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Recent Geopolitical Shifts and Their Implications for Global Health: A New World Order in The Making

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Abstract

The global geopolitical landscape is undergoing a profound transformation, marked by a shift from multilateralism to nationalism, the rise of multipolarity, and the partial withdrawal of traditional powers from international cooperation frameworks. This paper explores how these shifts are reshaping global health governance, financing, and implementation practices, with downstream impacts on health systems and individual health outcomes. Anchored in realist international relations theory, the globalization and health framework, and the social determinants of health, the analysis draws on historical precedents and current trends such as donor disengagement, weakened global institutions, disrupted supply chains, and widening health inequities. It highlights the cascading consequences of reduced funding for agencies like USAID and WHO, including setbacks in disease control, pandemic preparedness, and sexual and reproductive health.

Three plausible future scenarios-Optimistic, Realistic, and Pessimistic are presented to illustrate the implications of varying degrees of international cooperation and geopolitical alignment. These scenarios are complemented by 13 evidence-informed recommendations that build on and enhance existing mechanisms across governance, financing, and practice. The paper argues that geopolitical determinants must be treated as central to global health planning. Strengthening inclusive multilateralism, diversifying financing, and supporting regionally tailored strategies are critical to advancing health equity and resilience in an increasingly fragmented world order. Recent geopolitical shifts and their implications for global health: A new world order in the making

Keywords: Global health; Health diplomacy; Pandemic response; Health governance; Health policy; Environmental health risks; Geopolitical tensions; public health infrastructure

Abbreviations: WHO: World Health Organization; USAID: United States Agency for International Development; GPC: Great Power Competition; CDC: Centres for Disease Control and Prevention; UN: United Nations; NIH: National Institutes of Health; IDSA: Infectious Diseases Society of America; IHR: International Health Regulations; ECDC: European Centre for Disease Prevention and Control's

Introduction

A new world order is unfolding, characterized by shifts in power dynamics, alliance structures, and geopolitical relationships [1-3]. This restructuring manifests through multiple interconnected phenomena: the emergence of multipolarity, exemplified by BRICS expansion from five to ten members and the rising influence of middle powers; [4,5] the escalation of economic tensions through tariffs, trade barriers, and retaliatory measures; [6] military invasion and conflict in Europe, the Middle East, and Africa; [7-9] the rise of economic nationalism, populism, and a trend toward deglobalization; [10-12] and democratic backsliding [13].

Most significantly for global health, this transformation is characterized by major powers' withdrawal from crucial international frameworks, including the Paris Climate Agreement, World Health Organization (WHO), and United States Agency for International Development (USAID) programs [14-16]. This new and evolving world order represents a dual transformation. Politically, traditional multilateralism is yielding to nationalist interests, while economically, global integration is giving way to protectionist policies and regionalized supply chains. These parallel shifts are fundamentally altering interstate relations and cooperation mechanisms, with profound implications for global health governance and individual health outcomes.

World leaders have consistently characterized recent geopolitical shifts as "historic turning points." German Chancellor Olaf Scholz used this term following Russia's invasion of Ukraine in 2022, as Germany pivoted toward increased military spending, potentially at the expense of global health initiatives [17-19]. Chinese President Xi Jinping described a "historical crossroads" at the 2018 APEC summit, [20,21] while U.S. President Joe Biden spoke of a "historical inflection point" at the 2024 UN General Assembly [22]. While these turning points carry different implications across domains from security to trade, climate finance to immigration and vary between Global North and South perspectives, this study examines their significance through a global health lens.

