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Geopolitical Realignments and the Ongoing Evolution of the New World Order: Reassessing the Implications for Global Health

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Abstract

The global geopolitical landscape is undergoing a profound restructuring, with direct implications for health governance, financing, and equity. This paper reassesses trajectories outlined in an April 2025 analysis against accelerated shifts including U.S. withdrawal from the WHO, widespread donor retrenchment, tariff-driven supply chain disruptions, and the introduction of the America First Global Health Strategy. Employing realist international relations theory, globalization and health frameworks, and political determinants of health, the study examines how reduced multilateralism and intensified nationalism shape health outcomes. Evidence indicates the emergence of the "realistic scenario" characterized by fragmented multilateralism, strengthened regional architectures, and selective bilateralism. Case studies include BRICS health initiatives, Africa CDC's expanded mandate, ASEAN health security mechanisms, and evolving financing innovations such as health taxes and debt-for-health swaps. Findings reveal widening inequities, weakened global standards, and increasing complexity in health governance. Yet, regional leadership and South–South cooperation offer adaptive alternatives, suggesting a polycentric global health order. The paper underscores both the risks of fragmentation and the opportunities for innovation, recommending distributed governance, diversified financing, resilient supply chains, and equitable digital health adoption. The analysis concludes that the ongoing fragmentation of health governance, financing, and practice has already resulted in substantial human costs and threatens to reverse decades of progress, underscoring the urgency of developing sustainable and equitable approaches to global health.

Keywords: Geopolitical Shifts; Global Health Governance; Multilateralism; Regional Health Architectures; BRICS; Africa CDC; Health Financing; Tariffs; Health Equity; America First Global Health Strategy; WHO Withdrawal; Polycentric Governance

Introduction

The global geopolitical landscape continues to undergo a profound structural transformation, with significant implications for global health governance and outcomes. The shift from multilateralism to nationalism, coupled with the rise of multipolarity, has moved from theoretical concern to tangible consequence, with measurable impacts on population health outcomes worldwide [1].

Recent developments, including but not limited to the modifications to aid architecture, [2] downsizing of the World Health Organization (WHO), [3] and ongoing negotiations regarding the Pathogen Access Benefits Sharing System (PABS), [4] illustrate the complex intersection of technical, commercial, and political considerations affecting global health systems [5]. Building on the analysis presented in a paper, "Recent Geopolitical Shifts and Their Implications for Global Health: A New World Order in the Making" (April 2025), which argued that the global geopolitical landscape is undergoing a change from multilateralism to nationalism and the rise of multipolarity, fundamentally altering international power dynamics and cooperation frameworks. This restructuring is directly reshaping global health governance, financing, and implementation practices, with consequences for health systems and individual health outcomes worldwide. It outlined three potential trajectories (optimistic, realistic, and pessimistic), which the current paper examines in the context of accelerated geopolitical shifts calling for a reassessment of these dynamics and analysis of subsequent developments since the previous paper. This includes assessment of the emerging patterns and updating recommendations in response to current conditions [1].

Several trends identified previously have now consolidated into established patterns. The suspension of United States foreign aid has become institutionalized, with other donor countries adopting comparable policies [6]. At the same time, nationalist orientations have intensified, accompanied by democratic backsliding [7] and the expansion of trade restrictions through tariffs [8]. Since April 2025, additional developments have emerged, including the elimination of vaccine mandates in several U.S. jurisdictions with potential to reinforce vaccine hesitancy, substantial reductions in funding and technical capacity at major global health institutions, most notably the U.S. Centers for Disease Control and Prevention (CDC) [9] and tariff policies that have disrupted supply chains for medicines and medical devices [10-12].

A newly released policy framework, the *America First Global Health Strategy*, marks a significant reorientation in U.S. global health policy. It emphasizes country *self-reliance* by requiring co-investment from recipient countries and planning transitions away from dependency on U.S. aid. The strategy narrows its focus to specific disease burdens, notably HIV/AIDS, malaria, tuberculosis, and polio, and increasing investment toward core medical supplies, diagnostics, frontline treatment, and healthcare staffing rather than broader systems strengthening. It also commits to strengthening global disease surveillance, with an articulated goal of being able to respond within 72 hours to infectious disease outbreaks. It states that *'We will strengthen bilateral relationships with key countries by entering multi-year bilateral agreements that advance American interests, save lives, and enable economic growth'* A move from multilateralism to bilateral arrangements for global health in the coming years is explicit [13,14].

Cumulatively, these changes constitute a fundamental restructuring of the international order. While geopolitical dynamics provide the analytical framework for this study, the primary focus remains the examination of consequences for global health, specifically governance structures, financing mechanisms, implementation practices, and health equity considerations. This approach maintains consistency with the previous analysis while incorporating recent developments into the assessment.

This paper tries to answer the research question which trajectory outlined in our previous analysis optimistic, realistic, or pessimistic has materialized, and what are the implications for the future of global health governance, financing, practice, and health equity?

