malaysia, Nepal, the Philippines, Singapore, Sri Lanka, Thailand, and Vietnam (ADB, n.d.-b). Recently, it has adopted a more holistic approach that incorporates climate change and social policy, including health (ADB, 2018). 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. Its investment in health aims to advance UHC by strengthening the core building blocks of health systems: governance, financing, service delivery, and the health workforce (ADB, 2022a). ADB intends to double the share of health in its total commitments to 6–10% by 2030 (ADB, 2022a). 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 complementary sectors including sanitation, education, and transport, while also addressing cross-border challenges such as climate change, migration, and disease transmission (ADB, n.d.-d). To achieve these objectives, the ADB utilises a diverse toolkit for health, including policy-based lending (PBL) to support systemic reforms and investment projects to build infrastructure and digital health systems (ADB, n.d.-c). 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 marginalised groups, as seen in Bangladesh and Bhutan.

AIIB is a new MDB led by China, which began operations in 2016 and is tasked with supporting infrastructure development across Asia (AIIB, n.d.-a). It has more than 100 member countries from the region (excluding Japan) and beyond (AIIB, 2017). AIIB was seen as an alternative to established institutions like the WB, which had faced criticism for its unfavourable terms and conditionalities (Investopedia, n.d.). It has entered the health sector more recently, adopting its first health strategy only in 2024 (AIIB, 2024). Unlike the WB and ADB, it primarily frames health as a co-benefit of infrastructure financing.

3.2 MDB Financing and Strategic Approaches

The WBG comprises five institutions, but only three directly channel resources to developing countries and governments: the International Bank for Reconstruction and Development (IBRD), International Development Association (IDA), and International Finance Corporation (IFC). The other two (Multilateral Investment Guarantee Agency [MIGA] and International Centre for Settlement of Investment Disputes [ICSID]) primarily serve risk mitigation and dispute resolution functions.

The WB's governance structure links voting power to financial contributions. The US is the WB's largest shareholder and traditionally appoints the Bank's president (Toussaint, 2024). The other major shareholders are Japan, Germany, the UK, France, and increasingly China (WBG, n.d.-b).

On the other hand, a comparable but more regionally concentrated institution is the ADB. The ADB was established in 1966. It is owned by 69 member states, 50 of which are from Asia and the Pacific (ADB, n.d.-a). Its primary mandate is to promote economic growth and regional cooperation by financing development projects through loans and grants and providing technical assistance (ADB, 1965). 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 (ADB, 2025). 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.

Additionally, the AIIB's recent approach has shifted to a more collaborative one with the WB, including co-financing projects to combine strengths and reduce duplication (AIIB, n.d.-c). 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 artificial intelligence (AI) and telemedicine, and mobilising private capital.

3.3 Financing Instruments and Terms for Lending

The WB and ADB mainly provide a broader mix of loans and grants for both social sector and infrastructure projects. The AIIB, however, has a sharper focus on non-concessional loans for infrastructure financing, and also seeks to mobilise private capital alongside its own lending. The table below shows the comparative lending and grant volumes for each institution:

Table 4: Comparative Lending and Grant Volumes in South and Southeast Asia

	World Bank	ADB	AIIB
South Asia			
Grants (USD)	2.06 billion	10.0 million	–
Concessional (USD)	2.75 billion	1.42 billion	–
Non-Concessional (USD)	2.37 billion	1.05 billion	1.10 billion
Mixed (USD)	1.74 billion	330.4 million	–
Total (USD)	8.92 billion	2.81 billion	1.10 billion
Southeast Asia			
Grants (USD)	82.1 million	–	–
Concessional (USD)	35.0 million	140.0 million	–
Non-Concessional (USD)	3.26 billion	2.18 billion	2.36 billion
Mixed (USD)	1.81 billion	158.1 million	–
Total (USD)	5.19 billion	2.47 billion	2.36 billion

Source: World Bank Projects & Operations (n.d.); ADB (n.d.-e); AIIB (n.d.-e); authors' compilation.

Note: ADB = Asian Development Bank; AIIB = Asian Infrastructure Investment Bank.

The IDA is the WB's concessional arm, offering grants and low-interest, long-maturity loans to low-income, low-creditworthy countries, funded through periodic donor replenishments. IBRD lends at or near market rates to middle-income and credit-worthy lower-income countries, financed by bond issuance in international capital markets. IFC, the Group's private sector arm, finances commercially viable private projects with development impact, including a modest but growing health portfolio, and some LICs 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 (Reinsberg, 2017; WBG, n.d.-a, 2023a). The growth of WB trust funds accelerated in the 1990s and 2000s, and as of 2024, it was the trustee of 26 FIFs holding USD 37.2 billion in assets, with health-related FIFs accounting for approximately 51% of these assets (Heinzel & Reinsberg, 2024; Winters & Sridhar, 2017; WBG, 2024). Among these are the Global Fund, CEPI, International Finance Facility for Immunisation (IFFIm), and the Pandemic Fund.

AIIB's lending terms are structured quite differently from the WB's donor-funded, trust-fund-heavy model. 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 MICs rather than a traditional development bank. Its Special Fund Window (SFW) has been used only once for an interest-rate buydown in Cambodia (AIIB, n.d.-b), indicating that concessionality is a marginal feature. Generally, its approach tilts towards commercially attractive projects and PPPs to attract private investors.

3.4 MDB Financing and Country Contexts

Table A–2 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 USD 14.1 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 WB (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 (Tichenor et al., 2021).

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 programmes 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 and Myanmar, the current portfolio is mainly made up of grants and short-term emergency projects.

3.5 Financing Modalities and Fiscal Implications for Health

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.

ADB's regional health portfolio is quite distinct from the WBG's. ADB's currently active health funding in South and Southeast Asia is mostly for large operations that target whole health systems instead of isolated facilities. The loans and grants in Table A–3 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 USD 5.28 billion.

Concessional loans and ‘loan-plus-grant’ packages are concentrated in lower-income countries such as Bangladesh, Bhutan, the Lao People’s Democratic Republic (Lao PDR), and Sri Lanka. Larger MICs 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. See Table A–3 for the full list of projects.

Lastly, in AIIB’s case, while its role in the region follows a similar trajectory, the scale of its lending is smaller and often co-financed by the other two banks (AIIB, n.d.-c). Table A–4 lists AIIB’s health-specific lending in South and Southeast Asia. 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 USD 100–500 million for COVID-19 emergency response and health-system preparedness. In Southeast Asia, Cambodia has a USD 50 million project for immunisation and resilient health infrastructure, plus a USD 33 million loan for One Health livestock and value-chain investment. Indonesia has three major loans: a USD 250 million COVID-19 emergency response operation, USD 500 million in additional financing, and a USD 999 million health-system modernisation project, as well as a USD 226.4 million hospital construction and integration loan, mostly co-financed with the WB, ADB, and the Islamic Development Bank (IsDB). The Philippines has a USD 300 million vaccine-focused project to support its COVID-19 health-system enhancement (AIIB, n.d.-d).

In general, grants and concessional loans are tied to detailed plans with performance indicators (McIsaac et al., 2018; WB, 2011). Historically, WB loans and grants have been associated with neoliberal health sector reforms and the prioritisation of external debt payments. At present, there is a significant reorganisation at the WB 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 in more private investment, the WB proposes a greater merger of the IDA, IBRD, and IFC, with greater alignment around the objective of attracting more financial capital into the development sector.

3.6 MDBs’ Expanding Role in Health Systems Strengthening

Following the COVID-19 pandemic, MDBs have channelled larger volumes of health-related finance to South and Southeast Asia. WB documents show nearly USD 12 billion mobilised for COVID-19 in South Asia, including USD 2.5 billion for 15 health projects and support to over 23,000 facilities, part of a USD 31 billion

regional package that included about USD 1 billion for vaccine purchase and deployment (WBG, 2023b). Between 2020 and 2023, ADB committed roughly USD 6.9 billion for COVID-19 emergency and crisis response, effectively doubling its health portfolio in under four years (Asian Development Bank, Independent Evaluation Department [ADB IED], 2025), while the AIIB financed 22 health projects totalling about USD 4.87 billion within a year of launching its inaugural health strategy in December 2024 (AIIB, 2024 & AIIB, 2025).

The three banks also interact with each other. Co-financed operations, such as Indonesia's large health-system modernisation 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, 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 further implication concerns the governance of MDBs and the influence they exert over national health priorities. Across the WB, ADB, and AIIB, voting power remains closely linked to financial contributions, meaning that larger shareholders retain greater influence over institutional priorities and decision-making. AIIB was initially established as an alternative to the WB's governance model, reflecting China's growing economic influence and principles such as non-interference, moving away from the policy influence exerted by established MDBs. This raises broader questions about where countries, particularly smaller economies in South and Southeast Asia, can exercise meaningful voice and influence within MDB governance structures. At the same time, increasing collaboration between MDBs and global health institutions—such as the WB's role in hosting the Pandemic Fund (and WHO acting as the technical lead organisation) and its co-financing arrangements with organisations such as the Global Fund—suggests growing convergence within the global health financing architecture. However, the conditionalities attached to MDB loans and grants continue to shape national health policies and reform trajectories. While these may complement WHO priorities in some contexts, they may also create tensions where financing incentives and policy conditions do not fully align with WHO's normative guidance. Understanding how these institutions interact, and the implications for country ownership and representation, warrants further examination.

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 has not worked in areas such as UHC reforms, hospital PPPs, or vaccine manufacturing, which could help governments' negotiations with private investors and transnational corporate actors.

4. Global Public–Private Partnerships

The literature defines GPPPs 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 (Kopańska et al., 2024). Pooling resources from major donors, they expand access to vaccines and other priority health interventions. With large budgets, bureaucracies, and programmes operating across the world, they have also become influential actors in global health stewardship and in the production of global health guidelines and policies (Abu El Kheir-Mataria et al., 2024).

This section examines Gavi, the Global Fund, CEPI, and, more recently, the WB-hosted Pandemic Fund as key GPPPs shaping GHG (Table 5). While LICs and lower-MICs across South and Southeast Asia continue to receive significant financial support from these partnerships, several MICs have also begun contributing financially and assuming greater roles in GHG.