Among these geopolitical developments' many implications, their impact on global health is particularly critical, as population health underpins societal stability and economic productivity [23-25]. Recent shifts in the global order are fundamentally reshaping health governance, financing, and delivery systems, with severe consequences for individual health outcomes [26-28]. The impact of USAID funding discontinuation illustrates this relationship starkly: within just two months (January-March 2025), the Stop TB Partnership's TB Counter model estimated 11,000 additional tuberculosis deaths [29]. Even more concerning, WHO Director-General Tedros Adhanom Ghebreyesus warned that disruptions to HIV programs threaten to reverse two decades of progress, potentially leading to 10 million new HIV cases and three million HIV-related deaths [30]. This paper examines how these geopolitical shifts impact global health governance, financing, and practices, analysing both immediate and long-term consequences for disease burden and mortality. It addresses two key research questions:

- How have historical geopolitical, economic, and foreign policy changes affected global and individual health?
- What are the implications of current geopolitical shifts for global and individual health outcomes?

The analysis unfolds across five sections: an introduction examining the new world order's historical context and health implications; a methods section outlining theoretical frameworks and operational definitions; an analysis of current trends and future scenarios; recommendations for global health governance, financing, and practices; and conclusions.

Past Geopolitical Trends

Global power distribution has historically been dynamic, shifting from the Cold War's bipolar structure to U.S. dominated unipolarity following the Soviet Union's collapse, and now transitioning toward multipolarity through the Great Power Competition (GPC) [31]. Recent years have witnessed unprecedented changes in international relations, marked by rising populism and protectionism. The U.S. implementation of substantial tariffs against allies in 2018 and 2025, along with Brexit driven by sovereignty concerns over immigration and trade exemplify this departure from established liberal international order [32-35]. The ongoing conflicts in Gaza and Ukraine further underscore the erosion of the post-World War II rules-based system, representing the most significant global restructuring since the establishment of the United Nations (UN) and Bretton Woods institutions [36-38].

The concept of a "new world order" has evolved significantly since its popularization by Woodrow Wilson after World War I [39]. While H.G. Wells envisioned it as a utopian system of unified global governance addressing inequality and social injustice through international cooperation, current trends suggest movement in the opposite direction. The recent expansion of BRICS to include Egypt, Ethiopia, Indonesia, Iran, and the United Arab Emirates signals an emerging alternative world order that amplifies developing nations' interests over those of traditional powers [40,41]. From a global health perspective, the critical turning point came with U.S. President Donald Trump's 2016 election and intensified with his second term commencing in 2025. As the largest donor of foreign aid through USAID and the United States President's Emergency Plan for AIDS Relief (PEPFAR), U.S. policy shifts have profound implications for global health initiatives and international development [42].

Methods

This study integrates three theoretical frameworks:

1. **Realist theory in international relations:** Provides analytical tools for understanding power dynamics between states, explaining how national interests and security concerns influence global health commitments and international cooperation [43].

2. **Globalization and health framework:** Examines interconnections between global economic processes and health outcomes, revealing how trade policies, market integration, and international agreements affect health systems and access to care [44,45].

3. **Social determinants of health framework:** Maps how broader social, economic, and political factors shape health outcomes, particularly how geopolitical shifts affect healthcare access, resource distribution, and health inequities [46].

The analysis is further enriched by historical analysis and the concept of path dependence, which posits that historical events and decisions significantly shape present and future policy trajectories. This theoretical foundation guides our evaluation of recent geopolitical shifts and informs three potential scenarios: Optimistic, Realistic, and Pessimistic. Together, these frameworks guide the analysis of how geopolitical transformations affect both institutional health governance and individual health outcomes, directly informing the study's two central research questions.

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Key Definitions

Geopolitical Shift: Changes in international power dynamics, including power redistribution, ideological spread, territorial changes, alliance formation, economic relationships, and security concerns among nations and regions.

New World Order: A fundamental transformation in global power dynamics characterized by shifts in geopolitical alignments, economic systems, and diplomatic paradigms. This systemic change reshapes international relationships, affecting global security, environmental sustainability, public health, economic development, and social equity.

Global Health: A multidisciplinary field prioritizing health equity and wellbeing for all populations worldwide. It addresses transnational health challenges through social, economic, environmental, and political determinants, transcending geographical boundaries. Global health integrates diverse disciplines, fostering solutions that bridge population-level prevention with individual clinical care. The field emphasizes health as a universal right, focusing on reducing disparities, strengthening health systems, and promoting sustainable interventions that respond to both local and global challenges [47,48].

