United Nations University
International Institute for Global Health

Malaysia's Response to a Changing Global Health Landscape

A National Roundtable | Kuala Lumpur, 27 July 2026

Summary Report

UNU Global Health

THE ASIAN COLLECTIVE FOR HEALTH SYSTEMS

Centre for Social and Economic Progress | CSEP
Independence | Integrity | Impact

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On **Monday, 27 July 2026**, the **United Nations University International Institute for Global Health (UNU Global Health)** brought together various stakeholders from government ministries, academia, and civil society to discuss Malaysia's strategic role in international and regional health governance. As part of a broader research initiative with the Center for Social and Economic Progress (CSEP) under the Asian Collective for Health Systems, the dialogue focused on how Malaysia can navigate a changing and complex global health landscape, and strengthen international health cooperation in ways that may benefit health in Malaysia and across the ASEAN region.

The meeting was attended by a diverse group of participants (see Appendix 1), and ran for 3.5 hours (presentation slides can be found in Appendix 2).

What follows is a summary of the key points from the scene-setting presentations, followed by a synthesis of the main themes that emerged during the subsequent discussions.

Scene setting presentations

David McCoy (Research Lead, UNU Global Health) discussed the shifting global health landscape, including the US withdrawal from many elements of the multilateral system, sweeping cuts in development assistance by traditional donors and many donors increasingly using their aid budgets to serve their own economic and strategic interests. He also highlighted the rise in geopolitical tensions and wars in Europe and the Middle East, as well as a rising mistrust in science and professional organizations as major public health challenges that must be tackled both nationally and internationally.

In thinking about internaitonal health cooperation, he presented a four-directional framework:

- *Looking upwards* at the with global architecture and structures, such as the WHO and World Bank.
- *Looking diagonally* at the more powerful national states, such as the US, who not only shape the global health architectue but who also increasingly wield influence through bilateral channels.
- *Looking sideways* at regional neighbours and other LMICs governance and building international health cooperation through regional platforms like ASEAN and or plurilateral platforms like BRICS+ and the G77.
- *Looking downwards* at building international health cooperation through non-governmental, professionas, academic and civic networks.

Dian Maria Blandina (Policy Research Associate, UNU Global Health) presented on the evolution of global health actors, noting the shift from a state-led model to a more 'complex mulilateralism' increasingly influenced by powerful private actors and neoliberal globalization. She highlighted the weakening of WHO, the emergence of Global Health Publc Private Patnerships and the influence of Multilateral Development Banks (MDBs), such as the World Bank, Asian Development Bank (ADB), and Asian Infrastructure Investment Bank (AIIB), which tended to promote commrcial and private-sector solutions. She also noted the growing influence of private foundations and their tendency to support selective and vertical interventions rather than strengthening public institutions and systems. In closing, she noted Malaysia's track record in

Global Health including Malaysia's role in WHO, its hosting of UNU Global Health, its co-founding of the Drugs for Nelected Diseases Initiative (DNDi) and the key role of civil society organisatios like Third World Network in conducting policy-relevant research and analysis for developing countries.

Ronald Eberhard Tundang (Policy Research Fellow, UNU Global Health) described the different regional platforms for heath and development cooperation including WHO's regional offices and ASEAN. He noted the region's shared epidemiological and public health challenges including ageing populations and climate challenges. To illustrate the benefits of improved regional health cooperation, he described three key choke points in the region's drug and vaccine supply chains: i) high dependency on imported active pharmaceutical ingredients (APIs) from China; ii) uneven and limited R&D and manufacturing capabilities in the region; and iii) divergent national regulatory pathways and uneven capacity. He argued that regional health cooperation could be improved and enabled by formally mapping regional capacity, defining clear technology transfer pathways (like compulsory licensing and local working requirement), incentivizing local R&D and revising trade agreements like the CPTPP which can restrict a government's ability to incentivize domestic R&D. He also called for regional pooled procurement and the sharing of price and supplier data to increase the bargaining power of ASEAN states against Big Pharma.

KEY DISCUSSION POINTS

Look inward

Discussants highlighted that Malaysia is well positioned to expand its role in international health cooperation, building on an existing foundation of international engagement including initiatives on eye care and dengue. However, it was emphasized repeatedly that greater external engagement and impact must require stronger internal coherence within the government and Ministry of Health, as well as improved cooperation between government agencies, academia, and industry. At the intersection of academia, policy think tanks, institutional capital, industry and public governance lies a powerful domestic ecosystem. Harnessing these collective strengths allows Malaysia to project leadership in global health while delivering tangible health benefits at home.