Table 5: 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, 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 COVID-19 Vaccines Global Access (COVAX).
The Global Fund	Established in 2002, the Global Fund pools public and private funds to finance programmes addressing HIV, tuberculosis (TB), and malaria. It functions as a financing mechanism for pooling international resources to support country-owned programmes combating the three diseases.
CEPI	CEPI, launched in 2017, mobilises public and private capital to accelerate vaccine development for epidemic-prone diseases.

Source: CEPI (2026); Gavi (2026); The Global Fund (2026).

Note: CEPI = Coalition for Epidemic Preparedness Innovations; COVAX = COVID-19 Vaccines Global Access; HIV = human immunodeficiency virus; IFFIm = International Finance Facility for Immunisation; TB = tuberculosis.

4.1 Evolution and Growing Role of Global Public– Private Partnerships

Over the past two decades, GPPPs have evolved beyond their original mandates of financing specific diseases and technologies into influential actors shaping GHG. Three interrelated developments have driven this evolution. First, GPPPs have developed strong bureaucratic secretariats as funding and staffing expanded over the past two decades. Second, they have increased financial autonomy from donors

by diversifying funding sources and introducing innovative financing mechanisms such as Gavi's IFFIm, which raises funds through vaccine bonds backed by long-term donor commitments. Third, they have expanded their mandates beyond their original focus areas to include areas such as health systems strengthening and pandemic preparedness (The Global Fund, n.d.-b). Inter-GPPP cooperation, with Gavi, the Global Fund, and CEPI increasingly working together, has further enhanced their influence.

The evolution of GPPPs is reflected in the changing roles of the major partnerships. Established in 2002, the Global Fund functions as a financing mechanism for pooling international public and private resources to support country-owned programmes addressing HIV, TB, and malaria. Having disbursed USD 69 billion since 2002, it has become one of the largest actors in global health (The Global Fund, n.d.-a). Similarly, Gavi, established in 2000, has evolved beyond vaccine procurement and financing to become a central actor shaping global immunisation policy through pooled procurement, innovative financing mechanisms such as IFFIm, and health systems support. CEPI, launched in 2017 following the Ebola epidemic, has expanded global investment in vaccine R&D for epidemic-prone diseases, while the WB-hosted Pandemic Fund represents a newer generation of GPPPs focused on financing pandemic preparedness and strengthening health security systems.

Increasing collaboration between these partnerships has further reinforced their role within the global health architecture. During the COVID-19 pandemic, Gavi, the Global Fund, CEPI, and other partners jointly established the Access to COVID-19 Tools Accelerator (ACT-A), with COVAX serving as its vaccine pillar. Although the limitations of COVAX exposed weaknesses within both the model itself and the wider system of GHG, ACT-A demonstrated the growing trend towards coordinated action across major GPPPs (Pushkaran et al., 2023). Likewise, the Pandemic Fund, launched in 2022 and hosted by the WB, was established to work alongside WHO, Gavi, and other partners, reflecting an increasing emphasis on coordination between governments, MDBs, UN agencies, and regional organisations in strengthening pandemic preparedness.

4.2 Financing and Governance Reforms in Global Public-Private Partnerships

Across GPPPs, declining financial commitments from traditional donors are driving significant reforms to financing models and governance arrangements. Rather than simply reducing programmes, organisations such as the Global Fund and Gavi are seeking to strengthen domestic ownership, improve sustainability, and integrate disease-specific investments within broader health systems.

The Global Fund illustrates this shift. Although its governance structure provides equal representation for donor and recipient constituencies alongside civil society and affected communities through its Board and Country Coordinating Mechanisms (CCMs), in practice major donors and private foundations continue

to exert disproportionate influence over strategic priorities and funding decisions (The Global Fund, n.d.-b). At the same time, the Fund's financing environment has become constrained. During its current replenishment cycle, the Global Fund has raised USD 12.654 billion, considerably below its USD 18 billion target as traditional donors including the US, UK, and France have reduced their contributions (The Global Fund, 2026; International Health Policies, 2025; Think Global Health, 2025).

These funding pressures have prompted important reforms. The Global Fund has revised its allocation formula based on countries' GNI per capita and disease burden, while introducing a strengthened Sustainability, Transition and Co-Financing Policy that requires recipient governments to increase domestic health investments alongside external grants (The Global Fund, 2026c). The Fund has also sought to move beyond its traditional role as a vertical disease financier towards providing more integrated support for health systems. The 2025 Memorandum of Understanding with the WB reflects this shift by aligning Global Fund grants with WB loans and national budgets to strengthen primary healthcare (PHC), laboratory services, supply chains, and human resources for health (HRH) (Health Policy Watch, 2026; WBG & The Global Fund, 2025).

Similar trends are evident within Gavi. Historically supported by major donors including the UK, the Gates Foundation, the US, and Norway (KFF, 2026), Gavi now faces a projected USD 2.5 billion financing gap for its 2026–2030 replenishment period following declining donor contributions (Gavi, 2025b). In response, Gavi has introduced significant reforms under its 6.0 strategy (2026–2030). To strengthen country ownership, the Alliance is replacing its traditional vaccine-by-vaccine financing model with a flexible multi-year “envelope financing” system, under which 90% of procurement funds will be allocated directly to national vaccine budgets. Operational reforms include reducing Secretariat overheads by 35%, streamlining the Partners' Engagement Framework to reduce duplication with WHO and the United Nations Children's Fund (UNICEF), and establishing a decade-long partnership with the ADB that will expand lending capacity by USD 100 billion, which includes support for health systems, immunisation programmes, and pandemic preparedness (ReliefWeb, 2025).

Collectively, these reforms demonstrate a broader shift across GPPPs away from stand-alone vertical financing mechanisms towards models that increasingly prioritise domestic ownership, sustainability, and integration with national health systems.

4.3 Countries' Changing Roles Within Global Public–Private Partnerships

A notable shift across South and Southeast Asia is the gradual evolution of countries from being purely recipients of GPPP financing towards assuming hybrid donor-recipient roles (Tables 6 and 7). While LICs and lower-MICs continue to rely heavily on external financing, several MICs have begun making financial contributions while simultaneously participating more actively in GPPP governance.

The Global Fund illustrates this transition. Countries including India, Indonesia, and Thailand now occupy hybrid donor-recipient positions, while Singapore participates as a donor despite not receiving support (Table 6). India represents the clearest example of this evolving role, having received USD 3.15 billion from the Global Fund while contributing USD 94 million and pledging a further USD 30 million towards the Eighth Replenishment (The Global Fund, n.d.-d). Indonesia has similarly received USD 1.71 billion while contributing USD 10 million, whereas Singapore has contributed USD 1.6 million and pledged a further USD 0.4 million despite not being a recipient (The Global Fund, n.d.-c, 2026a).

Table 6: Global Fund Recipients and Contributors from South and Southeast Asia

Country	Country Status	Total Funds Received (up to 2026) (USD)	Funds Contributed (up to 2026) (USD)	Pledges (8 th replenishment, 2026–2028) (USD)
India	Donor and recipient	3.15 billion	94 million	30 million
Indonesia	Donor and recipient	1.71 billion	10 million	10 million
Pakistan	Recipient	1.65 billion	Nil	Nil
Bangladesh	Recipient	998 million	Nil	Nil
Myanmar	Recipient	910 million	Nil	Nil
The Philippines	Recipient	802 million	Nil	Nil
Vietnam	Recipient	673 million	Nil	Nil
Thailand	Donor and recipient	633 million	27 million	Nil
Afghanistan	Recipient	380 million	Nil	Nil
Nepal	Recipient	345 million	Nil	Nil
Cambodia	Recipient	295 million	Nil	Nil
Laos	Recipient	190 million	Nil	Nil
Sri Lanka	Recipient	129 million	Nil	Nil
Timor-Leste	Recipient	38 million	Nil	Nil
Bhutan	Recipient	31 million	Nil	Nil
Malaysia	Recipient	20 million	0.13 million	Nil
Singapore	Donor	Nil	1.6 million	0.4 million
Brunei	Non-participant	Nil	Nil	Nil

Source: The Global Fund (2026b).

A similar pattern is emerging within Gavi. Although many countries across South and Southeast Asia continue to receive substantial Gavi support, a number have also begun contributing financially to the Alliance (Table 7). India has contributed USD 17 million between 2013 and 2025 and pledged a further USD 20 million under Gavi 6.0 despite receiving USD 3.15 billion in country-level support (Gavi, 2025b, 2025c). Indonesia has pledged USD 30 million despite having received USD 1.71 billion in support, while Singapore has pledged USD 1 million following earlier contributions through COVAX (Gavi, 2025b, 2025c). Although these contributions remain modest relative to those of traditional donors, they reflect an important shift in the region's role within GPPPs, with countries increasingly acting not only as beneficiaries but also as contributors to global health financing.

Table 7: Gavi Funding

Country	Cumulative Contribution to Date (USD)	Type	Pledges for Gavi 6.0 (2026) (USD)
SAARC			
Afghanistan	Nil		Nil
Bangladesh	Nil		Nil
Bhutan	5,000 (2020)	COVAX	Nil
India	17 million (2013–2025)	Direct Contribution	20 million
Maldives	Nil		Nil
Nepal	Nil		Nil
Pakistan	Nil		Nil
Sri Lanka	Nil		Nil
ASEAN			
Brunei	Nil		Nil
Cambodia	Nil		Nil
Indonesia	Nil		30 million
Malaysia	100,000 (2021–2025)	COVAX	Nil
Laos	Nil		Nil
Myanmar	Nil		Nil
The Philippines	1.2 million (2021–2025)	COVAX	Nil

Country	Cumulative Contribution to Date (USD)	Type	Pledges for Gavi 6.0 (2026) (USD)
Singapore	5 million (2021–2025)	COVAX	1 million
Thailand	Nil		Nil
Timor-Leste	Nil		Nil
Vietnam	1 million (2021–2025)	COVAX	Nil

Source: Gavi (2025a; 2025c).

Note: ASEAN = Association of Southeast Asian Nations; COVAX = COVID-19 Vaccines Global Access; SAARC = South Asian Association for Regional Cooperation.

This transition extends beyond financial contributions to participation in governance. The Global Fund’s governance model was designed to provide equal representation between donor and recipient constituencies alongside civil society and affected communities through its CCMs (The Global Fund, n.d.-b). Similarly, Gavi’s Board includes five implementing-country government seats and five donor-country government seats alongside other constituencies. Countries rotate periodically based on selected criteria and characteristics, with Indonesia, Bhutan, and Pakistan currently representing implementing-country constituencies alongside Japan and South Korea as donor representatives (Gavi, n.d., 2024). While these arrangements provide greater representation for recipient countries, in practice major donor governments and private foundations continue to exercise disproportionate influence over strategic priorities and funding decisions.