Middle Powers: Middle powers are states that exert significant influence in international relations but do not possess the same level of dominance as great powers or superpowers. They are characterized by their ability to shape international events through diplomatic, economic, and sometimes military means, without dominating any single area [49].

Analysis and Results

Geopolitical shifts throughout history have consistently shaped global and individual health outcomes through the social, commercial, and geopolitical determinants of health. These non-medical factors including employment conditions, income/poverty levels, and job security mediate how global policies translate into health impacts at the individual level [46,50,51].

Historical Perspectives: Lessons Learned

Major geopolitical transitions have significantly influenced global health governance, as evidenced by three key periods in modern history:

1. **Post-World War II Era (1945-1980):** The establishment of the WHO marked a breakthrough in international health cooperation, culminating in the global eradication of smallpox in 1980 [52]. This achievement demonstrated possible cooperation even amid Cold War tensions, as both superpowers recognized mutual benefits in disease elimination [53].

2. **Cold War Dynamics (1949-1956):** UN bodies become ideological and diplomatic battlefields. Ideological tensions affected global health institutions when the Soviet Union and its allies withdrew from the WHO in 1949, citing American dominance [54]. This withdrawal impacted the WHO's financial capacity and operational scope until 1956, when Nikita Khrushchev, the new leader of the Soviets, emphasized a "peaceful coexistence" policy and all communist countries except China returned to the WHO [55].

3. **Post-Cold War Period (1989-Present):** The international health landscape transformed from ideologically driven assistance to negotiated development approaches, codified in the Paris Declaration on Aid Effectiveness and the Accra and Busan Accords [56-58]. These instruments were intended to promote sector-wide (horizontal) approaches for integrated and sustainable programs. Nonetheless, disease-focused (vertical) global health initiatives dominated, such as the Stop TB Partnership; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and Roll Back Malaria [59-62].

Current and emerging trends show

- Challenge to Bretton Woods institutions by Asian powers, including China's emergence as a major donor with fewer conditions [63,64].
- Shift toward nationalism and regionalization (America First, Brexit) [65-67].
- Weakening support for multilateral agencies like the WHO [54].
- Growing complexity in global health negotiations amid multipolarity [54].

These shifts continue to reshape global health governance, financing, and individual health outcomes in the emerging multipolar world order [54].

Impact of Recent Geopolitical, Economic, and Foreign Policy Changes on Global Health

Current geopolitical trends toward nationalism, populism, and economic protectionism mirror historical patterns where isolationist policies undermined international health cooperation. Additionally, geopolitical risk, which is a construct to measure adverse geopolitical events such as wars, nuclear threats, and terror threats is rising [68-70]. In response, the foreign policies in several countries have changed [71].

Weakened global health governance

Geopolitical fragmentation undermines global health governance in multiple ways. The U.S. withdrawal from the WHO exemplifies this trend, disrupting critical health coordination mechanisms, such as coordinated responses to global health

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emergencies. For example, the Trump administration has directed the Centres for Disease Control and Prevention (CDC), which hosts the WHO Collaborating Center for Surveillance, Epidemiology, and Control of Influenza, to cease communications with the WHO. Argentina has also announced that it will withdraw from the WHO, which signals potential cascading defections from international health frameworks [72]. This fragmentation risks undermining global consensus on critical health issues such as:

- Global pandemic response capabilities
- International disease surveillance systems
- Progress toward Sustainable Development Goals (SDGs)
- Implementation of pandemic treaty agreements
- Coordinated emergency health responses

Disruption in health funding and program implementation

Realist theory can help to understand the rationale behind recent cuts in international aid where sovereign nations tend to put their interests ahead of others. International aid reductions, driven by national self-interest, have created significant healthcare access barriers globally. Evidence demonstrates severe impacts.