Consider the development of a coherent Malaysian Global Health Strategy

Participants recommended that a coherent Malaysian Global Health Strategy be developed. This would ensure that national priorities are clearly articulated and remain anchored in domestic needs, rather than being disproportionately shaped by external funding agendas. The Strategy should encompass Malaysia's global and regional health interests, an institutional framework, financing modalities, negotiating principles, delivery indicators, and a review mechanism.

Establish a global health diplomacy council with a permanent secretariat

One idea that emerged was to establish a global health diplomacy council to strengthen capacity in international health work. The Council could implement and help coordinate the Strategy rather than become another general bureaucratic layer. A two-tier model could be workable: a compact, government-only decision-making council paired with a multi-stakeholder advisory

body. Core government membership could include the Prime Minister's Department or another designated central agency, the Ministry of Health, Foreign Affairs, Finance, Economy, Investment, Trade, Industry, and Science. The advisory body could be a platform for academia, professional bodies, and civil societies. Capacity building should be integrated as a program of this Council. Priority areas for capacity building include training diplomats, economists, scientists, and clinicians in WHO governance processes, global health financing mechanisms, and crisis negotiation. By consolidating diverse perspectives, the Council would anchor the implementation of a coherent Malaysian Global Health Strategy, ensuring that national priorities are clearly defined and not overly shaped by external funding agendas.

Strengthen health within ASEAN

This agenda aligns with ongoing regional developments, notably the forthcoming ASEAN Strategic Health Agenda (ASHA) 2026–2030, which is expected to be formally announced at the upcoming ASEAN Health Ministers' Meeting. Ensuring domestic alignment behind this strategy will require deliberate inter-ministerial convening to secure policy coherence and implementation support.

Such coordination will also be critical for defining Malaysia's strategic niche within ASEAN. Rather than duplicating capabilities across member states, Malaysia could position itself as a regional hub for research and development and clinical trials, complementing countries like Indonesia with large-scale manufacturing capacity. This differentiation would strengthen the regional pooled procurement proposal. One participant suggested that to move forward with the pooled procurement, ASEAN could consider the ASEAN Minus-X formula as applied in ASEAN economic agreements.

Finally, participants highlighted the importance of strengthening ASEAN's collective voice in global health governance. One proposal is to advocate for ASEAN Secretariat observer status at the WHO, similar to that of the European Union. This would enable more systematic engagement with global processes, improved institutional memory, and better coordination of regional positions in international forums.

Provide more leadership through WHO and WPRO

There was strong agreement on the need to elevate health within ASEAN's institutional architecture to complement WHO's regional work. Currently situated under the socio-cultural pillar, health lacks the political and financial leverage required to address its public health needs. Participants recommended reframing health as a non-traditional security issue and advocating for its inclusion under the political-security pillar. Malaysia, as the current ASEAN health chair and a country with a track record of shaping regional agendas, is well placed to lead this shift in collaboration with key partners such as Indonesia and Singapore.

Priority Thematic Areas for Malaysia and ASEAN Health Engagement

Participants suggested a number of thematic areas spanning supply chain resilience, clinical trial harmonization, aging, digital health, and planetary well-being. These themes underscore the need for Malaysia to integrate health into economic, trade, and environmental frameworks, while addressing gaps in regional cooperation and funding structures. The following priority areas could potentially serve as key pillars for shaping Malaysia's international health engagement.