Methodology

Theoretical Frameworks

This analysis maintains methodological consistency with the theoretical foundations used in our April 2025 publication, facilitating direct comparison and trajectory assessment [1]. The study employs three interconnected analytical frameworks to examine the multifaceted relationships between geopolitical transformations and health outcomes: Realist International Relations Theory, [15] the Globalization and Health Framework, [16] and the Political Determinants of Health Framework [16,17].

These complementary frameworks elucidate the mechanisms through which decreased multilateral engagement, protectionist trade policies including tariff implementations, reductions in Official Development Assistance (ODA), and supply chain disruptions ultimately affect health services and health outcomes. The analytical approach traces the pathways through which geopolitical decisions manifest as health outcomes, mediated by social, economic, and institutional factors [18].

Literature Search Strategy

A literature review was conducted covering the period from April 2025 to September 2025, capturing developments after the initial analysis. The search strategy employed a comprehensive approach across multiple source types to ensure timely identification of emerging trends and policy changes.

Database and Source Selection

The review utilized three primary categories of sources. First, peer-reviewed literature was searched through PubMed, Scopus, and Web of Science databases. Second, policy documents were retrieved from international organizations, including but not limited to the WHO, World Bank (WB), International Monetary Fund (IMF), CDC, Africa Center for Disease Control and Prevention (Africa CDC), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and Gavi, the Vaccine Alliance (GAVI). Third, media audit from established outlets and policy institutions, including Reuters, Financial Times, Brookings Institution, Geneva Health Files, Health Policy Watch, Health Affairs, Chatham House, Council on Foreign Relations, and the Center for Global Development. The deliberate inclusion of grey literature and news sources was a methodological choice to address the temporal lag inherent in peer-reviewed publication processes. It ensured the capture of recent policy developments and their implications were not missed.

Search Parameters

Keywords included: "geopolitical shifts AND global health," "multipolarity AND health governance (OR health financing OR health equity)," "health nationalism, "USAID funding freeze," "PEPFAR discontinuation," "tariffs AND pharmaceuticals (OR Medical Devices)," "BRICS health initiatives," "regional health architectures," "vaccine mandate elimination," "pandemic treaty negotiations," "health aid fragmentation," and "Global South health leadership."

Inclusion Criteria

Materials were included for analysis based on four criteria: (1) publication date on or after March 1, 2025, or documentation of ongoing developments if published earlier; (2) demonstrated

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relevance to the intersection of geopolitics and health; (3) evidence of implications for global health governance, financing mechanisms, implementation practices, or health equity; and (4) publication in credible sources with verifiable documentation.

Analytical Approach

The analysis consisted of three interconnected parts to systematically examine geopolitical developments and their health implications. The first component involved comparative analysis, wherein recent developments were mapped against the baseline analyses from the April 2025 publication. The second component comprised trajectory assessment through evidence synthesis to determine which of the three previously identified scenarios-optimistic, realistic, or pessimistic most accurately characterizes the current global health landscape. The third component incorporated empirical impact assessment, where data availability permitted. This quantitative dimension provided empirical validation to the narrative assessments and strengthened the evidence base for trajectory identification.

Analysis and Results

Key New Geopolitical Developments with Implications for Global Health

Russia-China-India Convergence and Its Limitations

The attempted revival of the Russia-India-China (RIC) trilateral format represents both the outcomes of the geopolitical shifts in power and its limitations. Following the August 2025 Shanghai Cooperation Organization summit in Tianjin, Russian Deputy Foreign Minister Andrey Rudenko's push for RIC revival met with measured responses from Beijing and New Delhi [19]. While China's Foreign Ministry spokesperson Lin Jian affirmed that trilateral cooperation "contributes to regional and global peace, security, stability, and progress," [20] India maintained cautious openness, with its Ministry of External Affairs describing RIC as merely "a consultative format" [21].

The limited progress highlights the reactive nature of the trilateral's revival rather than a proactive partnership for development and the underlying strategic mistrust. For example, border tensions between India and China persist despite diplomatic engagement [22]. These bilateral frictions constrain meaningful health cooperation, even if all three nations recognize shared interests in reforming global health governance. The failure to establish concrete health initiatives, thus far, through RIC, despite rhetorical support for cooperation, exemplifies how geopolitical rivalries impede collective action on shared health challenges and developmental issues in general. However, a possibility of such a partnership should not be ignored, given that these three nations are part of the BRICS bloc, which has started health partnerships and is an emerging global health player.

BRICS Expansion and Global South Leadership

In contrast to RIC's limitations, BRICS has demonstrated greater cohesion in advancing alternative health governance models from as far back as 2014 [23]. The July 2025 BRICS Summit in Rio de Janeiro yielded the Partnership for the Elimination of Socially Determined Diseases, endorsed by all member states plus partner countries, including Malaysia and Bolivia. This initiative addresses health inequalities driven by income, race, gender, and geography, with Brazilian President Luiz Inácio Lula da Silva declaring, "We are choosing cooperation and solidarity over indifference, placing human dignity at the center of our decisions" [24-26].