For instance, the results from one survey in an East African country with high-HIV prevalence found that 62% of respondents reported difficulty accessing pre-exposure prophylaxis (PrEP), and 46% of people living with HIV (PLHIV) experienced disruptions in HIV treatment [73]. In Latin America/Caribbean, a survey of 49 organizations reveals widespread service disruptions caused by U.S. funding cuts [74]. This includes key populations experiencing reduced healthcare access; and PLHIV reporting increased emotional distress resulting from program cuts. These disruptions highlight how funding reductions in an interconnected world affect transnational disease control, undermining both local and global health security.

Compromised pandemic preparedness and response to communicable diseases

The global retreat from multilateralism has significantly diminished the leadership capacity of the WHO, particularly in coordinating effective responses to pandemics [75]. During the COVID-19 crisis, geopolitical tensions heightened vaccine nationalism a practice wherein governments prioritized domestic access to vaccines at the expense of global equity [76,77]. These undermined international efforts to ensure fair distribution.

Data from the WHO highlighted the scale of this inequity: by mid-2021, only two percent of the population in low-income countries (LICs) had received at least one dose of a COVID-19 vaccine, compared to 65% in high-income countries (HICs) [78]. This inequity in vaccine access led to preventable deaths and cases of illnesses in low-income countries, and slow economic recovery [79]. This disparity was mitigated in part through the WHO-led Access to COVID-19 Tools (ACT) Accelerator, which demonstrated the potential of global cooperation to redress systemic imbalances in vaccine distribution and pandemic tools access [80].

However, the weakening of multilateral mechanisms now threatens the future of such coordinated responses. According to the Infectious Diseases Society of America (IDSA), funding cuts to the U.S. National Institutes of Health (NIH) are already delaying the development of essential vaccines, diagnostics, and treatments. These delays have direct implications for the early detection, containment, and prevention of emerging infectious diseases [81].

Past WHO interventions further illustrate what is at stake. For example, during the 2022 Ebola outbreak in Uganda, the WHO rapidly mobilized essential equipment including testing kits and isolation units enabling swift containment of the disease within 69 days as a result of rapid mobilization, international cooperation, and community-driven approaches. Without this effort, the number of cases and deaths could have been higher [82]. These efforts not only limited domestic transmission but also prevented the spread of the virus to neighbouring East African countries and potentially beyond. The erosion of the WHO's operational capacity therefore risks the loss of crucial emergency response infrastructure at a time when global health threats are escalating.

Impact on non-communicable diseases

Recent geopolitical changes have put millions of lives at risk, including people living with non-communicable diseases (NCDs) [83]. The CEO of NCD Alliance said that while USAID hasn't played a significant role in funding the response to NCDs, the major halt in funding is expected to have "a ripple effect on all different health issues." Funding cuts force low- and middle-income countries (LMICs) to reallocate limited resources to the most acute/critical programs like HIV and maternal health, while deprioritizing NCDs. In the U.S., the cancellation of a 30-year nationwide diabetes surveillance study has compromised long-term disease monitoring capabilities which could have helped reduce the impact of the disease. Similarly, a grant for another study whose findings had the potential to reduce the Maternal Mortality rate was cancelled [84,85].

Impact on reproductive and sexual health

As a condition of receiving U.S. foreign assistance for family planning, the Global Gag Rule (GGR) prohibited foreign non-governmental organizations (NGOs) from advocating for the liberalization of abortion laws or counseling on, referring for, or providing abortion services as a method of family planning. A scoping review in 2019 reported that GGR's development and implementation were consistently associated with poor impacts on health systems' function and outcomes globally [86]. Over the course of the 90-day freeze on foreign aid, around 11.7 million women and girls will be denied contraceptive care in 2025. Of

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these, 4.2 million will experience unintended pregnancies, and 8,340 will die from complications during pregnancy and childbirth [87].