- **Health in a Broader Economic Paradigm:** Health is persistently viewed by economic and finance ministries (like the Ministry of Investment, Trade, and Industry) as a financial expenditure rather than a foundational investment. Trade agreements often prioritize commercial interests, like patent evergreening, at the direct expense of public health budgets and affordable medicine access. Reframing health from an operational expense to a strategic investment lies at the heart of the 'Economics of Health for All' paradigm. This shift enables Malaysia to harness alternative financial instruments like Islamic Social Sukuk while converting domestic health capabilities into economic assets—expanding our leadership across medical tourism, clinical research, halal pharmacueticals and potential bio-manufacturing capabilities.
- **Aging and Wellbeing:** An aging population and the rise of non-communicable diseases (NCDs) are shared pressures across ASEAN. The well-being and aging agenda is highly strategic because it easily bridges ministerial divides, uniting different government sectors around a common, non-controversial cause.
- **Commercial Determinants of Health:** Policies aimed strictly at attracting foreign direct investment can bypass the Ministry of Health's mandate, enabling industries (like big tobacco, food, and weapons) to negatively shape public health. These commercial drivers often lead to marginalized groups, such as indigenous populations facing displacement, being left behind in the pursuit of economic development. To safeguard public health, Malaysia needs a dedicated policy platform to address the structural tensions between public health goals and commercial trade interests—specifically balancing population health against economic growth, foreign direct investment (FDI), and tax revenues from food, beverage, and tobacco industries. We must shift the national narrative: moving from blaming consumer behavior to actively governing the commercial practices that shape population health.
- **R&D, Supply Chain, and Clinical Trials:** The ASEAN region suffers from severe supply chain choke points, notably a heavy dependence on importing Active Pharmaceutical Ingredients (APIs) from China, and uneven local R&D capacity that is heavily restricted by intellectual property patents. Government funding criteria (and also other donors) rarely acknowledge that drug development is a 10 to 15-year process, demanding unrealistic short-term tangible results. While ASEAN member states have committed to regional regulatory harmonization and joint clinical trial frameworks, execution falls short on the ground. National regulatory sovereignty and a hesitance to accept shared clinical dossier data continue to create duplicative barriers across neighboring markets.
- **Rare Disease & Precision Medicine:** Despite strong domestic support and decades of championing precision medicine and rare diseases, Malaysia frequently fails to be part of these proposed topics tabled at ASEAN-level discussions. Lack of broad inter-ministerial representation in Malaysia's delegations contribute to this missed opportunity.
- **Digital Health:** Digital health is a major area where Malaysia has robust domestic expertise but continues to miss regional opportunities. Because Malaysia often sends delegates specialized in particular topics to ASEAN and other high-level meetings, the digital health portfolio is frequently assigned to other nations like Indonesia.

- **Planetary Health:** Addressing health through a planetary lens requires an "un-siloed," solution-based systems thinking approach. Participants noted that issues like climate change are directly linked to rising clinical health problems, such as increasing allergy cases.
- **Refugee and Migrants Health:** ASEAN's strict non-interference policy severely hinders regional cooperation on the health of refugees and migrants. More political dialogue is needed at the regional level to address resource allocation and the health impacts faced by these vulnerable, cross-border populations.

Suggested Next Steps and Continued Dialogue

This report identifies three follow-up areas. Malaysia should formulate a Global Health Strategy, underpinned by a comprehensive mapping of existing institutions, mandates, and coordination gaps, and evaluate whether a Council on Health Diplomacy would constitute a meaningful decision-making addition. Leveraging its role as lead country for the ASEAN Drug Security and Self-Reliance initiative and its Chairmanship of the ASEAN Health Ministers Meeting in 2026, Malaysia should propose, at the next appropriate ASEAN health-sector forum, a concept note for an opt-in pooled-procurement pilot based on flexible participation, drawing on the 'ASEAN Minus-X' principle. Furthermore, Malaysia should commence the legal and institutional preparations necessary for systematic ASEAN participation at WHO, including the option of observer status.

In terms of immediate next steps, the meeting report should be circulated widely to capture the range of insights offered and to encourage continued inter-ministerial and multi-stakeholder dialogue. In parallel, targeted capacity-building efforts will be critical to cultivating the multidisciplinary expertise required to advance Malaysia's health interests regionally and globally.

APPENDIX 1 - Participant Representation

The roundtable brought together a diverse and multi-sectoral group of participants, reflecting the breadth of stakeholders engaged in global and regional health governance. Attendees represented governmental ministries, academic institutions, and civil society and research think tanks.

Governmental ministries included the Ministry of Health (Datuk Dr. Fariza binti Ngah, Nurhafiza Md Hamzah, and Dr. Juliana Sharmini Paul) and the Ministry of Foreign Affairs (Nurul Aishah Mohd Yunus). **Academic institutions** included Universiti Kebangsaan Malaysia (Professor Mohd Rizal Abdul Manaf), Universiti Utara Malaysia (Dr. Siti Darwinda Mohamed Pero), and the Sunway Centre for Planetary Health (Dr. Amir Hamzah Abdul Latiff). **Civil society and research think tanks** included the Institute for Democracy and Economic Affairs, or IDEAS (Durrah Sharifah Ahmad Azlan), Third World Network, or TWN (Dr. Lim Chee Han, PhD), and Drugs for Neglected Diseases initiative, or DNDi (Vanessa Daniel).