India occupies a particularly distinctive position within this evolving landscape. Beyond being both a donor and recipient, it represents Gavi’s primary source of global vaccine inventory. While India is a legacy beneficiary of USD 3.15 billion in direct country-level disbursements, Indian biopharmaceutical manufacturers provide a dominant share of Gavi’s vaccine procurement, making the Alliance a major procurement market for India’s pharmaceutical industry. Consequently, India’s engagement with GPPPs extends beyond development assistance, positioning it as a structural exporter of global immunisation solutions while simultaneously strengthening its role within GHG (Ramakrishnan, 2025).

4.4 Financing Transitions and Challenges for Middle-Income Countries

While GPPPs are promoting domestic ownership, the transition away from external financing remains uneven across South and Southeast Asia. Declining donor resources have prompted organisations such as Gavi and the Global Fund to tighten

eligibility criteria and strengthen domestic financing requirements. Although these reforms are intended to improve sustainability, they also create new challenges for countries transitioning from concessional support.

Under Gavi's revised eligibility policy, introduced in January 2026, only countries with a GNI per capita below USD 2,300 remain eligible for support (Gavi, 2026a). As a result, Afghanistan (currently in the initial self-financing phase), Cambodia, Lao PDR, Myanmar, Pakistan, Nepal, and Timor-Leste (currently in the preparatory transition phase) continue to receive Gavi assistance, while Bangladesh has entered the accelerated transition phase (Gavi, 2025a). However, recognising that many MICs continue to face significant burdens of vaccine-preventable diseases, Gavi has also introduced a middle-income country policy through which countries such as Indonesia and Vietnam continue to receive targeted support designed to prevent backsliding in immunisation coverage (Gavi, 2026b; MIC Support Mechanisms and Gavi 6.0, n.d.). India similarly continues to receive Gavi assistance for selected health systems strengthening initiatives (Ramakrishnan, 2025).

The Global Fund has adopted comparable reforms through its revised allocation formula and strengthened Sustainability, Transition and Co-Financing Policy, which encourage countries to progressively increase domestic investments while reducing reliance on external grants (The Global Fund, 2026c). Together, these reforms illustrate a broader shift across GPPPs towards increasing country ownership and reducing long-term dependence on external financing.

These reforms also expose an emerging 'transition trap' for several MICs within South and Southeast Asia. As countries graduate from concessional financing, they risk losing access to preferential GPPP pricing and grants before domestic health systems possess sufficient fiscal capacity to absorb these costs (Madan Keller et al., 2026). This challenge is particularly evident in countries such as Indonesia and Vietnam, which have largely transitioned from broad Gavi support yet continue to require targeted assistance to maintain immunisation coverage. Likewise, Bangladesh's accelerated transition illustrates the financial pressures associated with assuming greater domestic responsibility while continuing to face substantial public health needs.

Rather than representing a simple withdrawal of donor support, these evolving financing arrangements reflect an attempt by GPPPs to redefine their role—from directly financing vertical programmes towards supporting countries in building more sustainable and nationally owned health systems. Whether these reforms successfully strengthen domestic ownership without creating financing gaps will be particularly important for countries across South and Southeast Asia, where many governments continue to balance increasing fiscal responsibilities with persistent burdens of communicable diseases and growing demands for broader health system strengthening.

4.5 Expansion of Global Public–Private Partnership Mandates

A defining feature of GPPPs has been the expansion of their mandates beyond disease-specific interventions towards pandemic preparedness, health security, and broader health systems strengthening. While Gavi and the Global Fund have integrated health systems support into their financing models, relatively newer partnerships such as CEPI, COVAX, and the Pandemic Fund show how GPPPs are assuming wider responsibilities within the global health architecture.

Founded in 2017 following the Ebola epidemic, CEPI was established to mobilise public and private investment for vaccine and biologics development against epidemic-prone diseases. Initially supported by the governments of Norway and India, together with the Gates Foundation, the Wellcome Trust, and the World Economic Forum, its coalition has subsequently expanded to include governments from Indonesia, Malaysia, the Philippines, and Singapore. Although CEPI's direct investments within South and Southeast Asia remain comparatively modest, they have strategically focused on strengthening regional vaccine manufacturing capacity through investments of USD 15 million in Indonesia's Biofarma and up to USD 30 million in outbreak vaccine manufacturing at the Serum Institute of India (CEPI, 2023, 2024). Rather than financing service delivery, these investments seek to strengthen regional preparedness and manufacturing capacity for future epidemics.

The WB-hosted Pandemic Fund represents a further evolution of this model. Endorsed by the G20 and launched in 2022, the Fund provides grants and catalytic financing to strengthen countries' health security systems while encouraging greater coordination between governments, MDBs, WHO, Gavi, UN agencies, and regional organisations. Like CEPI, it reflects a broader shift away from financing individual disease programmes towards investing in collective preparedness and resilience.

Together, these developments illustrate how GPPPs are increasingly moving beyond their original mandates to address broader global public goods. Pandemic preparedness, regional manufacturing capacity, and health security have become integral components of the contemporary GPPP agenda, complementing more traditional investments in vaccines and disease control.

4.6 Governance Challenges in Global Public–Private Partnerships

The increasing influence of GPPPs has generated important governance challenges alongside their substantial contributions to global health. Although these partnerships have expanded access to vaccines, disease control programmes, and pandemic preparedness financing, their growing role within GHG has also shifted authority away from traditional multilateral institutions and towards increasingly autonomous transnational partnerships.

One of the principal concerns relates to the continued dominance of vertical programming. Despite recent reforms, GPPPs have historically been organised around specific diseases or technologies, resulting in siloed programmes with dedicated financing, procurement systems, and monitoring mechanisms (Williams & Wyner, 2017). While these vertical programmes have contributed significantly to achievements such as childhood immunisation and disease control, they have also fragmented national health systems by creating parallel reporting structures, duplicating administrative requirements, and encouraging governments to align national priorities with external funding opportunities rather than comprehensive health system needs (Singh, 2023).

Recognising these limitations, both Gavi and the Global Fund have begun introducing reforms that seek to reconcile vertical financing with broader health systems strengthening. Gavi's transition towards "envelope financing" and the Global Fund's partnership with the WB through "health compacts" represent important attempts to integrate disease-specific financing within national health systems rather than operating through parallel structures (WBG & The Global Fund, 2025). These reforms suggest an acknowledgement that sustainable health outcomes increasingly depend upon strengthening PHC, workforce capacity, and health systems rather than financing isolated programmes alone.

These developments also reflect a broader transformation within GHG itself. The growing prominence of Gavi, the Global Fund, and CEPI represents a shift away from the centralised UN-led architecture of the 20th century towards a more multi-layered system in which private actors, philanthropic foundations, and specialised partnerships exercise increasing influence. For South and Southeast Asia, emerging powers such as India and Indonesia are assuming greater ownership by becoming contributors to GPPPs while also supporting new initiatives such as the Pandemic Fund. Nevertheless, they remain embedded within financing models and governance arrangements that are shaped by major traditional donors and private actors.

This evolution creates a complex relationship with the WHO. While the WHO possesses the universal legitimacy to establish normative standards and regional priorities—including UHC and the growing focus on NCDs—its technical authority operates alongside powerful financing institutions capable of shaping implementation priorities through funding decisions (Centre for Social and

Economic Progress, 2026). The disproportionate influence of GPPP secretariats over WHO's more democratic governance processes therefore remains a concern. As health becomes embedded within broader trade, industrial, and geopolitical strategies, there is also a risk that WHO's technical leadership may be overshadowed by the market-shaping agendas of major GPPPs (de Bengy Puyvallée, 2024).

Ultimately, the future of GHG in South and Southeast Asia will depend on whether countries can move beyond being passive recipients or symbolic donors to become active architects of regional health governance. The increasing financial contributions of countries such as India and Indonesia, together with reforms promoting greater country ownership, provide opportunities for governments to align GPPP resources more closely with national health priorities. However, without deliberate efforts to strengthen national stewardship and ensure that external financing supports domestic priorities, there remains a risk that the health agendas of the region's 2 billion people will continue to be shaped by the priorities and performance indicators of increasingly influential transnational partnerships rather than by nationally determined health needs (Singh, 2023).

5. Regional Governance Organisations (ASEAN, SAARC, and BIMSTEC)

The South and Southeast Asian regions exhibit different characteristics when contextualised within their historical and institutional trajectories. They present sharply contrasting political economies that shape their regional health governance.

5.1 Origins, Mandates, and Institutional Evolution

ASEAN is the primary regional organisation in Southeast Asia. Established in 1967, its focus was more on catalysing regional stability than on an overt emphasis on health. Subsequently, through successive processes of formalisation, its governance model has gradually evolved, but not at the cost of diluting member-state sovereignty in favour of a supranational body. Through the landmark 1976 Bali Summit and the 2007 ASEAN Charter, the bloc gained an instrument that outlined a more structured, rules-based system with three operational pillars. Nevertheless, the “ASEAN Way” norms of consultation, consensus, and non-interference remain key.

Within this structure, health governance falls under the ASEAN Socio-Cultural Community (ASCC) pillar, with the ASEAN Secretariat and its Health Division acting as coordinating and convening bodies. As these entities lack both the fiscal and legal authority to officially mandate compliance, there exists a genuine implementation gap between regional declarations and national execution across highly diverse member states (Cockerham, 2010; Weatherbee, 2019).

For SAARC, an intergovernmental regional unit set up to facilitate cooperation among the eight nations of South Asia, established soon after in 1985, it is much the

same. SAARC's Charter is framed around the foundational values of "promoting the welfare of the peoples of South Asia" and "improving their quality of life," and it is within one of its five original areas of cooperation—"Health and Population Activities"—that health is independently featured (Ministry of Foreign Affairs, Nepal, n.d.).

A third, overlapping grouping emerged just over a decade later, with a narrower membership and a more technocratic bent. BIMSTEC, established in June 1997, 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 has been 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 from a standalone sector to a sub-sector within the "Science, Technology & Innovation" sector, separate from other social sectors, effectively deprioritising health and framing health as a technological issue.