The BRICS health platform extends beyond rhetorical commitments. Member states approved joint programs for vaccine development at the recent BRICS meeting in Brazil, where the importance of multilateralism in reducing health inequities was emphasized. Specific initiatives include-BRICS Vaccine Research and Development Center, which aims to enhance regional and global capacity for innovation, production, and equitable access to vaccines; the strengthening of the BRICS Public Health and Health Systems Research Network; and the creation of the BRICS Conference of National Health Institutes, whose recommendations will help advance public health knowledge and support decision-making processes. Some other plans include a "basket" of best practices and priority health system policies-a key foundation for technical cooperation among BRICS Health Ministries; A book on BRICS health systems, authored by each member country; A joint research project on topics of mutual interest and training programs in priority areas for BRICS countries. Also, plans to progress and promote innovation and technology transfer; establish the Electronic R&D Repository for agile data sharing [27-29].

They also have 'The BRICS Health Journal' which aims to promote medical research, public health, and scientific cooperation among the BRICS countries [30]. Moreover, BRICS is not only an exemplar of regional health governance initiatives but a partner in regional-regional cooperation, for example, with PAHO. "The BRICS countries are not only economic and political powers but also public health leaders," said Dr. Barbosa, PAHO Director, and called for joint efforts and new partnerships [31]. These initiatives represent alternatives to traditional Western-dominated health programs, though their scale remains limited compared to historical US contributions; however, they do signal potential for future leadership and a platform to reshape global health governance.

Post-Tariff Diplomatic Shifts and Pharmaceutical Supply Chain Realignment

In February 2025, the US announced plans to impose 25% tariffs on imported pharmaceuticals, which spurred several concerns across the globe due to the industry's heavy reliance on foreign countries for raw materials and manufacturing. The impact could include margin erosion, higher drug prices for US consumers, supply chain disruption, and a potential negative

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effect on the R&D pipeline, given the reliance of the industry on markets such as the US. [12,32] On a patient level, the resultant cost inflation would diminish health-care accessibility, potentially increasing out-of-pocket expenses for patients and exacerbating population health outcomes through delayed treatment and higher mortality rates [10]. In April 2025, the US administration issued an executive order imposing a 10% tariff on all imports except specified exemptions, with higher reciprocal rates (up to 50%) for countries marked as having nonreciprocal or discriminatory trade practices. These included inter alia pharmaceuticals [33,34].

Recent developments in the global biotechnology sector indicate a significant shift in leadership from the United States to China, driven by a combination of U.S. policy retrenchment and China's expanding manufacturing and innovation capacity. A decade-long strategic investment in biopharmaceutical capabilities has enabled China to deliver medical products more rapidly and cost-effectively, while U.S. federal funding cuts, regulatory slowdowns, and trade measures such as tariffs have constrained domestic competitiveness. This environment has accelerated the rise of Chinese firms in global licensing deals and positioned China as a central player in the biotech landscape, signaling a reconfiguration of power dynamics in the industry [35]. More recently, the US administration publicly threatened tariffs as high as 250% on imported pharmaceuticals, with an initial "small tariff" set to rise to 150% and then potentially 250% within 12-18 months. This has caused concerns among several manufacturers, such as CSL in Australia [36,37].

The Council on Foreign Relations analysis examines how the current US administration's tariff policies toward key allies-Canada, the European Union, Japan, Australia, and New Zealand have strained longstanding diplomatic, economic, and security relationships, prompting strategic realignments in trade, defense, and energy policy. These shifts risk weakening multilateral cooperation and trust, which are essential for addressing transnational challenges, including global health security. By diverting political capital toward bilateral trade negotiations and fostering uncertainty in alliances, the tariffs may indirectly undermine coordinated international responses to health crises, pandemic preparedness, and other collective public health initiatives [38]. Rather than signaling deglobalization, these measures have accelerated a selective fragmentation with protectionist policies, and they have catalyzed significant adaptations in both governmental and corporate strategies worldwide, leading to the emergence of new coalitions, trade blocs, and an altered global supply network [39-41].

Institutional Transformations and Their Cascading Effects

The WHO Crisis and Legitimacy Deficit

The formal withdrawal of the United States from the WHO, enacted through an Executive Order on January 20, 2025, precipitated a multifaceted institutional crisis [42]. WHO's budget for 2026-2027 has been reduced to 4.2 billion USD, leaving a shortfall of 1.9 billion USD, or 45 percent of the planned allocation. This constitutes the most severe financial challenge faced by the organization since its founding. The WHO Director-General announced that staff reductions would be required across all levels and regions, alongside the potential consolidation of divisions and relocation of functions [3,43].