Improving global and regional
health governance and international
health cooperation:
Malaysia Roundtable


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Kuala Lumpur, 27 July 2026

APPENDIX 2 – Presentation Slides

Centre for Social and Economic Progress | CSEP | Independence | Integrity | Impact

THE ASIAN COLLECTIVE FOR HEALTH SYSTEMS

UNU Global Health

Improving global and regional health governance and international health cooperation: Malaysia Roundtable

Kuala Lumpur, 27 July 2026

Introduction

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Background to this roundtable

Aim

Collate and present data and information

Catalyse conversation

Facilitate action

Methodology and methods

- Desk-based research
- Expert consultation
- In-country stakeholder consultations

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Health governance and international health cooperation

Looking upwards, diagonally, sideways and downwards

- The system of GHG and multilateralism
- Resurgent bilateralism
  Emergent great powers rivalry
- Neighbours and allies
- Professional and civic networks

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Structure and aims of the roundtable

- Presentations + roundtable reflections and comments x 2 on
  - Shaping the future of Global Health
  - Strengthening international health cooperation at a sub-global level
- What can UNU Global health usefully do to contribute going forward?

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Session 1

Navigating the Global Health Governance Landscape

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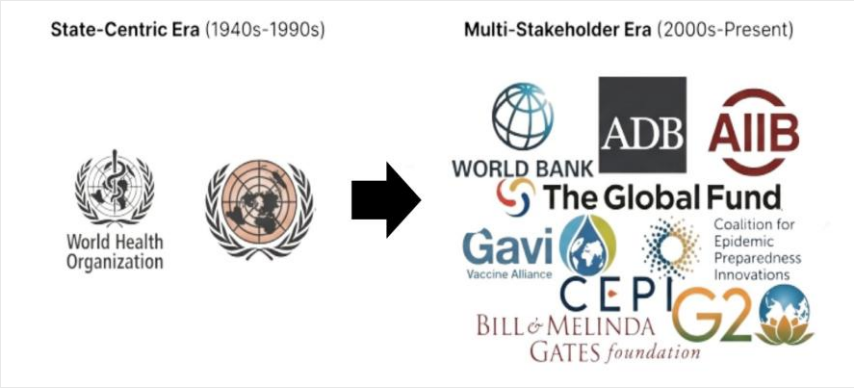
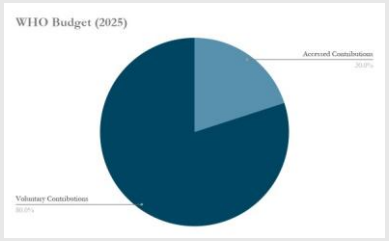
GHG model has evolved into a more complex and fragmented system

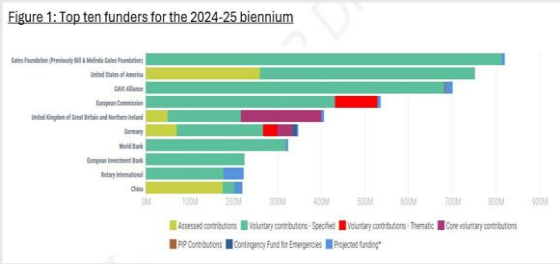


Power, financing, and influence are no longer centralized, but dispersed across a wide range of public, private, and hybrid entities.

WHO remains the directing and coordinating authority, but its autonomy is constrained by its funding structure.

Despite its **unique normative authority** to shape global health and develop binding international health law BUT heavy reliance on earmarked voluntary funding (over 80%).





Specified Contributions **which are earmarked to a specific project and/or geographic area and represents 87% of all VCs.**

Sources: WHO Programme Budget 2024–25; WBG (IBRD/IDA HNP, IFC committed portfolio, trust funds); IHME Financing Global Health 2025.

Malaysia & WHO

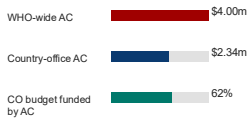
Country-office budget

The COVID-era surge has normalised. In 2024–25, priorities shifted toward essential services and foundational health systems.

Read this as a change in function and financing mix—not simply institutional retreat.

Contribution from Embassy of the Philippines in current biennium.

Financial footprint (2024–25)



Assessed contributions financed roughly three-fifths of the country-office budget, providing more flexibility than heavily earmarked funding.