5.2 Governance Architecture and Health Cooperation Mechanisms

Health emerged as a prominent priority for ASEAN only after transboundary disease outbreaks highlighted the severe economic and security risks of inaction. The outbreaks of SARS in 2003 and H5N1 in 2004 served as critical catalysts, elevating health on the regional agenda and prompting member states to redefine surveillance, preparedness, and cross-border coordination as shared regional responsibilities rather than isolated domestic concerns (Rahman-Shepherd et al., 2025; Spencer et al., 2018).

The post-2015 health architecture reflects a higher priority given to health. A previously disjointed set of projects was reorganised into four health clusters, constituting an important rationalisation of the health agenda (Rahman-Shepherd et al., 2025; Spencer et al., 2018). With ASEAN's principles of advancing cooperation in functional areas that do not seriously disturb national policy autonomy, its strongest health cooperation has developed in areas of the maximum transboundary risks and where member states' interests overlap. These include infectious disease surveillance, laboratory networking, emergency operations, and public-health preparedness (Cockerham, 2010; Spencer et al., 2018).

This evolution relied significantly on external partnerships. By bringing China, Japan, and South Korea into post-SARS initiatives, ASEAN Plus Three widened the region's health framework, while dialogue partners contributed essential financing and technical support. During COVID-19, established networks functioned alongside new ASEAN tools like the Response Fund, medical supply reserves, and

vaccine security frameworks. This successfully extended ASEAN's functional reach, yet it simultaneously exposed how much regional health cooperation still relies on outside assistance (Rahman-Shepherd et al., 2025; Spencer et al., 2018).

Table 8 illustrates this partner-supported ecosystem of regional health governance, underlining the role of a patchwork of ASEAN-led, Plus Three, and donor-supported arrangements in regional cooperation rather than that of a single, well-financed regional authority. This helps explain why ASEAN can be institutionally central yet operationally uneven (Rahman-Shepherd et al., 2025; Spencer et al., 2018).

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 (Spencer et al., 2018).

Table 8: ASEAN's Health Cooperation With Development Partners

Partner	Focus Areas	Key Milestones and Outputs	Timeframe
China	• ID control and surveillance • Traditional medicine • Health systems strengthening • IP protection and benefit-sharing	• Joint SARS and Emerging ID response • Annual ASEAN–China Health Minister Meetings • Material Transfer Agreements and equitable benefit-sharing	2003–ongoing
Japan	• ID control • Universal Health Coverage • Ageing populations • Digital health innovation • ACPHEED	• ACPHEED established and funded (~USD 50 million) • ASEAN–Japan UHC Initiative focusing on ageing populations	2003–ongoing
South Korea	• Digital health solutions and IT infrastructure • Ageing populations • Emerging health threats • Health R&D partnerships	• Joint statements on digital health cooperation	2024–ongoing

Partner	Focus Areas	Key Milestones and Outputs	Timeframe
UK	• Health security and pandemic preparedness • Climate-related health risks • ASEAN One Health Plan	• 5-year Health Security Partnership Programme announced in 2025	2025–2030
US	• Health security, disease surveillance • Workforce training and PHC • Airborne Infection Defense Platform (TB and pandemics)	• Permanent ASEAN-US Health Ministers Meeting established (2024) • Enhanced digital health collaboration	2024–ongoing
Australia	• Health security and pandemic preparedness • IDs and AMR • Health systems strengthening and UHC • Environmental and climate-related health risks	• ASEAN-Australia Comprehensive Strategic Partnership (2025–2029) • Support for ASEAN Regional Reserve of Medical Supplies and ACPHEED	2025–2029
India	• Pandemic preparedness and disease surveillance • Affordable medicines and pharmaceuticals • Traditional medicine and healthcare innovation • Digital health and UHC	• ASEAN–India COVID-19 conference • USD 1 million contribution to ASEAN COVID-19 Response Fund • Plan of Action (2026–2030)	2022–2030

Source: Authors' compilation.

Note: ACPHEED = ASEAN Centre for Public Health Emergencies and Emerging Diseases; AMR = antimicrobial resistance; ASEAN = Association of Southeast Asian Nations; ID = infectious disease; IP = intellectual property; IT = information technology; PHC = primary healthcare; R&D = research and development; SARS = severe acute respiratory syndrome; TB = tuberculosis; UHC = universal health coverage.

SAARC's institutional architecture for health, however, looks quite different from ASEAN's donor-dependent, cluster-based model. Within SAARC, the organisation is structured in a manner where the 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. This is supported by several technical specialised bodies, the most prominent in the health sector being the SAARC Tuberculosis Centre, established in 1992 as a result of the region's porous borders, dense populations, and high TB prevalence, which subsequently expanded its mandate and was renamed the SAARC Tuberculosis and HIV/AIDS Centre (STAC) (STAC, 2025). 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 May 16, 2018. The Centre continues to produce epidemiological reports, training modules, and regional strategies, including guidance during COVID-19 on maintaining TB services (STAC, 2021).

Other examples of regional health cooperation include the 2003 Malé Declaration on SARS, which aimed to create a regional response strategy through proposals for a "SAARC CDC" or "Rapid Deployment Health Response System" (SAARC Secretariat, n.d.), though this did not materialise. 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.

Overlapping in membership but distinct in scope, BIMSTEC offers a second lens on regional health cooperation in South Asia: 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 Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER)–BIMSTEC Telemedicine Network (JBTN), launched in 2017 to enable medical institutions to provide tele-consultations and share specialised medical knowledge (BIMSTEC, n.d.), directly merging health with technology and communication. This digital health agenda is synergistic with the BIMSTEC Master Plan for Transport Connectivity (ADB, 2022b; Medical Dialogues, 2017). Adopted in 2022, this plan's infrastructure corridors are seen as enablers for the rapid movement of medical supplies and personnel during health emergencies (Ministry of Health and Family Welfare, Government of India [MoHFW], 2019), creating a dual high-tech and high-logistics approach to health security.

5.3 Crisis Response and Structural Constraints

The COVID-19 pandemic had a considerable impact on ASEAN's institutional priorities. Not only did it spur on its prioritisation of health security as an agenda, but it also created conditions whereby 46 different response mechanisms (both pre-existing and newly created), such as coordination networks, medical supply reserves, and dedicated emergency funds, were deployed. However, ASEAN's functional

performance remains weak and fragmented. The very principles grounding it institutionally act as bottlenecks to its ability to implement actions effectively. ASEAN is thus straitjacketed by its core tenets of national sovereignty, non-binding agreements and a rigid reliance on consensus (Rahman-Shepherd et al., 2025).

ASEAN's health trajectory is 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, health-aware regional organisation, without abandoning the sovereignty-preserving logic of the "ASEAN way". That model has been sufficient to build trust, provide convening power, and facilitate the development of shared crisis instruments. Still, 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 a wider coalition for regional action beyond governments alone (Cockerham, 2010; Spencer et al., 2018).

Conversely, SAARC's constraints are less about implementation capacity than about political will at the outset. Despite a mandate for cooperation, political mistrust has long undermined its operations and remains a persistent challenge (Adil et al., 2025). India–Pakistan tensions have rendered SAARC's apex decision-making body, the Summit of Heads of State, inactive since 2016. Despite its political wing being 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 (STAC, n.d.).

The SAARC COVID-19 Emergency Fund exemplifies this. After it was proposed by India with an initial USD 10 million pledge, Pakistan's insistence that the Fund be managed by the SAARC Secretariat to ensure true multilateral control (Dawn, 2020; Embassy of India, Doha, n.d.) did not allow consensus to be reached. Proposals for a "common research platform", information-sharing procedures, and shared Pandemic Protocols (SAARC Secretariat, n.d.) similarly stalled for lack of 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 (Bhattarai, 2025). Moreover, the organisation is constrained by an underfunded secretariat and lacks the mechanisms to ensure that any agreements are monitored and implemented.

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 states (Centre for Social and Economic Progress, 2016). 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 (Ravi, 2014), a role reinforced during COVID-19 (Centre for Public Policy Research, 2020).

BIMSTEC, often framed as SAARC's alternative, has not entirely escaped this pattern of underperformance. Owing to much of the same geopolitical tensions, BIMSTEC's successes have also 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 from the region's fundamental health challenges of scarcity of reliable data, weak PHC systems, and lack of trained human resources.

Table 9: Comparison of Regional Institutions for Global Health Governance

Feature	SAARC	BIMSTEC	ASEAN	Relationship to WHO ROs
Geographic Composition	Afghanistan Bangladesh Bhutan India Maldives Nepal Pakistan Sri Lanka	Bangladesh Bhutan India Nepal Sri Lanka Myanmar Thailand	Brunei Cambodia Indonesia Laos Malaysia Myanmar The Philippines Singapore Thailand Vietnam Timor-Leste	SEARO WPRO EMRO
Year of Inception	1985	1997	1967	SEARO: 1949 WPRO: 1952 EMRO: 1949
Mandate	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).	
Governance Structure (Health)	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).	

Feature	SAARC	BIMSTEC	ASEAN	Relationship to WHO ROs
Framing of Health	Health as Social Welfare.	Health and Technological Problem (solved by innovation, telemedicine, tech transfer). Health is a sub-sector under Science and Technology.	Health as Regional Security and Socio-Cultural Development (a human development goal framed as a security issue).	
Key Health Initiatives	COVID Emergency Fund, TB, and HIV Centre.	Focuses on technocratic projects: JIPMER - BIMSTEC Telemedicine networks, transport connectivity, and proposed centres for Tropical/ Traditional Medicine.	Institutional focus: ASEAN Centre for Public Health Emergencies (ACPHEED), ASEAN Health Clusters, and a Regional Reserve of Medical Supplies.	WHO SEARO has been a collaborator on several projects (see section on SAARC).
Primary Drivers	Shared epidemiological vulnerabilities and land borders.	Geopolitical imperative to create a viable alternative to the paralysed SAARC.	Shared cross-border threats (pandemics), crisis-driven catalysis (SARS, COVID-19), and strong external partner support.	
Primary Challenges	Paralysed 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.	

Source: Authors' compilation.

Note: Colours represent the division of countries within the WHO regional offices.