In addition to financial strain, the WHO now confronts a legitimacy challenge. The U.S. withdrawal has emboldened other nations to question the organization's authority and to resist its recommendations. Several member states have signaled their intention to review their commitments, [44-47] while regional organizations increasingly bypass WHO coordination mechanisms, which could be seen either as a mere responsive adaptive strategy or a welcome regional strengthening. For instance, in July 2025, the Africa CDC convened a workshop with ten African countries to co-develop a continental framework aimed at decentralizing laboratory services. This initiative, pursued in collaboration with WHO, seeks to enhance local and regional outbreak detection, accelerate response capacity, and improve laboratory mapping [48]. The accompanying roadmap for 2025-2027 sets out goals to strengthen cross-border surveillance, build regional health system capacity, and reinforce laboratories and alert systems [49-51]. While WHO remains a partner in such efforts, the expansion of regional and bilateral initiatives highlights a growing trend toward decentralized health security coordination. Looking ahead, the WHO will need to navigate competing visions of global health governance: one prioritizing pandemic preparedness and health security, largely advanced by high-income countries, and another emphasizing health equity and the social determinants of health, advocated more strongly by the Global South.

US CDC Restructuring, Retreat from Science, and Internal Disagreements

The dismantling of the U.S. CDC's global health infrastructure following funding reductions initiated in January 2025 marked a significant turning point in public health governance. The dismissal of CDC Director Susan Monarez in August 2025 was followed by the resignations of several senior officials, including Chief Medical Officer Deb Houry, National Center for Immunization Director Demetre Daskalakis, and Director of the Division of Emerging Diseases Daniel Jernigan, in protest [52]. These departures led to a substantial loss of institutional knowledge built over decades, undermining the agency's capacity to monitor and respond effectively to global health threats.

The reconstitution of the Advisory Committee on Immunization Practices (ACIP) with individuals described by critics as "anti-vaccine activists" introduced profound changes to U.S. vaccine policy [53]. The committee's recommendations, which restricted COVID-19 vaccination to individuals aged 65

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and older or those with defined risk factors, stood in contrast to prevailing scientific consensus and contributed to fragmentation in national public health practice. In response, California, Oregon, and Washington established a joint initiative to disseminate information on vaccine safety, while Florida moved to abolish all vaccine mandates [54,55].

This polarization sets a concerning precedent for the politicization of public health decision-making, with the potential to influence similar debates in other contexts. Although no direct implications for global health have been observed to date, parallel patterns of internal contestation and policy divergence have emerged in several countries, including France, Nepal, and Indonesia [56-59]. Such dynamics compel governments to navigate challenges simultaneously on two fronts: externally, through foreign policy issues such as trade, supply chains, and global agreements, including the pandemic treaty and the PABS system; and internally, through domestic policies on vaccine mandates, health coverage, and universal health coverage (UHC).

Regional Organizations Filling the Governance Void

As global institutions weaken, regional health architectures assume greater responsibilities. The Africa CDC expanded its mandate to include direct pharmaceutical procurement, disease surveillance coordination, and health workforce training [51,60,61]. The organization's Africa Pooled Procurement Mechanism secured essential medicines for 15 member states, demonstrating capacity for collective action independent of Western support.

Similarly, the Gulf Health Council emerged as a coordinating body for Middle Eastern health systems, facilitating technology transfer and joint procurement agreements [62,63]. The ASEAN Health Security Framework, or the ASEAN Public-Health Emergency Coordination System (APHECS) implementation accelerated, with member states establishing common standards for disease reporting and cross-border health emergencies [64]. ASEAN Member States are setting up ACPHEED, which will serve as a regional hub to strengthen capabilities to prevent, detect, and respond to infectious disease threats [65].

These regional initiatives, while promising, face challenges of limited resources, varying capacity among member states, and potential duplication of efforts.

Financial Architecture Collapse and Alternative Mechanisms

The Dismantling of Traditional Donor Architecture

The scope of US funding cuts exceeds initial estimates. Beyond the headline $6.5 billion PEPFAR freeze, the administration canceled 83% of USAID contracts by March 2025, affecting maternal health, nutrition, water and sanitation, and disease control programs [66,67]. The Lancet analysis indicates USAID funding was associated with preventing 91.8 million all-age deaths between 2001 and 2021, including 30.4 million children under five [68]. The abrupt cessation threatens to reverse these gains, with projections of 14 million additional deaths by 2030 if funding is not restored [69].

European donors, facing domestic pressures and economic constraints, reduced health Official Development Assistance, [70] compounding the funding crisis. The combined effect creates a gap in global health financing, forcing recipient countries to make impossible choices between maintaining HIV treatment programs, childhood immunization campaigns, and basic health services. A G20 Joint Finance and Health Task Force estimated that an additional US$10.5 billion per year in international financing will be required to fund fit-for-purpose systems globally to provide global public goods for health [71].