US$ 2million voluntary contribution to WHO Investment Round

Malaysia – WHO Engagement

- **Member:** 1958 | EB: 4x (2021–24 Vice Chair, 75th WHA & 152nd EB)
- **Resolutions:** Behavioural science (76th WHA) | Integrated lung health
- **SCHEPPR Chair:** 24-hr PHEIC meeting trigger | Called Dec 2023 EB Special Session on Palestine
- **IHR amendments:** Submitted early proposals | Secured equity + health product allocation (77th WHA)
- **Pandemic treaty (INB):** Co-facilitated financing subgroup | Group of Equity & PABS Coalition
- **Hosts:** WHO Global Service Centre (Cyberjaya, +15 yrs) | 5 Collaborating Centres
- **Various technical groups**

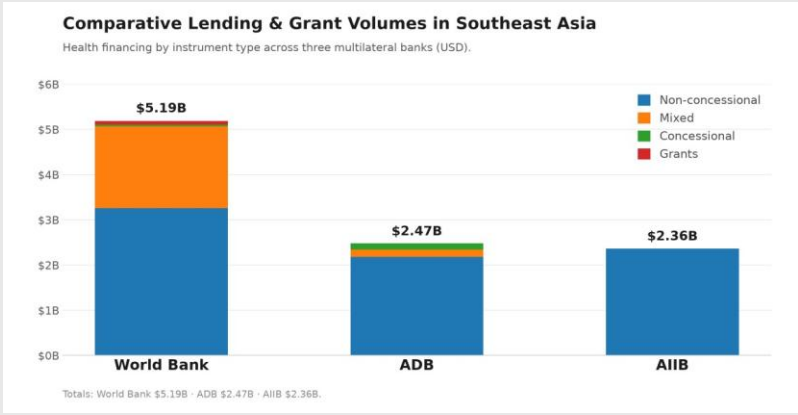
Sources: WHO Programme Budget Portal and contributors data (2024–25); MOH Malaysia, Malaysia's Leadership in Global Health Security (2026).

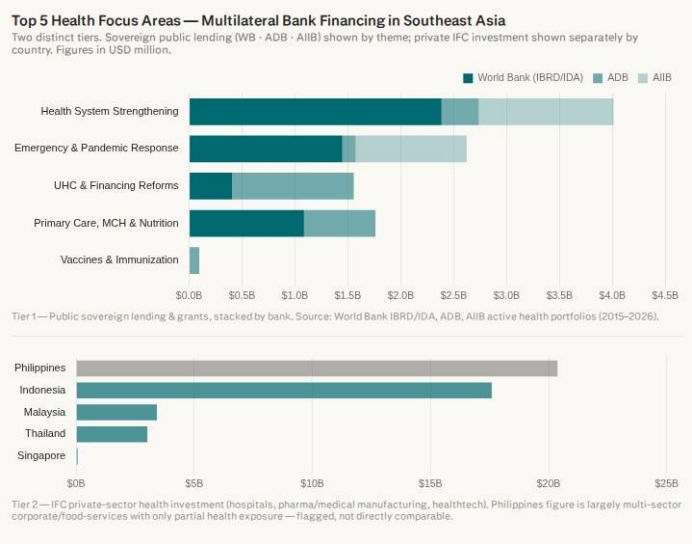
Development Banks are powerful policy shapers, deploying massive financial influence across the region.

THE WORLD BANK

ADB

AIIB





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Malaysia across Global Health Partnerships

- These partnerships shape vaccine access, epidemic R&D, and preparedness.
- Malaysia engages as recipient, implementer, small donor, and co-investor.
- They support HIV, TB, immunization, labs, AMR, and emergency readiness.
- But vertical, donor-shaped priorities can fragment national planning.
- Transition pressures make stronger domestic financing and coordination more important.

Mechanism	Malaysia's role	Contribution / support
Global Fund	Current implementer and recipient; small historic donor.	$3.56m allocation (2023 –25); $132,216 contributed historically
Gavi	COVAX participant and small donor; relevant to vaccine access and regional procurement.	$100,000 COVAX AMC pledge (2021)
CEPI	Sovereign investor supporting epidemic -vaccine R&D and regional preparedness.	$6m cumulative contribution
Pandemic Fund	Beneficiary/co -investor, not a direct financial contributor; part of a Western Pacific regional project.	Part of $35.99m, 13 -country regional grant

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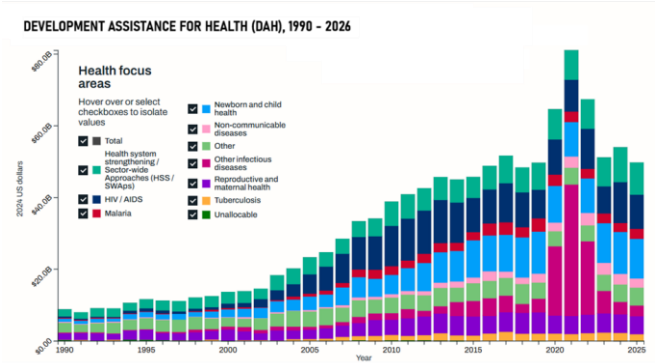
Development Assistance for Health (DAH)

All the financial resources and technical assistance transferred from international donors, including governments, foundations, and NGOs, to LMICs to fund health programs and improve health systems.