Pharmaceutical supply chain, scientific research, and innovation

Rising economic protectionism and trade wars are reshaping global medical supply chains, creating shortages and cost increases in essential medical supplies [88-92]. While the full impact may take some time to materialize due to existing contracts and inventory stockpiles. Experts predict drug costs will rise by at least 10% in the U.S [93,94]. The retreat from multilateralism, coupled with U.S. withdrawal from the WHO and funding cuts to the NIH and CDC, threatens international research collaboration, potentially delaying critical advances in vaccine development and medical treatments [95]. These disruptions particularly impact global health innovation networks and research partnerships.

Malnutrition and hunger

As the world's largest food aid donor, USAID's annual $5 billion commitment through programs like Feed the Future has been crucial in addressing hunger across Africa, Latin America, and Southeast Asia. While emergency food assistance continues, the suspension of programs addressing food safety, nutrition, climate resilience, and agricultural productivity threatens long-term food security [96,97]. Conflict zones like South Sudan face particularly severe consequences from these program disruptions where 24.6 million people are facing food shortages [98-100].

Impacts on advocacy efforts and the voice of patients

The withdrawal of U.S. support affects advocacy at both global and local levels. Within the WHO, reduced engagement weakens civil society's ability to shape health strategies through forums like the World Health Assembly [101]. Locally, USAID/PEPFAR-funded organizations face closure, eliminating crucial support systems for vulnerable populations and diminishing patient representation in health policy discussions [102].

Increased health inequality

Reductions in international development assistance will amplify disparities in access to healthcare [103]. Moreover, the guidelines, manuals, and reports the WHO produces are trusted tools for shaping national health policies and improving public health outcomes in countries across the world. The loss of U.S. funding and technical expertise will hinder the WHO's ability to generate such crucial resources and the capacity to support evolving health systems [72].

Scenarios

Our historical analysis of geopolitical shifts highlights their significant impact on global health, currently at a critical crossroads. Future developments may lead to a revival of multilateralism or exacerbate existing challenges. To explore these divergent paths, we present three scenarios Optimistic, Realistic, and Pessimistic that depict alternative futures for global health governance, financing, and practices. These scenarios are further compared in (Table 1), highlighting key features and the roles of stakeholders.

Optimistic Scenario: Renewed multilateralism and global solidarity

In this scenario, states led by major powers such as the U.S. recognize the shared nature of global health threats and recommit to multilateral cooperation. This renewed engagement catalyses reinvestment in global health institutions, bolsters regional capacity, and fosters inclusive innovation.

- The international community, drawing upon lessons from the COVID-19 pandemic, acknowledges that health security is indivisible from global security.
- Donor nations (including the U.S.) fully restore and expand funding for institutions like USAID, PEPFAR, and the WHO.
- A robust and binding WHO Pandemic Treaty is successfully negotiated and implemented, ensuring equitable pandemic preparedness and response.
- Cross-bloc collaboration emerges, with BRICS and G7 nations launching joint initiatives to combat shared health threats such as antimicrobial resistance, NCDs, and climate-driven disease burdens.
- Investment in local vaccine and medical supply manufacturing enhances resilience in LMICs.
- Strategic public-private and philanthropic partnerships close funding gaps and accelerate innovation across diagnostics, therapeutics, and delivery systems.

Implications

- Revitalized global health governance with stronger, better-resourced institutions.
- Reaffirmed WHO leadership, supported by stable political and financial backing.
- Significant reductions in health disparities through targeted investments and health systems strengthening.
- Enhanced global preparedness for pandemics and other cross-border health emergencies.

Realistic Scenario: Fragmented multilateralism and regional cooperation

Here, multilateralism persists in a diminished and uneven form. The U.S. selectively re-engages, while regional powers and blocs increasingly shape health agendas. The WHO remains

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operational but under financial and political constraints. Global health governance enters a mixed state: partial U.S. re-engagement alongside the continued rise of regional powers (e.g., China, India, the EU) shaping their own health aid strategies.