Emerging Alternative Financing Mechanisms

The funding crisis catalyzes innovation in health financing, though new mechanisms remain insufficient to fill existing gaps. Sin taxes on tobacco, alcohol, and sugar-sweetened beverages could generate 3.7 trillion dollars in just five years [72]. In July 2025, the WHO launched a new initiative urging countries to raise real prices on tobacco, alcohol, and sugary drinks by at least 50% by 2035 through health taxes in a move designed to curb non-communicable diseases (NCDs) and generate additional resources for health. The "3 by 35" Initiative comes at a time when health systems are under strain from rising NCDs, shrinking development aid, and growing public debt [73]. Tobacco use remains one of the leading causes of preventable death globally, claiming approximately eight million lives each year and contributing to a wide range of cancers, cardiovascular diseases, and respiratory conditions. Taxation on tobacco can lead to reduced usage and hence better health, reduced health costs, and generate additional resources [74,75].

For example, the EU tobacco excise duties generated over €80 billion in tax revenue across the EU in 2023 alone [76]. Similarly, in the UK, the Soft Drinks Industry Levy generated £338 million in the year 2023-2024 [77]. In terms of the direct health impact, the Task Force on Fiscal Policy for Health has shown that increasing the price of tobacco, alcohol, and sugary beverages by 50% could save 50 million lives over 50 years [78]. Although the evidence is clear, it is the implementation of such revenue sources that is tricky, especially in developing nations, which need it the most. Cryptocurrency-based health funds, pioneered by UNICEF's Crypto Fund, distributed $8 million to health technology startups

[a] Launched in 2007, Debt2Health allows creditor and debtor countries to convert -or swap-part of their debt into lifesaving health investments. Currently focused on the conversion of official bilateral debt, all swaps are flexibly and independently negotiated in partnership with the Global Fund and are designed to meet the needs of creditor and debtor countries alike.

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in developing countries [79]. While innovative, the volatility and regulatory uncertainty surrounding cryptocurrencies limit their reliability for sustained health financing.

In 2024, developing countries paid $25 billion more to external creditors than they received in new disbursements. That means 3.4 billion people or more than 40% of the world's population live in countries that spend more on interest payments than on health or education. As aid flows decline, developing countries' debt vulnerabilities will only increase, as will the threats to people's well-being [80,81]. In this context, debt-for-health swaps, negotiated by several African countries with international creditors, could free up millions of dollars for health investments, though implementation remains complex [82]. 14 Debt2Health[(a)] transactions have contributed US$330 million to lifesaving programs and relieved close to US$500 million in bilateral debt in 11 Global Fund implementer countries Cameroon, Côte d'Ivoire, Democratic Republic of Congo, El Salvador, Egypt, Ethiopia, Jordan, Indonesia, Mongolia, Pakistan, and Sri Lanka [83].

Geopolitics and Global Health Financing

In 2025, debates on global health have been dominated by discussions on financing, especially during the Fourth International Conference on Financing for Development, convened in Seville recently [84]. A growing body of work highlights the damaging effects of certain economic measures adopted by states. In their analysis, Francisco Rodríguez and collaborators provide new evidence that economic sanctions have negative health implications, estimating that sanctions imposed by the United States and the European Union contributed to approximately 564,258 deaths each year between 1971 and 2021. This figure exceeds the annual number of deaths from armed conflict, estimated at 106,000. These conclusions echo earlier research published in The Lancet Global Health, which showed that sanctions on development aid in low- and middle-income countries were associated with annual increases of 3.1% in infant mortality and 6.4% in maternal mortality between 1990 and 2019 [84].

Health Practice Transformations and System Adaptations

Health practice is shifting toward digitally enabled, regionalized, and resilience-focused care models. Health systems are deploying AI for clinical decision support, imaging, triage, and administrative co-pilots to expand capacity and reduce delays, a response to persistent workforce gaps and rising demand. The World Economic Forum highlights real-world use cases from stroke imaging to ambulance triage, while noting that health care remains below average in AI adoption despite a projected 11 million worker shortfall by 2030, which positions AI as a practical lever for access and efficiency if deployed safely and at scale [85]. Parallel system adaptations emphasize interoperable data foundations, cybersecurity, and workforce upskilling so that digital tools are trustworthy and usable at the point of care. The OECD synthesizes evidence that AI can free clinicians' time, help prevent errors, and unlock value in underused data, while warning that fragmented data, bias, and weak accountability can entrench inequities unless policy and governance checks are in place [86].

Geopolitical turbulence is also pushing practice toward risk management, transparency, and regional self-reliance. Corruption has reemerged as a first-order threat to service delivery and outcomes, with analyses in The Lancet Regional Health Americas linking higher corruption to lower health spending and poorer health results, which in turn compels providers and payers to build anti-corruption safeguards into procurement, supply chains, and clinical operations. Ongoing geopolitical realignments have created new uncertainties in the governance and financing of global health. These dynamics coincide with rising defense budgets and the prospect of reduced aid allocations from traditional donor nations. For countries that rely on external assistance but are now facing fiscal pressures, the priority is to strengthen domestic resource mobilization with a focus on efficiency and transparency, making anti-corruption focus even more important in practice [87,88].