- Post-COVID DAH is declining sharply: $49.6B in 2024 to $39.1B in 2025.
- Cuts are driven mainly by major donors, especially the U.S.
- Southeast Asia faces tighter, more selective aid flows, with bilateral aid to the region projected to fall 20% by 2026 (Lowy Institute, 2025).



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DAH – continued..

- DAH includes funding from states, multilaterals, NGOs, and philanthropies such as the Gates Foundation.
- It has long supported infectious disease control, RMNCH (Reproductive, Maternal, Newborn, and Child Health), and health system capacity in LMICs, but donor priorities remain highly selective and disease-specific.
- In Southeast Asia, philanthropy matters less as a volume story than as an agenda-setting force in vaccines, innovation, and regional partnerships.
- Health for Human Potential Community, launched in 2025, aims to mobilise US$100 million by 2030 for MNCHN and infectious diseases in Indonesia, the Philippines, and Vietnam, showing how regional philanthropy is becoming more organised and catalytic (Philanthropy Asia Alliance Report, 2026).

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NON-REGIONAL PLATFORMS FOR INTERNATIONAL HEALTH COOPERATION

Feature	G20	BRICS	Belt and Road Initiative
Identity	Economic powers (85% global GDP)	Counterweight to "Western order"	Broad Global South coalition (134 members)
Health Role	Political accelerator; finances solutions (Pandemic Fund, GIDH)	Technical cooperation (TB network, vaccine R&D)	Norm-setter (TRIPS, health as human right)
SA & SEA Members	India, Indonesia	India, Indonesia	All developing Asian countries
Main Leverage	Finance & political weight	Coalition-building & South-South coordination	Agenda-setting & solidarity
Key Limit	Informal, no enforcement	China-India rivalry	Weak implementation

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Non-Governmental Platforms & CSOs

1. Long-Standing CSO

- Provide sustained institutional memory & independent technical expertise
  - Challenge incoherence between health mandates & commercial interests
  - Track institutional drift, expose corporate capture, amplify Global South voices

2. Epistemic & Professional Networks

- Improve healthcare quality through exchange of knowledge & expertise
- Operate parallel to political tensions or economic competition
- Enable practical steps regardless of formal government cooperation , even during conflict

3. Issue-Based & Industry-Linked CSOs

- **Issue-Based:** Mobilize around specific crises (e.g., access to medicines, pandemic preparedness)
- **Industry-Linked:** Represent commercial/professional interests, enable partnerships but risk co-optation

4. Enabling Platform: Regional Conferences as Voice Multipliers

- **Example:** Prince Mahidol Award Conference (PMAC) – held annually in Thailand
- **Function:** Facilitates academic & research cooperation within Asia
- **Impact:** Elevates regional voices in global health discussions traditionally dominated by Northern institutions

Overarching Goal: Just, democratic, and technically sound international health cooperation.

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Session 1: Guiding Questions

- **In light of the shifting global health landscape, what should Malaysia's priorities and strategic posture be?**
- **How should Malaysia navigate its relationships with global health institutions, including WHO, development banks, and GPPPs, as traditional donors retreat and new actors emerge?**
- **As Malaysia transitions from being a recipient of external health support, what should its evolving role be, both as a contributor to global health and as a partner to other countries in the region?**
- **What opportunities exist for Malaysia to strengthen regional health cooperation in South and Southeast Asia, and what are the main obstacles?**
- **Beyond formal institutions, how can international health cooperation be strengthened through academic, professional and civil society networks?**
- **What broader political, economic, and structural factors should Malaysia consider in shaping its approach to global health cooperation?**

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Session 2

Strengthening Regional Health Governance

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Why regional health cooperation matters first

Regionalism is useful only when it helps solve shared problems that national or bilateral action cannot address well.