ACPHEED = ASEAN Centre for Public Health Emergencies and Emerging Diseases; ASEAN = Association of Southeast Asian Nations; BIMSTEC = Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation; COVID-19 = coronavirus disease 2019; EMRO = Regional Office for the Eastern Mediterranean; HIV = human immunodeficiency virus; JIPMER = Jawaharlal Institute of Postgraduate Medical Education and Research; RO = regional office; SAARC = South Asian Association for Regional Cooperation; SARS = severe acute respiratory syndrome; SEARO = Regional Office for South-East Asia; STAC = SAARC Tuberculosis and HIV/AIDS Centre; TB = tuberculosis; WHO = World Health Organization; WPRO = Western Pacific Regional Office.

In summary, ASEAN's strength lies in its institutional structures and diplomatic norms that encourage regional political and economic cooperation built on a consensus model that respects state sovereignty while enabling collective action when interests align. But this is also a source of weakness, as regional health action through consensus-building and persuasion can be slow or ineffective. Strengthening this balance, as well as clarifying the roles and responsibilities of its member states to address the escalating complexity of health threats, pandemics, NCDs, and the impacts of climate change, will be key to ASEAN's health security and development in the decades ahead. Furthermore, in a region where several states are underdeveloped, building a socio-cultural and political community would require a bold commitment and willingness to pool resources and to balance human security with economic and political security (Amador, 2015). The current fragmented financing raises key questions about who defines the region's priorities, and to what extent they are driven by country cooperation, by the ASEAN secretariat, or the donors. The ASEAN 2045 Vision's commitment to strengthening institutional capacity and effectiveness will be important. Finally, ASEAN will need to consider how it can mobilise synergies with two WHO ROs: WPRO and SEARO.

SAARC, despite its formation around shared borders and disease conditions, has been constrained by political conflicts between two key member countries. BIMSTEC, in contrast, may be an emerging platform for regional health governance with a geopolitical composition more conducive to cooperation. However, while BIMSTEC's technocratic and connectivity-focused approach offers some advantages, it may also prevent it from being robust enough to address the region's core health system challenges. Viewed collectively, all three institutions are fragmented in terms of geography and degree of financial fragmentation and programmatic cooperation, preventing a holistic, coordinated response.

6. Non-Regional Platforms for International Health Cooperation

Beyond the WHO and development banks, other platforms, global and sub-global, play a role in shaping international health cooperation and are relevant to countries in South and Southeast Asia. Of these, we discuss G20, BRICS+, and G77.

6.1 Southern Countries in Global Platforms

Recognising the need to include emerging economies in international financial decision-making, bridging the gap between global leaders and the Global South, the G20 was amongst the first global platforms to institutionalise a more inclusive global economic framework with the inclusion of Brazil, China, India, Indonesia, and South Africa. Over time, its agenda broadened to include trade, climate change, sustainable development, and health. The COVID-19 pandemic helped institutionalise the connection between economic governance and health

security, embedding health within the G20 Finance Track and reframing pandemic preparedness as an investment rather than a cost.

BRICS brought together countries of the Global South, aimed at strategic alignment, coalition-building, coordinating positions on global issues, amplifying demands for multilateral institutional reform through collective bargaining power, and promoting broader South–South cooperation. It expanded from its original membership to include six other countries: Saudi Arabia, Egypt, the United Arab Emirates, Ethiopia, Indonesia, and Iran (BRICS Brasil, 2025a), with the aim of creating a broader South–South coordination platform (de Carvalho et al., 2025). In doing so, it functions as a counterweight to global structures that are not representative of the Global South (Patrick et al., 2025). Both its membership and its agenda have expanded to issues such as environment, energy, science and technology, and health (BRICS Brasil, 2025a). Health is a core area of cooperation within BRICS, evident from the annual health ministers’ meeting and the establishment of initiatives such as the Vaccine Development and Research Centre (BRICS Think Tanks Council, 2025), the BRICS TB Research Network (BRICS TB Research Network, n.d.), and AI-focused digital health initiatives (BRICS Brasil, 2025b). Leadership on these initiatives, however, has depended on each country’s strengths and who holds the presidency, rather than a unified regional plan.

The G77 serves as a geopolitical platform for the Global South to counter Western-centric global governance. Backed financially and politically by China, the ‘G77+China’ configuration unites developing nations despite internal power differentials.

6.2 Strengths of Global Platforms

The G20 comprises 21 members (including the European Union [EU] and African Union) and is backed by 85% of global GDP and 75% of world trade, and hosts 78% of the world’s top pharmaceutical headquarters (Rahman et al., 2019). The G20’s economic weight combines with its informality to contribute to the G20’s strength. Its leverage lies in the collective power of its member nations, which dominate international development aid, global health funding, and pharmaceutical breakthroughs. The absence of a permanent secretariat enables quick crisis response and swift political alignment. Its strength also lies in its noncompetitive identity, where the platform mobilises political consensus and support for WHO-led initiatives (Kickbusch et al., 2018). 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. Policy input is provided through “Engagement Groups” of business, civil society, think tanks, and other non-state stakeholders (Lucas, 2019) to enable broader inclusion in decision-making.

BRICS+ operates through consensus-based governance, with leaders’ summits, annual ministerial meetings, and technical working groups. Yet, there is a degree of power asymmetry within BRICS+, with some noting China’s stronger influence (Garcia-Herrero, 2024). Nevertheless, it 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 (Käkönen, 2019). Its engagement with other groupings such as G20 and its push for reforms in multilateral structures such as the UN Security Council, IMF, and WB underline its focus on aligning with broader agendas (Patrick et al., 2025). Health cooperation within BRICS+ reflects a pluralistic engagement in the multilateral system, rather than producing a unified agenda or single developmental model for South–South cooperation (Käkönen, 2019). This does offer flexibility but holds the potential to dilute collective bargaining power. As the grouping expands its health agenda, managing internal fragmentation will remain central to its effectiveness as a Global South health actor.

The G77+China's influence lies primarily in agenda-setting, norm-shaping, and building cross-regional solidarity. The G77 and China have articulated a shared Global South agenda on equitable access to health technology (Shashikant, 2008). Through coordinated positions in UN General Assembly debates on global health and foreign policy, it has consistently framed health as a human right, defended Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities, and called for fair access to vaccines, medicines, and diagnostics, as well as for strengthened health systems and workforces in developing countries (UN, 2014). This helps shape the normative backdrop for GHG by linking health to debt relief, development financing, and science and technology cooperation across the South (Group of 77 and China [G77], 2024; United Nations Office for South–South Cooperation [UNOSSC], 2023).

6.3 The Asian Representation and Voice

With five Asian nations (China, India, Indonesia, Japan, and South Korea) that serve as central pillars in global supply chains and healthcare innovation, being members of G20, the platform's importance for the region stands underlined. Their membership has significantly influenced global policies on pandemic preparedness, digital health governance, and pharmaceutical access. Notably, India and Indonesia leveraged their respective G20 presidencies to actively champion critical initiatives surrounding health equity, supply-chain resilience, and digital healthcare delivery (Hadda & Jain, 2023). During its 2022 presidency, Indonesia bridged the gap between developed and developing nations, leading to the establishment of the Pandemic Fund. India, in its 2023 presidency, sustained this agenda and further prioritised digital health innovation and medical equity, culminating in the launch of the Global Initiative on Digital Health (GIDH). Further, the African Union was integrated as a permanent G20 member (Kumar, 2024) during India's tenure. These presidencies have contributed to the 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.

Within BRICS+, the inclusion of Indonesia enhanced South and Southeast Asian representation beyond India. Greater partnership from the Asia region (Malaysia, Vietnam, and Thailand) has been furthered through the introduction of “partner

country” status, allowing nations to attend the summit and, with member consensus, join additional meetings. Despite an expression of interest from other countries in the region, however, their participation is constrained by the BRICS+ policy of admitting countries with strong economic standing and influence (Papa, 2024).

In the case of G77, member states from South and Southeast Asia use their collective voice to bargain for fair trade, technology transfers, and climate finance. Nations like India and Indonesia strategically utilise the platform to assert regional leadership and advocate for a fairer, multipolar international order, continuing a long tradition of South–South cooperation in critical areas like health and education infrastructure.

In summary, the G77+China is the most numerically representative platform for advancing South–South voices and cooperation, in comparison with the G20 and BRICS+, but it operates with a broader, more diffused 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 select global health initiatives more directly.

7. Navigating the Fragmented Architecture of Health Governance in South and Southeast Asia

The contemporary health governance landscape affecting South and Southeast Asia is a dense, multi-layered ecosystem driven by four distinct categories of actors, which include i) the normative and standard setting institutions (WHO and its ROs); ii) financial institutions (MDBs, including the ADB) which channel over USD 14 billion in health-system and infrastructure operations across the region, shaping domestic health sector reforms through grants and concessional loan modalities; iii) transnational PPPs that deploy expansive vertical resources targeted at specific commodities and diseases; and iv) the political blocs, including both non-regional platforms (G20, BRICS+, and G77) and regional organisations (ASEAN, SAARC, and BIMSTEC).

This multifaceted GHG ecosystem stands at a critical juncture, characterised by an increasingly complex institutional landscape, funding volatility, and shifting geopolitical alignment. The traditional systems have given way to a multi-layered, fragmented architecture. For the nations of South and Southeast Asia—collectively home to a third of the world’s population—navigating this fragmented landscape is no longer just a diplomatic exercise; it is a public health and economic imperative.

An assessment of how this complex global architecture interacts with South and Southeast Asian nations, in the context of intra-regional and global variables, as well as the variable conceptualisation of health across levels of governance and institutions, reveals significant structural imbalances, with both vulnerabilities and opportunities. Viewed in terms of the framework presented earlier in the paper, focused on intra-regional and external variables as well as the perception of health,

there emerge distinct benefits of the governance architecture, several systemic vulnerabilities, alongside regional opportunities that could shape the future of health cooperation across South and Southeast Asia, but not without risks.

7.1 Gains in Global Health

In the focus on the challenges of the health governance architecture, it is easy to ignore what has been achieved. The system of governance institutions has, till now, offered considerable resource mobilisation, targeted disease reduction and emerging Southern leadership. The rise of GPPPs and co-financed MDB packages has brought about a significant growth in funding to the region. Vertical funding models have delivered undeniable gains in the management of infectious disease burdens such as HIV, TB, and malaria. Beyond specific diseases, the expansion of mandates within GPPPs to include health systems strengthening and pandemic preparedness, stronger cooperation across Gavi, the Global Fund, and CEPI, and financing reforms have contributed to reconciling vertical funding with horizontal health system strengthening. The shift from the traditional UN-led model towards GPPPs has also enabled select emerging economies in South and Southeast Asia to assert more ownership in global governance. However, these gains are not without their challenges and have often come at a cost. The over-attention to biomedical technologies and select diseases, combined with fragmented short-term approaches, has undermined the building of local institutions and coherent health systems. This is explored further in the next section.