Table 1: Comparison of scenarios by their key features

	Optimistic scenario	Realistic scenario	Pessimistic scenario
Health Equity	Improves significantly, driven by equitable funding models, expanded access to vaccines and medicines, as well as health infrastructure investment in LMICs.	Improves unevenly. Some regions (e.g., ASEAN, Africa) benefit from localized initiatives, but others face service gaps. Refugees and stateless populations may remain underserved.	Deteriorates sharply, with increased mortality and morbidity in LICs and vulnerable populations. Decades of progress on diseases like HIV, TB, and malaria are reversed.
Pharmaceutical Companies	Collaborate with the WHO and LMICs to expand R&D partnerships, share technology (e.g., mRNA platforms), and support local production hubs.	Focus on profitable markets but also engage in tiered pricing and licensing under the WHO/UN-backed frameworks. Focus on regional alignment with production hubs in India, Brazil, and South Africa.	Prioritize high-margin markets in HICs. Innovation pipelines narrow, generics in LICs face shortages, and intellectual property (IP) becomes even more guarded.
Diagnostics Companies	Scale affordable and portable testing tech across the Global South, embedding tools into routine health systems for NCDs and infectious diseases.	Target mid-income markets, with innovation focused on cost efficiency. Limited penetration in fragile states without donor support.	Withdraw from low-profit regions; only essential pandemic-related diagnostics are maintained via emergency response.
Innovation	Surges via open-access science and WHO-coordinated research platforms.	Moderately robust but concentrated in some regions. Data-sharing frameworks remain fragmented; language and IP policies vary by region.	Slows significantly. Multilateral research halts, and non-sharing of data prevents collaborative advancement. Vaccine and drug development become national assets, not global goods.
Non-Communicable Diseases (NCDs)	Integrated into universal health coverage (UHC) plans, with investment in preventive programs, early diagnostics, innovative treatments, and digital health solutions.	Slowly integrated into national health strategies, with support from philanthropic orgs and regional development banks.	Neglected due to lack of donor interest; infrastructure collapse in fragile states worsens outcomes.
The WHO's Role	Revitalized and better funded, leading global emergency preparedness and coordinating equitable access mechanisms like ACT-A 2.0. Gains stronger enforcement tools and autonomous financing mechanisms.	Maintains a technical and normative leadership role. Stretched thin financially, relies on voluntary earmarked funding and regional offices for implementation.	Marginalized, underfunded, and politically undermined. Becomes an advisory body with minimal operational capacity. Treaty processes collapse and global surveillance of diseases deteriorates.
Health System Strengthening	Prioritized through long-term investment, technical training, and resilience planning, especially for primary care and supply chain diversification.	Driven by donor consortia and south-south cooperation, but progress depends on regional political stability and domestic prioritization.	Severely underfunded; local health systems deteriorate. Brain drains and supply chain collapse deepen the fragility of services.
Investment by Country Income Level	• HICs restore and increase ODA commitments. • Upper-middle-income countries (UMICs) contribute via regional initiatives and south-south cooperation. • LICs are recipients of targeted technical and financial aid but with improved autonomy and accountability.	• HICs focus on strategic or bilateral partnerships. • UMICs become key donors in their neighborhoods. • LICs face inconsistent support, increasingly expected to self-finance essential services.	• HICs divert health funds to domestic resilience and defense. • UMICs focus on national interests, not regional leadership. • LICs face widespread abandonment, increasing reliance on NGOs with shrinking footprints.

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- A hybrid global health architecture emerges: partial U.S. involvement alongside the growing influence of China, India, the EU, and regional health alliances.
- The WHO continues to provide technical guidance but is increasingly reliant on support from middle powers and philanthropic entities.
- Pandemic treaty negotiations result in a diluted framework, with limited binding commitments and uneven uptake by Member States.
- Regional organizations such as Africa Centres for Disease Control and Prevention, the Association of Southeast Asian Nations (ASEAN) health bodies, and BRICS health platforms expand their functions and autonomy.
- Global health financing partially rebounds but remains vulnerable to domestic political shifts in donor countries.
- Efforts to localize production and diversify supply chains advance, though regulatory barriers and vaccine nationalism persist and hamper equitable access.