Trajectory Assessment

Evidence supports that the realistic scenario-fragmented multilateralism with strengthened regional cooperation has emerged as the dominant trajectory. This manifests through multiple indicators across governance, financing, and practice dimensions. The persistence of some multilateral engagement, albeit weakened, confirms the realistic scenario's predictions. While the US withdrew from the WHO, other major powers maintain participation, preventing complete institutional collapse. The organization continues technical functions with reduced scope, publishing guidelines, and coordinating limited emergency responses. Similarly, the Global Fund maintains operations despite funding reductions, adapting through innovative financing mechanisms and an expanded donor base beyond traditional contributors.

Regional health architectures demonstrate increasing autonomy and capability, as anticipated in the realistic scenario. The Africa CDC's evolution from a technical advisory body to an operational implementing agency, complete with procurement capacity and emergency response capabilities, exemplifies this trend. Africa's pursuit of greater health sovereignty showcases advances observed in system-wide capacity building, domestic production of medical goods, more coordinated epidemic responses, and an emphasis on mobilizing internal financial resources for health. During the 12th Annual Conference of Speakers of National and Regional Parliaments in September 2024, the Director General of the Africa CDC, Dr. Jean Kaseya, highlighted the importance of reinforcing public health leadership, securing increased domestic funding, and expanding

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investment in infrastructure. He urged governments to uphold the Abuja Declaration's target of allocating 15 percent of national budgets to health and to follow through on commitments made at the 2019 African Leadership Meeting to ensure steady annual growth in health spending. In addition, Dr. Kaseya pointed to the Africa Epidemics Fund, created in 2022, as a critical instrument for advancing the implementation of the New Public Health Order. BRICS health initiatives, while not replacing Western-dominated institutions, provide alternative platforms for collaboration among emerging economies. The establishment of parallel standards, protocols, and financing mechanisms creates a polycentric global health landscape rather than the unified governance of the optimistic scenario.

Development assistance for health projections aligns with realistic scenario expectations. Rather than complete cessation (pessimistic) or sustained funding (optimistic), we observe selective continuation with political conditionalities. European donors maintain reduced support for specific programs aligned with national interests, while emerging donors like China expand assistance tied to geopolitical objectives [89-91]. This creates a complex patchwork of health aid, less efficient than unified approaches, but avoiding complete system collapse.

Several factors accelerated movement toward the realistic scenario faster than originally projected. The speed of institutional collapse exceeded expectations, with CDC leadership resignations and ACIP reconstitution occurring within months rather than years. The comprehensive nature of funding cuts, affecting 83% of USAID contracts simultaneously, created immediate rather than gradual impacts [66]. The application of technological developments such as artificial intelligence in health is currently concentrated in high-income countries and select middle-income nations. Although with immense potential, it remains to be seen if this widens or bridges the health disparities. It will depend on the AI governance mechanisms and frameworks that will be established, which allow or restrict technology transfer, data sharing, and large-scale implementation of AI-based solutions.

The intersection of health with broader geopolitical tensions, particularly US-China competition, politicizes previously technical health decisions. Vaccine development, disease surveillance data sharing, and medical supply chains become arenas for strategic competition rather than cooperation. This securitization of health accelerates fragmentation beyond original projections. However, South-South cooperation emerges as a significant adaptive mechanism with BRICS and ASEAN health initiatives.

Future Trajectory Considerations

Looking forward to 2026 and beyond, several factors will determine whether the realistic scenario persists or shifts toward more extreme trajectories. The outcome of legal challenges to US funding cuts could restore partial support, pulling back from pessimistic scenarios. Conversely, expansion of nationalist policies could accelerate fragmentation beyond current levels. Climate change impacts increasingly intersect with health system capacity, potentially forcing renewed cooperation on climate-sensitive diseases and disaster response. The approach of the global health community to tackle current and emergent health problems will showcase whether fragmented regional systems can mount an effective coordinated response.

Technological advancements in vaccine platforms, diagnostic tools, and digital health systems have the potential either to reduce or to exacerbate existing disparities, depending on the governance frameworks, technology transfer arrangements, data-sharing policies, and intellectual property regimes that shape their adoption. The progression of BRICS health initiatives, along with comparable regional mechanisms, from initiatives to fully operational systems, will be a critical test of whether alternative governance models can achieve viability and long-term sustainability, since they too will be subjected to the questions of funding and legitimacy.

Implications

Governance: The New Polycentric Reality

The transformation from unified global health governance to polycentric regional systems fundamentally alters how health challenges are addressed. WHO's diminished authority means technical standards increasingly diverge across regions, complicating international health regulations and cross-border disease control. WHO's role as a source of technical advice and normative guidance remains, but its ability to shape global health priorities and mobilize collective action is diminishing.