Global health multilateral institutions have also delivered important gains by providing specialised public health expertise and proven experience in managing health emergencies and outbreaks. GHG institutions, specifically the WHO, set standards, guidelines, and monitoring frameworks for oversight on issue-based areas of technical cooperation that shape national policies in line with what is to be followed globally. The value-setting role holds the potential to enable civil society and other institutional actors to hold national governments accountable and couch core values of equity, justice, and fairness within national agendas.

The current architecture of regional governance in Asia reveals a stark discrepancy between South and Southeast Asia. While both regions face shared epidemiological, demographic, and health systems challenges, their institutional responses and trajectories of cooperation have diverged considerably. In Southeast Asia, there is a relatively well-established understanding of shared norms and collective mechanisms. Platforms such as ASEAN have developed provisions for regional stockpiling, pooled procurement of vaccines, and cross-border management of disease outbreaks. These arrangements are tailored to regional priorities and common vulnerabilities, and they draw upon a history of articulating shared challenges. ASEAN's institutional memory and infrastructure—built initially during the Cold War for political and economic cooperation—have gradually enabled the consolidation of a regional identity. Over time, this has facilitated processes of trust-

building, norm diffusion, and pragmatic cooperation. Smaller states, including the Pacific Island countries, have also demonstrated an acute awareness of the shared benefits of addressing cross-border threats collectively, particularly given their vulnerability to climate-sensitive health risks and supply chain disruptions. On the other hand, platforms in South Asia have been less effective.

7.2 Vulnerabilities

Financing and Governance

The financing architecture for global health is broad, including development banks, GHPs like the Global Fund, Gavi, and CEPI, bilateral aid agencies and private foundations. While they are essentially financing institutions, they are strong influencers of policy, primarily on account of their financing heft, without strong multi-country cooperation. Importantly, health is viewed differently by these stakeholders. While the WHO views it as a public good and a basic right, the WB and others view it in economic terms (as a market), while others view it as a tool for foreign policy. This difference affects the agenda and policy priorities of these actors with respect to health.

In part due to the number of financing actors, the global health financial architecture reveals a stark mismatch between resource control and demographic and disease realities. With 87% of voluntary funding carrying specified conditions, it fundamentally constrains the WHO's independent strategic planning, routinely reducing it to an implementation agency for major donors. This systemic fragility was laid bare by the immediate budget cuts triggered by the US's withdrawal in early 2025. This situation is compounded by a severe resource allocation mismatch, where funding favours infectious diseases and reproductive health, even though NCDs account for nearly 40% of the avoidable disease burden in these regions. The financial asymmetry is more pronounced regionally, reflecting the gap between demographic growth and WHO spending. Collectively, countries in South and Southeast Asia account for nearly one-third of the global population, yet they receive a modest portion of the total WHO budget. Important to note is that countries often contribute even less than they receive.

The increasing influence of GPPPs created governance challenges, with their growing role within GHG shifting authority away from traditional multilateral institutions and towards increasingly autonomous transnational partnerships. DAH is undergoing a significant structural shift, with LMICs losing access to concessional pricing and grants from GPPPs before their domestic financing mechanisms are robust enough to fill the void. Financial reforms have been undertaken by GPPPs to improve country ownership, but they have created new challenges for countries transitioning from concessional support. There is also a shift in official DAH from traditional donors—with many countries, especially the US, adopting more bilateral approaches and being more explicit and aggressive about using aid as an instrument of foreign policy.

Regional health governance functions as a partner-supported web of overlapping initiatives. Rather than being driven by a centralised, well-financed regional power, cooperation is sustained by a patchwork of external donors. This structural fragmentation explains ASEAN's central role in the region's diplomacy yet unevenness in its practical operations. The fundamental flaw is not a shortage of platforms for dialogue, but the weak institutionalisation backing them. The dependence on external aid constrains regional health cooperation, which is also limited by vast economic disparities, political diversity, and slow, consensus-based decision-making.

Institutional Fragmentation and the Limits of Sub-Regional Platforms

Efforts to project a unified Asian voice in global health are fundamentally bottlenecked by geographic silos, uneven institutionalisation, and geopolitical tensions.

Within the WHO, the institutional bifurcation of Asia across SEARO and WPRO fragments the region's collective weight and complicates cross-border policy coordination. The region receives a mere 14.9% of the combined global WHO budget despite serving a disproportionately high share of the world's population. In both South and Southeast Asia, the system of regional health governance faces real constraints. Regional institutions such as ASEAN, SAARC, and BIMSTEC remain siloed, underfunded, or dependent on external funds, and constrained by political conflict. Diplomatic and financial capacity remains limited, and consensus-building is slow. The fragmentation, in terms of geography and degree of financial and programmatic cooperation, combined with overlaps across the three governance institutions, undermines the development of a holistic agenda and coordinated response for the region.

While ASEAN has built the most mature, three-tiered health architecture—catalysed by transboundary crises like SARS and COVID-19—its operational efficacy remains limited by the “ASEAN Way”. Its strict adherence to national sovereignty and consensus-based, non-binding agreements often results in a persistent implementation gap between ambitious regional declarations and national execution. Despite sharing deep epidemiological vulnerabilities and porous land borders across South Asia, SAARC remains politically dysfunctional due to ongoing India–Pakistan conflicts, leaving its technical arms (like STAC) to operate in isolation without apex political backing. Several structural factors help explain this divergence between ASEAN and SAARC. Persistent geopolitical tensions, especially between major actors, have constrained trust formation. There is little historical precedent for sustained regional coordination, and significant capacity asymmetries between countries inhibit equal participation. The presence of a single large regional power further complicates dynamics, shaping perceptions of dominance and limiting the emergence of a cohesive regional voice.

As a geopolitical alternative to SAARC, BIMSTEC's focus on technocratic and connectivity-driven models risks prioritising high-visibility, tech projects over the region's foundational health challenges: critical human resource shortages, weak PHC systems, and data scarcity. Health cooperation within SAARC and BIMSTEC has remained fragmented and sporadic, with limited political backing and minimal institutional follow-through.

Governance arrangements remain weak across the board. The ASEAN Secretariat has limited authority and resources, and health is not the primary mandate of regional bodies. Consequently, health agendas are frequently subsumed under trade, economic, or security priorities. Power disparities within regions mean that dominant players can shape agendas, while smaller states struggle for influence. Across both regions, there is also a shortage of dedicated health technocrats and health diplomats tasked with representing national health interests in regional forums. In many cases, unequal national commitment further undermines sustained cooperation.

Power Asymmetries, Role Overlaps, and Continuing Inequities

WHO's technical position and democratic processes are increasingly being undermined by the financial heft of its donors and the disproportionate influence of the GPPP secretariats. As health becomes a core element of the region's trade and industrial strategies, market-shaping agendas driven by GPPPs risk sidelining the vital technical expertise of WHO. A similar tension exists between the aspirations of the WHO and MDBs, where, while the former intends to strengthen regulations, the latter seek to open health systems further to commercial forces. At the same time, there is an ideological pivot surrounding health financing from a "Washington consensus" to a "Wall Street consensus," commonly understood as a paradigm where development is funded by private sources instead of direct state investment.

Power asymmetries also remain between global governance institutions and countries in South and Southeast Asia. Within the Global Fund, for instance, despite the provision of equal representation for donors, recipients, and other stakeholders in its governance structure (through its Board and Country Coordinating Mechanisms), the disproportionate influence of major donors and private foundations over strategic priorities and funding decisions continues.

Resistance to reform presents structural challenges within a decades-old system of governance. While formal equality is espoused, agenda-setting often reflects the priorities of powerful states as geopolitical tensions increasingly shape and overshadow technical and scientific processes, deliberately slowing down progress. Similarly, these institutions undertake a top-down approach to decision-making where agendas are set before even understanding the contextual realities for their implementation. This is exacerbated by a lack of accountability and enforcement mechanisms, which are feeding into contemporary challenges where polarisation is undermining collective problem-solving.

7.3 Reclaiming Stewardship: From Passive Recipients to Active Architects

Despite the structural shortfalls, a paradigm shift is evident, driven by a growing appetite for South–South solidarity and “poly-alignment”. Emerging economies, such as India and Indonesia, are transitioning from legacy aid beneficiaries to regional donors and pillars of the global healthcare supply chain, as evidenced by their respective G20 presidencies, which produced structural global goods like the Pandemic Fund and GIDH. Thus, while for some countries within South and Southeast Asia, the wide complex of global and regional health actors may be of limited significance, for the smaller countries, stronger regional-level governance or cooperation could assist them to be more effective in their engagements with global health actors.

Power asymmetries at the global level point to the potential and imperative for reform at the regional level. Regional arrangements are more conducive to nimble, flexible configurations that are more representative of national priorities, serving as a network connecting national and global actors. Such models hold the potential to extend national capacity, enhance accountability, and foster trust through more equitable participation both at a regional and global level. Smaller coalitions or issue-based groupings may offer greater agility and responsiveness than formal intergovernmental platforms.

Opportunities, therefore, lie in pursuing low-hanging, non-controversial areas of cooperation to build institutional precedent and confidence. Health, as a comparatively “soft” agenda item, may serve as an entry point for reviving regional cooperation in contexts otherwise characterised by political stalemate. Inter-regional learning—for instance between ASEAN, SAARC, and BIMSTEC—could facilitate adaptation of successful practices while recognising contextual differences. Even where formal institutions are weak, they can still function as convening platforms to enable dialogue, knowledge exchange, and agenda-setting.

7.4 Ongoing Risks

While multilateralism creates opportunities for reform, given the above-mentioned challenges of influence by other entities—the growth of private enterprises and development finance institutions—there is a risk of path-dependence and institutional feedback loops that ultimately limit the scope for meaningful structural change. Within GHG regimes, political capture and financial dependency are deeply intertwined, shaping agenda-setting and institutional priorities.