Implications

- Global coordination becomes fragmented; regional frameworks begin to fill governance voids left by faltering multilateral institutions.
- The WHO's role becomes more technical than directive, and financing gaps limit its capacity.
- Health equity improves slowly, with significant progress in some regions and stagnation in others.
- Pandemic preparedness becomes inconsistent and reactive across regions. Continued risk of uncoordinated responses to future pandemics.

Pessimistic Scenario: Strategic isolation and retreat from global health cooperation

This scenario envisions deepening protectionism, the erosion of multilateral institutions, the WHO's loss of influence, and growing donor fatigue. Global health becomes increasingly politicized, underfunded, and reactive.

- Major donors, including the U.S., disengage fully from the WHO and other international health mechanisms.
- The WHO faces a legitimacy crisis, with steep budget cuts and diminished operational capacity.
- Heightened geopolitical rivalry leads to uncoordinated, duplicative health aid programs, with little coordination and increased politization of vaccine delivery, research funding, and technical assistance.
- Global health funding stagnates or declines, undermining essential services in LMICs.
- Trade disputes and protectionism further destabilize pharmaceutical supply chains, raising costs and limiting access to essential medicines.
- Global data sharing and scientific collaboration wanes, stalling innovation and compromising pandemic surveillance.
- Conflicts and climate-related crises stretch already fragile health systems, especially in vulnerable and conflict-affected regions.

Implications

- Global health governance is weakened, fragmented, and poorly resourced.
- Health disparities widen dramatically, with disproportionate impacts on LICs and marginalized populations.
- The world is ill-prepared for future pandemics, increasing both human and economic costs.

Conclusion

Recent geopolitical transformations have led to a marked decline in global cooperation, with significant consequences for global health governance and financing. This retreat undermines collective capacity to respond to both current and emerging health threats and curtails progress toward equitable health outcomes. The immediate impact of foreign aid withdrawal such as the loss of U.S. support to USAID and the WHO has already translated into measurable increases in morbidity and mortality, particularly for diseases like tuberculosis and HIV. These developments not only jeopardize decades of public health gains but also establish a dangerous precedent in which global solidarity and cooperation are deprioritized in Favor of narrow national interests.

In summary, the analysis demonstrates that geopolitical, economic, and foreign policy shifts profoundly impact global health governance and equity, leading to both immediate health disruptions and long-term vulnerabilities. Understanding these patterns is essential to foster renewed global cooperation and strengthened multilateral frameworks to promote public health and global health equity. Furthermore, weakened global health is negative for all stakeholders. Ultimately, renewed investment in multilateral frameworks and inclusive governance is not merely aspirational it is imperative. Only through sustained cooperation and shared responsibility can the global community build resilient health systems, reduce inequalities, and safeguard public health for future generations. A weakened response to global health governance, financing, and practice would be bad for every country, and for everyone.

Recommendations

Drawing from historical analysis and emerging global health challenges, we present 13 recommendations across governance, financing, and practice. These are designed to bridge gaps in existing efforts, build on successful models, and ensure health

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systems remain resilient, equitable, and responsive in a shifting geopolitical context.

Governance

Establish a consensus-based operational definition of global health

While the WHO, The Lancet Commission on Global Health, [104] and academic institutions have offered valuable definitions of global health, there remains no consensus across policy and funding actors. A shared operational definition one that clarifies roles across equity, access, innovation, and resilience is necessary to align donor agendas, national policies, and institutional mandates.

Embed transparency and accountability into global health architecture

Building on the WHO's proposed reforms under the Pandemic Accord [105] and the International Health Regulations (IHR), [106] we recommend the institutionalization of peer accountability mechanisms. These could include public dashboards of donor commitments (e.g., modelled after Gavi's scorecards) and independent review panels to assess the alignment of contributions and outcomes.

Institutionalize inclusion and equitable power sharing

To expand on the inclusive vision of UHC2030 [107] and the Global Action Plan for Healthy Lives and Well-being [108], we propose a Global Health Equity Forum. This would formalize civil society and LMIC representation in agenda-setting, with rotating regional leadership and direct pathways to influence strategic planning at the WHO, Gavi, and the Global Fund.