Regional organizations assume governance functions with varying effectiveness. While the Africa CDC demonstrates capacity for disease surveillance and emergency response, gaps remain in regulatory harmonization and quality assurance. The proliferation of regional standards for pharmaceuticals, medical devices, and health technologies creates regulatory complexity that increases costs and could potentially delay access to innovations.

The governance implications extend to global health security. Without a unified pandemic preparedness implementation framework, the world faces heightened vulnerability to emerging infectious diseases. Regional approaches to pathogen sharing, vaccine development, and outbreak response may prove insufficient for threats that do not respect political boundaries. The International Health Regulations, already weakened by compliance failures during COVID-19, lose further relevance as nations prioritize sovereignty over global health security.

Financing: From Aid to Investment

The collapse of traditional aid architecture necessitates a fundamental reconceptualization of health financing. Countries must rapidly develop domestic resource mobilization strategies,

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though many lack tax bases sufficient to replace external funding. The shift from grants to loans, even on concessional terms, creates debt sustainability challenges for countries already facing economic pressures. Alternative financing mechanisms show promise but face implementation and scalability challenges. Blended finance attracts private capital but requires sophisticated financial management capacity, which many countries lack. Sin taxes have the potential to generate revenues but face industry resistance.

Practice: Divergence and Its Consequences

A more multipolar and contested order is likely to produce a health practice with greater divergence in standards, data governance, and technology pathways. Providers and payers will need dual competencies: harnessing AI to expand access and productivity, and hard-wiring safeguards against bias, privacy breaches, misinformation, and cyber risk. OECD guidance points to concrete levers such as workforce training, clinician involvement across the AI lifecycle, harmonized data governance, and broad accessibility requirements to prevent inequitable rollouts. At the same time, anti-corruption controls become a clinical issue as much as a governance issue because procurement integrity and transparent contracting influence price, availability, and quality of care [86,87].

The introduction of the America First Global Health Strategy has multiple implications for global health partnerships, particularly in low- and middle-income countries. By prioritizing bilateral health agreements over multilateral or NGO-mediated channels and shifting emphasis toward direct provision of drugs, diagnostics, and treatment (rather than technical assistance and administrative costs), this strategy could reshape incentive structures for recipient countries and implementing organizations. It may lead to greater emphasis on health systems' ability to absorb and sustain such responsibilities. On one hand, the focus on co-investment and outcome-oriented agreements could increase accountability and efficiency; on the other hand, there is a risk that while key disease specific interventions are reinforced, broader areas such as maternal and child health, vaccine-preventable diseases outside the chosen disease set, and preventive public health infrastructure may be deprioritized. Monitoring how this strategy interacts with the existing global health architecture will be essential to understanding its full impact [13,14,92,93].

Recommendations

Building on the recommendations from our paper published in April 2025, we propose updated and additional measures responding to current realities:

Updated Recommendations from the Previous Paper

1. **Strengthen Regional Health Security Frameworks:** Accelerate development of regional disease surveillance and response systems with interoperability standards enabling cross-regional coordination. The Africa CDC model provides a template, requiring adaptation to other regional contexts such as APAC, the Middle East, and Central Asia. Some of these regions already have such frameworks, for example, the ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED) established by the Association of Southeast Asian Nations (ASEAN) in 2020.

2. **Diversify and Redefine Health Financing:** Shift from a donor recipient mindset toward development assistance and equitable partnerships with clear short term, medium term, and long-term goals focused on strengthening health systems for priority diseases. Broaden financing sources to include emerging economies, the private sector, and innovative mechanisms. Establish regional health funds with contribution formulas based on economic capacity and disease burden, ensuring sustainability and shared responsibility.

3. **Protect Core Health Interventions:** Define and ring-fence essential health services that must be maintained regardless of political changes. These should include communicable diseases such as HIV and TB, surveillance and outbreak response, as well as critical noncommunicable disease services, particularly for cancers, cardiovascular conditions, mental health, and neurological disorders. Establish emergency financing mechanisms that can be automatically activated during funding crises to safeguard the continuity of these interventions.

4. **Promote Regional Manufacturing and Resilient Supply Chains:** Partner with the pharmaceutical and medical device industries as key public health allies to build sustainable regional production capacity. Create favorable conditions and incentives for investment in nontraditional manufacturing locations, while jointly developing regional hubs through technology transfer, supportive regulatory environments, and strategic reserves. Strengthen diversified supply chains and rapid surge manufacturing capacity to ensure reliable access to essential medicines, devices, and diagnostics, particularly during emergencies.

5. **Transform Global Health Governance Through Distributed Authority and Performance-Based Legitimacy:** Fundamentally restructure the WHO from a state-centric coordination body into a networked governance system that combines global standard setting with empowered regional implementation. Establish performance-based representation in key decision-making bodies where voting weight reflects both priority and investments in health, and demonstrated health system performance, moving beyond the current one-country-one-vote model for technical and funding decisions. Ensure autonomous regional health authorities with independent budgets and a mandate to adapt global frameworks to local epidemiological and cultural contexts, while maintaining WHO's role in setting evidence-based standards, coordinating cross-border responses, and ensuring interoperability.