The rise of nationalism, causing more inward-looking policies, has implications for globally applicable policy prescriptions. Therefore, strengthening health governance in South and Southeast Asia requires strategic alignment between global agenda-setting and regional implementation. However, reform is not straightforward. Regional solidarity cannot be assumed. If cooperation is driven solely by narrow

national interests tied to economic, technological, or political gains, deeper systemic issues may remain unaddressed. Health alone may not provide sufficient motivation for collective action. The heterogeneity of Asian regions—politically, economically, and demographically—complicates the design of equitable and representative platforms. External actors may still exert disproportionate influence, shaping priorities in ways that do not reflect regional needs. Intra-regional competition and the growing role of the private sector may further fragment agendas, reinforcing self-preservation over collective ‘Asian’ positioning. Stronger voices can overpower weaker ones, and a lack of political will to prioritise health and find common ground remains a persistent barrier. Across both regions, rising nationalism risks undermining the progress made in regional coordination.

7.5 Pathways Forward: A Shared Regional Agenda

To truly insulate themselves from external shocks and donor-driven agendas, the countries of South and Southeast Asia must collectively move beyond being passive recipients or symbolic donors. They must step forward as active architects of regional governance and key contributors to global governance. The growing economic weight and technical expertise of countries in South and Southeast Asia have made both regions central to the future of global health. However, the region’s capacity to project a coherent voice and protect its population of nearly 3.8 billion people remains constrained by a highly fragmented global and regional governance architecture.

To translate this current systemic turmoil into a strategic opportunity, future regional cooperation across South and Southeast Asia could focus on the following pathways:

- **Role clarity across global health governance institutions:** In the context of ongoing debates on WHO, it is clear that WHO needs to retain its mandate to act as the legitimate, intergovernmental ‘directing and coordinating authority on international health’. This will require reducing its dependence on conditional grants, which undermine its independence and autonomy, placing it under the influence of major governmental and private funders. A possible pathway to do this is by minimising the flow of earmarked voluntary funds through WHO and strengthening WHO’s role in norm-setting and coordination between donors and country governments to avoid/reduce the influence of external donors on norm-setting and decision-making within the WHO. Another core function of the WHO that must be preserved is the technical role it plays in supporting health priorities in countries of the Global South, which may be compromised by the increasing demands placed on the WHO.
- **Amplifying the regional voice:** Given the increasing role being played by MDBs and GPPPs in priority setting, stronger regional cooperation could help countries engage more strategically and efficiently with these structures, so that these priorities are aligned with country needs in the region, and fragmentation

across different institutions is limited. This requires a strong regional voice and negotiating capacity.

- **A regional bridge:** Regional governance institutions exist, but are fragmented, as discussed. Two options emerge by way of addressing the need to add coherence across regional bodies and mobilise countries to engage effectively with institutions at a global level. One entails expanding ASEAN's remit in global discussions and negotiations, through flexible mechanisms like ASEAN plus, in areas where priorities may align with countries beyond those in Southeast Asia. The second entails creating a wider platform across the South and Southeast Asian region, modelled on the G20—a smaller, flexible, strategically focused forum for political dialogue and coordination across subregions—which may be better suited for agenda-setting (this includes co-developing regional standards to guide MDB infrastructure investments) and representation for South and Southeast Asia. This can convene diverse stakeholders around specific objectives without the procedural rigidity of traditional GHG institutions. Through this, health can be elevated politically through summits, ministerial meetings, and declarations.
- **Bridging the sub-regional divide:** Closer cooperation must be forged to create operational synergies between ASEAN's health clusters, BIMSTEC's technological corridors, and the technical expertise of WHO's ROs. This can be coordinated by the WHO ROs given their ability to jointly mobilise the members of these different governance institutions. It can also be facilitated by existing non-governmental organisations (NGOs), CSOs, and academic networks, with some of these stakeholders taking up an active role in ensuring implementation, feedback, and accountability.
- **Strengthening regional governance:** It is evident that regional governance institutions need strengthening through increased investment in the Secretariat's capacity, greater integration of health, disaster management, and economic mechanisms, and a broader coalition for regional action beyond governments alone. Most importantly, however, the institutions need greater ownership amongst the members. Lessons from ASEAN and other regional institutions could be leveraged to deepen trust and ownership within SAARC and BIMSTEC, facilitated by epistemic communities, CSOs, and academic networks.

It is important to identify the functions that require collective action so that regional governance institutions are focused on these. These could include the following:

- Management of cross-border health threats and risks;
- Pooling of purchasing power;
- Sharing of scarce or specialised expertise;
- Economies of scale and efficiency gains for quality assurance and regulatory approval of new medicines, vaccines, and diagnostics;
- Economies of scale and efficiency gains for R&D; and for training and capacity development;
- Creating opportunities for intra-regional development assistance;

- Strengthening the voice and bargaining power of countries in the region vis-à-vis global organisations (e.g., the WB), global negotiations (e.g., the pandemic treaty), or powerful nation-states (e.g., the US and China).
- **Strengthening non-government forums:** In the context of limitations and obstacles to effective inter-governmental cooperation, strengthening regional health governance and cooperation through informal or non-governmental forms of regional governance and cooperation is underlined. This would entail building on the strengths of existing non-governmental regional networks and platforms as well as identifying areas where such networks and platforms are missing.

There are many networks with varied approaches, which have made contributions to fostering partnerships, producing knowledge, and informing national policies. As expected, however, the nature and extent of influence vary significantly across networks. Many networks face challenges in securing active participation from policymakers and state representatives.

Despite the growing significance of regional health security and cooperation, the intersection of geopolitics and health remains minimally explored through existing networks. Geopolitical dynamics, such as trade regulation, migration, cross-border disease threats, and international competition, increasingly shape health outcomes, yet they are not addressed as explicitly as needed in regional health networks. Additionally, Asia's successes in health can be leveraged to create a unified regional or sub-regional health offering, representing the region's successes on the global stage. Despite its acknowledgement by various stakeholders and organisations, the potential remains underleveraged.

- **Multilateralism versus regionalism versus bilateralism:** A key question going forward is what kind of cooperation is desired for global health equity and what type of governance mechanisms are best able to mobilise this cooperation. Multilateral institutions either are not delivering on equity, in the absence of agency and voice of economically poorer countries, or are constrained by a host of structural factors that make governance ineffective and complex, with overlapping roles across many institutions.

Inter-governmental regional institutions, at least in the case of South and Southeast Asia, are fragmented and often divided internally due to political tensions or have not prioritised health in any meaningful manner. Increasing national self-interest, in contrast to cooperation, has led to an increase in bilateralism, within a construct where power drives who gains and in what manner. The mobilisation of common interests requires countries to work together, which bilateralism is unlikely to promote.

There is a hypothesis that both multilateralism and regionalism can together advance health equity: the former for the reasons discussed, and the latter by addressing the structural and power plays that constrain poorer countries

and communities from gaining through multilateral institutions. The shifting nature of geopolitics and conflict between major powers increasingly speaks to the need for LMICs and LICs to carefully navigate this landscape. The question therefore may not be one of multilateralism versus regionalism, but strengthening both, in a way that regionalism helps ‘give a seat’ to smaller countries within multilateralism, as well as advancing equity within the region through sharing expertise and pooling resources.

Ultimately, the health security of Asia’s billions cannot depend on the performance indicators of distant, autonomous transnational boards or the shifting political priorities of foreign bilateral donors. By building robust, self-reliant regional governance mechanisms, South and Southeast Asia can pool their immense technical expertise, protect their fiscal space, and ensure that health is treated not merely as an economic asset or a security risk, but as a fundamental human right.

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Appendix

Table A-1: 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, and GLC4HSR
Health systems strengthening	PHC	WHO PHC Forum, SEARCH, and 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	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, 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	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	AAAH

Theme	Issues	Networks
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, and SEARCH
Public health	Health promotion, healthy lifestyles	AUN-HPN, Global Health Strategies
Data and monitoring	National health accounts, health data systems, evidence synthesis, embedded research, systems thinking	ANHSS, APHEN, APNHAN, and Alliance for Health Policy and Systems Research
Mental health	Mental health, advocacy, and research	South Asian Hub for Advocacy, and SHARE

Source: Author's compilation.

Note: AAAH = Asia Pacific Action Alliance on Human Resources for Health; AeHIN = Asia E-Health Information Network; ANHSS = Asia Pacific Network for Health Systems Strengthening; APAC = Asia-Pacific; APHEN = Asia Pacific Health Economics Network; ASEAN = Association of Southeast Asian Nations; AUN-HPN = ASEAN University Network–Health Promotion Network; CVD = cardiovascular disease; GLC4HSR = Global Learning Collaborative on Health Systems Resilience; HRH = human resources for health; NCD = non-communicable disease; NHA = national health account; P4H = Providing for Health; PHC = primary healthcare; SAFANSI = South Asia Food and Nutrition Security Initiative; SEA = Southeast Asia; SEARCH = Southeast Asia Collaborative for Health; SHARE = South Asian Hub for Advocacy, Research and Education on Mental Health; UHC = universal health coverage; WHO = World Health Organization.

Table A-2: Active World Bank Health Funding Through IBRD and the IDA in South and Southeast Asia

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 (ARTE, GFF)	Grant	241	N/A
South Asia	Afghanistan	Afghanistan Health Emergency Response (HER) Additional Financing	Nutrition	2023	Trust funds (ARTE, GFF)	Grant	267	N/A
South Asia	Afghanistan	Afghanistan Health Emergency Response (HER) Project	Nutrition	2022	IDA + Trust Funds (ARTE, 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 (ARTE)	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)

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
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
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 and 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

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
Southeast Asia	Cambodia	Cambodia Nutrition Project II	Maternal, Child, and Adolescent Health and Nutrition	2022	Trust Funds (Cambodia Freestanding 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 (SASDTF MDTF)	Grant	5.9	N/A
Southeast Asia	Cambodia	Cambodia Nutrition Project	Maternal, Child, and Adolescent Health and 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

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
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, Empowerment and Resilience (MPOWER)	Adolescent Health	2025	IBRD	Non-concessional	35	~20-year avg., ~5-year grace
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 Program	Health Emergency Preparedness and Response	2022	IBRD	Non-concessional	500	~20-year avg., ~5-year grace

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
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 (HTMDTF)	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

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
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 and Nutrition	2025	IDA	Grant	40	N/A

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
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

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
South Asia	Pakistan	Sindh Integrated Health and Population Project	Maternal, Child, and Adolescent Health and 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	The Philippines	Philippines Health System Resilience Project	Health System Strengthening	2025	IBRD	Non-concessional	496	~20-year avg., ~5-year grace
Southeast Asia	The Philippines	The Philippines Multisectoral Nutrition Project	Nutrition	2022	IBRD	Non-concessional	178	~20-year avg., ~5-year grace
Southeast Asia	The 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

Region	Country	Project Name	Thematic Area	Approval Year	Financing Source ^a	Instrument ^b	Amount (USD Million)	Typical maturity (years) ^c
Southeast Asia	The 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

Source: Author's compilation.