Cross-border risks

- Outbreaks, AMR and vector-borne disease
- Migration, mobility and health-workforce movement
- Climate shocks, flooding, heat and food-system risks

Shared system pressures

- NCDs, ageing and dual disease burdens
- Primary-care and workforce constraints
- Fiscal pressure on UHC / JKN-type schemes

Collective leverage

- Medicines, diagnostics and vaccine supply
- Data standards and surveillance norms
- Financing, technology transfer and benefit-sharing

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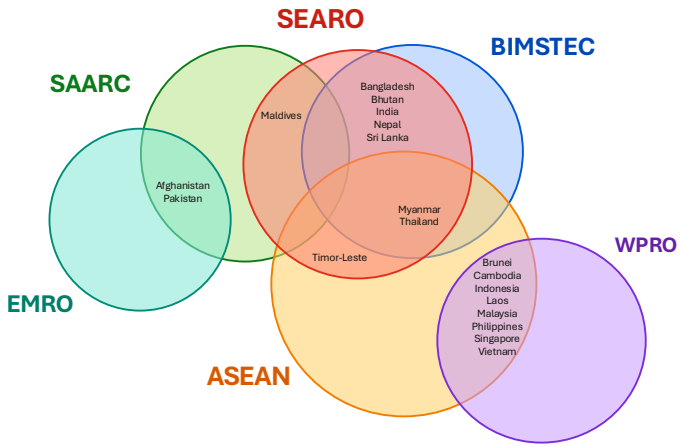
Overlap of regional institutions for health in South and Southeast Asia



Regional resilience: interdependence and strategic self-reliance

Post-COVID supply-chain politics and US–China competition are shifting medical supply strategy toward security, resilience and risk management.

Interdependence remains

- Medicine supply chains are multi-country and difficult to localise fully
- Purely national stockpiling can raise costs and fragment markets
- Regional purchasing and staging can preserve access while managing risk

Self-reliance pressures

- COVID exposed dependence on critical goods
- Medicines are increasingly treated as strategic-industrial assets
- Regions needs resilience without a subsidy race or protectionist lock-in

Regional leverage

- Balance strategic autonomy with shared responsibility
- Pool demand, standards and data governance where possible
- Convert domestic production capacity into regional resilience

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ASEAN Health Cooperation:
Architecture, COVID-19 Response, and Outlook to 2045

Current Architecture & COVID-19 Response	Future Potential & Persistent Constraints
Governance: AHMM (political), SOMHD (strategy), 4 Health Clusters, small ASEAN Secretariat Health Division (1 of 46 divisions).	**Potential:** ASEAN Vision 2045 provides political space to expand from crisis response toward UHC,community resilience, and broader population health.
Scope: Cooperation spans health security, UHC/health systems, NCDs, mental health, ageing, and One Health. **COVID-19:** ASEAN activated existing networks and added new mechanisms, including the COVID-19 Response Fund, RRMS, and ACPHEED.	**Constraint:** An "effectiveness-expectations gap" persists; regional commitments often outpace national follow-through.
Performance: Rapid institutional accumulation, but slow operationalisation of stockpiles, funds, and pooled capacities; vaccine procurement remained largely bilateral.	**Constraint:** Consensus-based decision-making and limited Secretariat capacity slow implementation on sensitive domestic issues.
Partners: Heavy reliance on external partners for financing and technical support, including Japan, the US, Australia, the UK, China, India, and South Korea.	**Constraint:** Progress remains weaker on NCDs, mental health, and health systems/UHC than on infectious disease and emergency preparedness.

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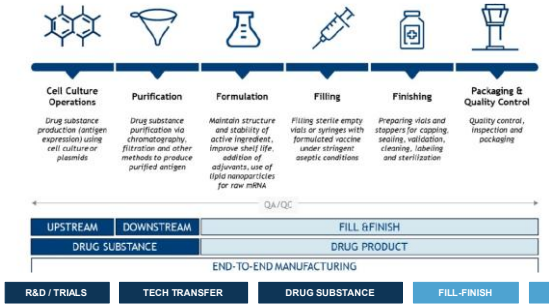
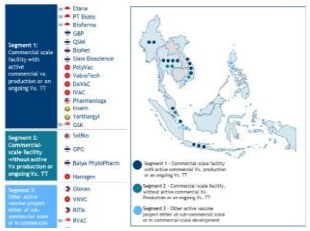
SESSION 3 · Vaccine manufacturing and pandemic preparedness

Current vaccine supply chain in ASEAN

ASEAN has meaningful assets, but they do not yet operate as a regionally coordinated system.





Manufacturing landscape

Selected countries provide R&D, clinical-trial, manufacturing and large-scale production expertise; the key task is to connect them as a regional public good.

RVM momentum exists: roughly US$1B in announced investments; 24 active manufacturers; 15 with commercial-scale production or ongoing technology transfer.