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6. **Introduce direct engagement mechanisms for sub-national actors:** Civil society, and private sector entities in governance structures, recognizing that effective health responses increasingly require multi-stakeholder coordination beyond traditional diplomatic channels. Establish clear accountability mechanisms with regular performance reviews of both global and regional bodies, ensuring that governance structures can adapt rapidly to emerging health challenges while maintaining legitimacy and technical credibility.

7. **Bridge the Digital Health Divide:** Ensure equitable access to digital health innovations by prioritizing capacity building, infrastructure investment, and inclusive design. Establish open source, interoperable platforms for health information systems that are accessible and adaptable to all countries, fostering regional and global data sharing for better decision making.

8. **Strengthen Civil Society Engagement:** Support civil society organizations (including Red Cross/Crescent; Stop TB; and others) as crucial bridges during institutional transitions. Support flexible, long-term funding enabling organizational sustainability and community-based service delivery.

9. **Harmonize Regulatory Standards:** While respecting regional autonomy, work toward mutual recognition agreements for pharmaceutical and device regulations. Establish baseline quality standards acceptable across regions that can be adjusted.

10. **Invest in Health Workforce Sustainability:** Develop retention strategies that address both financial and professional development needs. Establish regional training centers and exchange programs to build local capacity and facilitate knowledge transfer. In the interim, strengthen collaboration through regional or country cluster hubs that can provide shared diagnostic and treatment capacity to help bridge workforce gaps.

11. **Establish Independent Monitoring Mechanisms:** Create and fund autonomous bodies tracking health outcomes and holding governments accountable for health commitments. Ensure transparent reporting accessible to civil society and affected communities.

12. **Build Climate-Health Resilience:** Integrate climate adaptation into health system strengthening to safeguard essential services and protect vulnerable populations. Anticipate and address the health impacts of climate change such as shifts in infectious disease patterns, rising burdens of respiratory and cardiovascular illness, and climate-driven nutrition challenges. Develop and expand early warning systems for climate-sensitive health threats to enable timely prevention, preparedness, and response.

13. **Promote Evidence-Based Decision Making:** Protect scientific integrity in health policy through independent advisory bodies and transparent decision-making processes. Resist politicization of technical health decisions through professional mobilization and public education.

New Recommendations Based on Current Analysis

1. **Establish Emergency Health Diplomacy Mechanisms:** Create rapid diplomatic response capabilities for health crises transcending political tensions. Formulate protocols that allow for the temporary suspension of sanctions and trade restrictions on health products during public health emergencies.

2. **Empower Patient Voices and Advocacy:** Institutionalize patient and community representation in health decision-making processes at national, regional, and global levels. Support patient advocacy organizations with sustainable funding and capacity building to ensure lived experiences are heard and shape policy priorities, service delivery, and accountability mechanisms.

3. **Harness Artificial Intelligence for Health Equity:** Promote responsible and equitable adoption of AI technologies to strengthen health systems, ensuring transparency, fairness, and accountability. Invest in AI-enabled tools for diagnostics, surveillance, and health service delivery while addressing risks of bias and exclusion. Support capacity building and equitable access so that AI benefits are shared across all regions, particularly in low- and middle-income countries.

4. **Strengthen South-South Cooperation Platforms:** Formalize and scale successful bilateral and regional cooperation models. Create knowledge-sharing platforms and technical assistance networks among developing countries.

5. **Develop Health Sovereignty Frameworks:** Balance national autonomy with global cooperation through flexible governance models. Respect diverse approaches while maintaining minimum standards for cross-border health threats and for providing global public health goods.

Conclusion

Our analysis confirms that the realistic scenario outlined in our previous paper has materialized. The realistic scenario of fragmented multilateralism and regional cooperation is emerging as the dominant paradigm, characterized by weakened global institutions, strengthened regional architectures, and widening health disparities that threaten decades of public health progress if timely and coordinated action is not taken. The confluence of US institutional withdrawal, funding cessation, and tariff impositions created shocks that caused a reorganization of global health governance, the emergence of adaptive mechanisms by regional bodies, the rise of middle powers, and shifting geopolitical coalitions.

The human costs of these transitions are unnecessary and tragic. Funding disruptions since January 2025 have caused more

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than 160,000 adult and 330,000 children's deaths. The reversal of decades of progress in disease control, health equity, and system strengthening constitutes a setback that would require decades to recover.

The emerging polycentric global health landscape presents both challenges and opportunities. While coordination complexity increases and efficiency decreases, the diversity of approaches may foster innovation and context-appropriate solutions. The transition from dependency to self-reliance could ultimately strengthen health system sustainability.

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