Note:

^a Financing Source distinguishes core WB windows (IBRD, IDA) from WB-administered trust funds. Specific facilities (e.g. ARTE, GFF, single or multidonor 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 trustfund grants is not visible. Thus, identifying the relative weight of trustfund grants versus IDA grants would require crosschecking 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 nonconcessional; IDA credits are concessional; and pure grants are nonrepayable. Operations combining IDA credits with grants or trust funds are 'mixed'. Several projects are cofinanced with external partners (eg., AIIB or bilateral donors) and governments. This table only reports the IBRD/IDA and WB-administered trustfund portions and does not capture the full size of blended financing packages. Parallel financing from other partners that is not channelled 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 and Operations database.

ASSIST = Assam State Secondary Healthcare Initiative for Service Delivery Transformation; ELP = Early Learning Partnership; HANS = Health Assistance and Nutrition Support; HER = Health Emergency Response; IBRD = International Bank for Reconstruction and Development; ICMR = Indian Council of Medical Research; IDA = International Development Association; KfW = Kreditanstalt für Wiederaufbau; KP = Khyber Pakhtunkhwa; Lao PDR = Lao People's Democratic Republic; MPOWER = Meghalaya Multisectoral Project for Adolescent Wellbeing, Empowerment and Resilience; NDRC = Nepal Disaster Resilience Development Policy Credit; PHSEP = Primary Healthcare System Enhancing Project; PHSP = Transforming India's Public Health Systems for Pandemic Preparedness Program; PPR = pandemic prevention, preparedness, and response; SAR = South Asia region; SRESTHA-G = Systems Reform Endeavours for Transformed Health Achievement in Gujarat; N/A = Not Available. ARTE = Afghanistan Reconstruction Trust Fund; GFF = Global Financing Facility for Women, Children and Adolescents; JSDF = Japan Social Development Fund; Cambodia Freestanding Trust Fund = Cambodiaspecific freestanding trust fund; SDTF = Sector Development Trust Fund; MDTF = MultiDonor Trust Fund; KfW SDTF = KfWfinanced Sector Development Trust Fund; SASDTF MDTF = South Asia Social Development Trust Fund (multidonor); HEPRTF = Health Emergency Preparedness and Response MultiDonor Trust Fund; PEF = Pandemic Emergency Financing Facility; SPF = State and Peace Building Fund.

Table A–3: Currently Active ADB Health Financing in South and Southeast Asia

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	COVID19 Response Emergency Project	COVID19 response; systems	Project loan	Concessional loan	2020	100.0
Bangladesh	COVID19 Vaccines for Recovery	Vaccines	Project loan	Concessional loan	2021	940.0
Bangladesh	Vaccines and Diagnostics Manufacturing	Health manufacturing; systems	Project loan	Concessional loan	2023	336.5
Bhutan	COVID19 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 and Transformation	Sector reforms	Programtype loan	Nonconcessional loan	2023	350.0
Indonesia	Primary Care and Lab Strengthening	Primary care and labs	Project loan	Nonconcessional 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	COVID19 Vaccination for Recovery	Vaccines	Grant	Grant	2022	10.0
India	Urban Primary Health Care (PMAB)	Urban primary care; infrastructure	Program/project	Nonconcessional loan	2020	300.0
India	Early Childhood Development, Meghalaya	Child health; nutrition; systems	Project/program	Concessional loan	2023	40.5

Country	Project (short title)	Main focus	Instrument ^a	Terms	Year	USD million ^b
India	Maharashtra Tertiary Care and Medical Education	Tertiary care; medical education	Sector program loan	Nonconcessional loan	2023	500.0
Pakistan	KP Health Systems Strengthening Program	Provincial health systems	Program loan	Nonconcessional loan	2022	100.0
The Philippines	Health System Enhancement for COVID19	COVID19 response; systems	Project loan	Nonconcessional loan	2020	125.0
The Philippines	Build UHC Program – Subprogram 1	UHC reforms	Policybased loan	Nonconcessional loan	2021	600.0
The Philippines	Build UHC Program – Subprogram 2	UHC reforms	Policybased loan	Nonconcessional 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	COVID19 Vaccines for Recovery	Vaccines	Project loan	Nonconcessional loan	2021	150.0
Vietnam	Local Health Care for Disadvantaged Areas Program	Local health services; insurance; reform	Sector program	Concessional loan + grant	2018	100.6

Source: Author's compilation; Asian Development Bank. (2025).

Note: COVID-19 = coronavirus disease 2019; KP = Khyber Pakhtunkhwa; Lao PDR = Lao People's Democratic Republic; MCH = maternal and child health; NCD = non-communicable disease; UHC = universal health coverage.

^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 programme 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.

Table A–4: Currently Active AIIB Health Financing in South and Southeast Asia

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	The 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

Source: 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".

Note: ADB = Asian Development Bank; AIIB = Asian Infrastructure Investment Bank; COVID-19 = coronavirus disease 2019; HEAL = Health System Enhancement to Address and Limit COVID-19; IsDB = Islamic Development Bank; RSAB = Rumah Sakit Anak dan Bunda; WB = World Bank.

About the authors



Sandhya Venkateswaran is a Visiting Senior Fellow at CSEP and leads the Human Development work, with a specific focus on health policy. Spanning a career over three decades, she has worked on a wide range of issues in the social sector from health, nutrition, gender, natural resources, to urban development and others. She has also authored books, multiple articles, and other publications on varied social sector issues. Over the last 15 years, her focus has been on policy issues, developing and leading the policy and advocacy portfolio in organisations such as the Bill and Melinda Gates foundation, Global Alliance for Improved Nutrition, and CARE. She has worked with grassroots campaigns and civil society organisations, as well as with government and international organisations. She is currently a member of the Lancet Citizens Commission on Reimagining India's Health System.



Nadine Monteiro is a Research Analyst in the Health and Human Development vertical at CSEP. She holds a bachelor's degree in Governance, Economics, and Development from Leiden University College, The Hague. Joining CSEP in 2024, her work has focused on the intersection of health and foreign policy, with particular attention to regional and global frameworks of health cooperation in South and Southeast Asia, as well as the social and political determinants of investing in health. Prior to her current role, Nadine interned with CSEP's Foreign Policy and Security Studies team, where she contributed to research on India-Africa strategic partnerships in critical minerals. Her research interests lie in social policy with an emphasis on advancing inclusivity and equity in health systems.



Diya Chaudhry is a Research Assistant at CSEP and is currently contributing to The Asian Collective for Health Systems, which has its secretariat at CSEP. She specialises in geopolitics, global health governance, public policy, and climate-health systems. Her training in International Relations informs a comparative and systems-focused approach to analysing policy landscapes, regional cooperation, and institutional reform. She is motivated by questions at the intersection of power, equity, and governance.

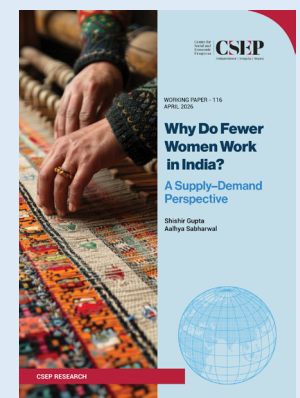
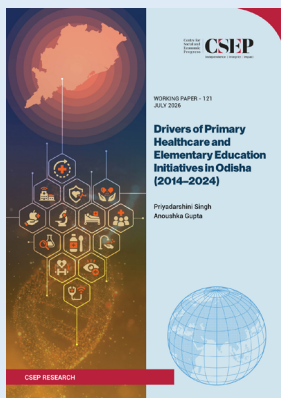
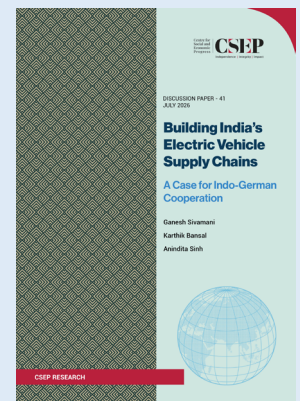
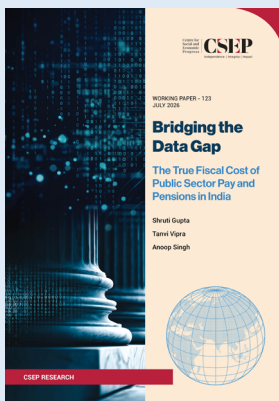
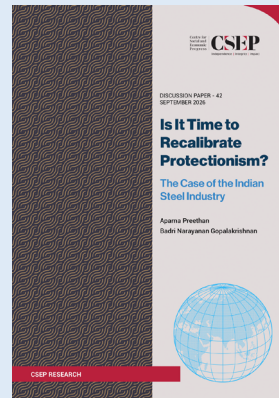


David McCoy is qualified as a medical doctor from Southampton University and spent six years as a clinician in the UK and South Africa, before entering a career in public health. He spent a further seven years in South Africa with the University of Cape Town and the Health Systems Trust where he supported the post-apartheid transformation of South Africa's healthcare system. On returning to the UK, he has worked in civil society and the non-government sector (Peoples Health Movement, Aidspace and Medact), in academia (University College London and Queen Mary University London) and in the public sector (the NHS).



Dian Maria Blandina earned her medical degree from the University of Indonesia and practiced clinically in urban and remote settings, grounding her work in frontline healthcare realities. Driven by the intersection of health systems and public policy, she pursued advanced studies in global public health at Queen Mary, University of London, and graduate research at Aristotle University of Thessaloniki, where she investigated the impacts of International Monetary Fund's programs on health systems worldwide. Her work bridges policy analysis and grassroots perspectives, informed by her roles with organisations like the People's Health Movement and the Geneva Global Health Hub. With experience across the public and private sectors, she brings a multidisciplinary lens to health governance challenges, from local practices to global policymaking.

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