Integrate health diplomacy into foreign policy training and institutions

Health diplomacy is emerging as a discipline, with precedents in Switzerland's Health Foreign Policy [109], the African Union's health attaché programs, and recent WHO-WTO collaborations [110]. We recommend embedding health diplomacy into foreign service training and creating permanent health–foreign affairs liaison offices in ministries to operationalize this function.

Develop a model foreign health policy framework for national adaptation

Countries like Brazil and Thailand have developed de facto foreign health policies, but there is no formal guidance for national governments. The WHO, in collaboration with the United Nations Development Programme and regional blocs, should develop a Model Foreign Health Policy Framework a flexible, modular tool to help countries embed health into trade, security, and diplomacy strategies.

Align global health objectives with existing milestones via real-time monitoring

Rather than generating new metrics, stakeholders should align with SDG Targets 3.8 (UHC), 10 (inequality), and 17 (partnerships). A global public health monitoring platform building on the WHO's Global Health Observatory should offer real-time insights into progress, flagging governance gaps early and enabling course correction.

Financing

Create a tiered reciprocity model for global health contributions

Inspired by the Green Climate Fund's "responsibility and capacity" model [111,112], we propose a similar structure for global health financing: tiered contribution levels based on GDP, fiscal space, and debt sustainability, with transparent rules and opt-in commitments reviewed by independent panels such as the OECD's Development Assistance Committee [113].

Diversify financing sources through innovative global health levies

Building on precedents like the UNITAID airline ticket levy [114] and France's financial transaction tax for development [115], countries should explore solidarity mechanisms such as levies on fossil fuels, digital advertising, or sugary drinks. These dedicated funds would support research and development (R&D), health systems strengthening, and pandemic preparedness in low-resource settings.

Practice

Develop exit-readiness benchmarks for global health interventions

Building on Gavi's transition planning frameworks [116] and PEPFAR's Sustainability Index and Dashboard (SID) [117], we recommend the co-development of globally applicable exit-readiness benchmarks. These would include indicators for fiscal independence, institutional capacity, and governance maturity to determine when to wind down external support responsibly.

Support country-led technical assistance through south-south models

While south-south cooperation is highlighted in the WHO's Technical Cooperation Strategy (PAHO) [118] and by platforms such as ASEAN Health Cooperation [119], funding and structural support remain limited. We recommend investing in LMIC-led Centres of Excellence, inter-country fellowships, and peer-learning exchanges to build context-appropriate expertise from within.

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Create a global risk intelligence hub for health

The WHO's Global Outbreak Alert and Response Network (GOARN) [120] and the European Centre for Disease Prevention and Control's (ECDC) epidemic intelligence tools [121] are valuable but fragmented. We propose a centralized, AI-supported Global Health Risk Intelligence Hub to pool data across countries, perform horizon scanning, and support coordinated anticipatory responses.

Support country adaptation and implementation of health systems sustainability frameworks

Frameworks such as the WHO Health Systems Building Blocks Framework [122] exist, but implementation remains weak. We recommend packaging these tools into localized implementation kits, with technical support and financing tailored to countries' political economy and health capacity realities.

Establish regional peer-learning networks to localize strategy design

Efforts such as the East African Community Medicines Regulatory Harmonization Initiative and the African Union Medical Supplies Platform, show the potential of regional cooperation [123]. We propose further formalizing regional peer-learning networks, grouped by epidemiological or geopolitical similarity (e.g., small island states, post-conflict countries), to co-design shared solutions and advocate for joint financing.

These recommendations are not aspirational ideals they build on existing mechanisms, global agreements, and lessons from recent geopolitical turbulence. What remains is to bridge the implementation gap and ensure that strategies are resourced, contextualized, and inclusive, and that progress is monitored and evaluated. In an era of multipolar fragmentation, global health actors must embed cooperation, equity, and adaptability in the heart of the governance agenda.

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