AVCS shows remaining capacity gaps: among seven reporting AMS, only two are actively engaged in vaccine production and three in local vaccine R&D.

Sources: RVMC–CHAI market-shaping paper (2026), pp. 2-4; World Bank, ASEAN Regional Vaccine Manufacturing and Development (2023) Executive Summary; AVCS Assessment Report (2025).

SESSION 3 · Vaccine manufacturing and pandemic preparedness

Chokepoints inside the current vaccine supply chain

The binding constraints sit at the interfaces: technology access, upstream inputs, regulatory recognition and demand aggregation.

RISK HEATMAP · discussion draft

Supply-chain function	Capacity gap	Import / external dependency	Coordination friction	Surge risk
R&D / platform access	High	High	Med	High
Drug substance / upstream	High	High	Med	High
Critical inputs & consumables	Med	High	Med	High
Fill-finish / packaging	Med	Med	Med	Med
NRA / NCL / market access	Med	Low	High	Med
Procurement / demand signal	High	Med	High	High
IP / licensing pathway	Med	High	High	High

Risk levels are analytical categories, not final empirical scores; they should be validated through HSline trade data, AVCS capacity data and country consultations.

Figure 3: Four NRAs in ASEAN are recognized by WHO as having achieved ML3/ ML4

WHAT MAKES THE HEATMAP RED?

60–90% estimated share of installed ASEAN capacity concentrated at PT Bio Farma

4 NRAs recognized by WHO as ML3/ML4 in RVMC–CHAI mapping

220M projected ASEAN routine immunisation doses annually by 2035

The bottleneck is systemic: concentrated capacity, fragmented regulation, weak routine demand visibility and limited routes for technology/IP access reinforce each other.

Sources: RVMC–CHAI market-shaping paper (2026), key takeaways and pp. 6-8; World Bank (2023), Regional SWOT and Way Forward; AVCS Assessment Report (2025).

ASEAN Drug Security and Self Reliance: Malaysia led ASEAN's shared framework

From diagnosis to action across four connected domains.

Malaysia's mandate

→ Lead country and focal point
→ MOH Malaysia designed the baseline survey
→ Coordinated ASEAN inputs, 2018–2020

Four connected domains

→ R&D and manufacturing
→ Regulation and registration
→ Supply and distribution
→ Procurement and pricing

Why cooperation is needed

→ Imported APIs and raw-material gaps
→ Uneven R&D capacity and production scale
→ Insecure supply of low-volume medicines

Endorsed by AHC3 (15 Sep 2021) and SOMHD (11 Oct 2021). Source: ASEAN Secretariat, ADSSR report (2023), pp. 1–2, 26 and 40–47.

From endorsed framework to an operating ASEAN mechanism

Malaysia can convene delivery by closing three linked implementation gaps.

Map and build capacity

- Maintain a manufacturer and capacity map
- Collaborate on GMP, training and R&D incentives
- Define practical technology-transfer pathways

Coordinate regulation and supply

- Emergency regulatory pathway and joint assessment
- Priority-drug list and regional stockpile
- Grouped production for low-volume medicines

Demand & accountability

- Share price and supplier data
- Common quantification and pooled-procurement rules
- Assign leads, indicators, timelines and resources

Source: ASEAN Secretariat, ADSSR report (2023), pp. 30 and 42–47. Unresolved: IP/licensing and sustainable financing.

Session 2: Guiding Questions

- **How can Malaysia strengthen ASEAN health cooperation beyond meetings? What practical steps (pooled procurement, regulatory harmonisation, or shared surveillance) would deliver tangible results?**
- **How should MDBs, GPPPs, and bilateral donors better align with Malaysian and ASEAN priorities? What changes in financing or project design would support national health goals?**
- **How should Malaysia engage with ASEAN and WHO to advance PPPR and UHC? How can it balance regional coordination with domestic health system strengthening?**
- **What domestic capabilities does Malaysia need for effective regional health diplomacy? What institutional and technical capacities are required to lead and negotiate in regional and global forums?**
- **How can Malaysia apply lessons from COVID-19 and Pandemic Treaty negotiations? What insights should inform its future regional and global health engagement?**

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THANK YOU

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ABOUT UNU Global Health

UNU Global Health serves as the UN's think tank on global health. The institute works to advance equitable, just and effective policies and practices by interrogating power and gender asymmetries in global health governance and accountability, health systems and workforces, digital health governance and security, climate health emergencies, and just transitions.

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