NAVIGATOR

D6.1 WORKING PAPER ON INSTITUTIONAL LANDSCAPE OF GLOBAL HEALTH GOVERNANCE: THE ROLE OF TEAM EUROPE

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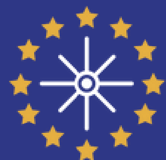
Executive Summary

This working paper examines Europe's role in global health governance, with a particular focus on how the European Union (EU) and its member states contribute to and engage with key international health organizations. While European countries collectively serve as one of the largest sources of global health funding, the EU itself remains an "actor in construction"—possessing significant potential but lacking a clearly defined mandate to influence global health policy in a coordinated and strategic manner.

Over the past three decades, European countries have been among the most significant funders of international health initiatives. While the United States has remained the largest single contributor, the EU member states collectively provide comparable levels of financial support. Notably, if anticipated cuts in US global health funding materialize, Europe will become the largest funding bloc in global health, filling critical financial gaps. However, despite their financial contributions, EU institutions have historically struggled to translate their economic power into geopolitical influence in shaping global health governance.

The analysis focuses on four major organizations using the NAVIGATOR methodological framework:

1. **World Health Organization (WHO)** – A formal, open organization with a mix of technical and normative functions. The WHO is the primary international body for health governance, setting global health norms and responding to health crises.
2. **UNAIDS** – A formal, open, and strongly normative institution dedicated to coordinating global efforts to combat HIV/AIDS. EU countries are the largest collective donors, yet the EU itself lacks a formalized role within UNAIDS, limiting its policy influence.
3. **Gavi, the Vaccine Alliance** – A formal, closed, and highly technical public-private partnership focused on increasing vaccine access. The EU has played an active role in financing and supporting initiatives such as the COVAX program and African vaccine manufacturing efforts.



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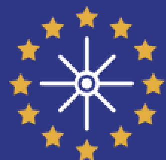
4. **United Nations Population Fund (UNFPA)** – A formal, closed, and normative institution focused on sexual and reproductive health. EU member states are its most important funding bloc.

Despite the EU's significant financial contributions to global health, structural limitations prevent it from exerting strong leadership. The EU lacks a formal mandate in global health policy, leading to fragmented engagement across institutions. Additionally, decision-making power within these organizations often resides with individual member states rather than with EU institutions, making coordinated action challenging.

Nevertheless, the EU has demonstrated its ability to lead in certain areas. The EU Global Health Strategy (2022) aims to consolidate Europe's role in shaping global health policy by leveraging multilateral structures and expanding bilateral partnerships. However, recent challenges—such as the failure to secure global support for a new pandemic treaty—highlight the EU's difficulties in translating financial support into geopolitical influence.



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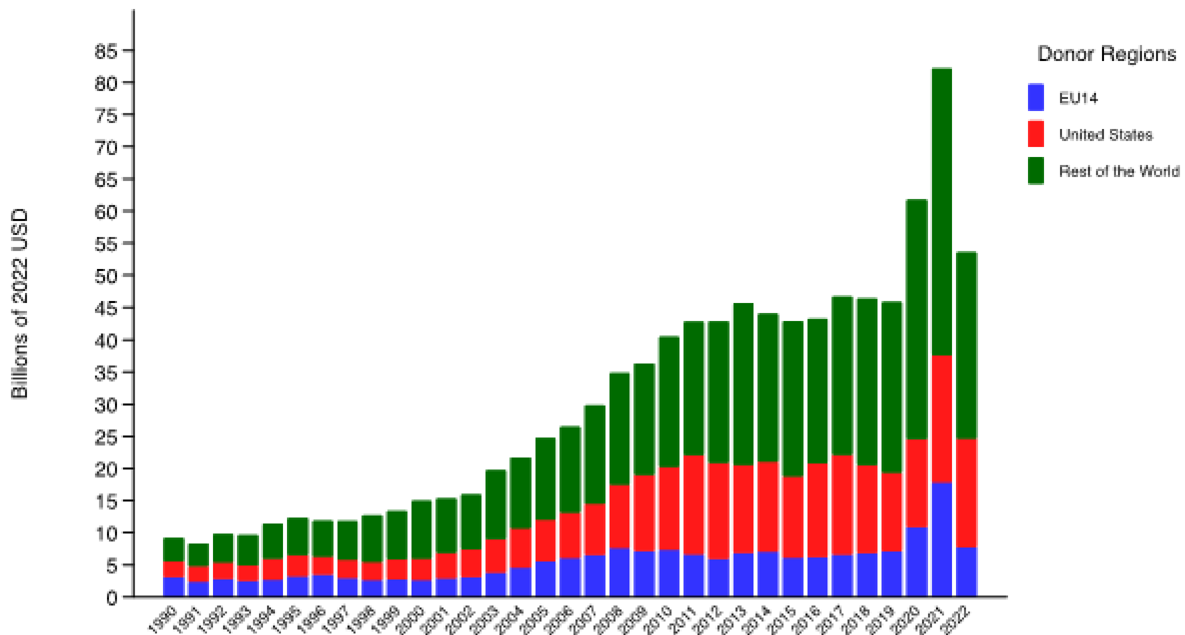
Introduction

International collaboration in the field of public health has a long history, but—aided by persistent large-scale funding allocations—in recent decades it has evolved into a highly differentiated system of 'global health governance.' The term generally includes a wide array of organizations that directly or indirectly influence public health around the world, ranging from national governments to intergovernmental organizations, from non-governmental organizations to the private sector, and from philanthropic foundations to professional associations (Frenk & Moon, 2013; Hein et al., 2009). Among this organizational field, international organizations stand out as having been the recipients of consistent financial and technical support by their wealthier members to develop varied activities in support of improvements in global health status.

European countries are among the largest funders of international cooperation in global health. Figure 1 shows the total flows of development assistance for health over the previous three decades, disaggregated by source: 14 European Union member states (data unavailable for countries that joined in the 2004 and 2007 enlargement waves), the United States, and the rest of the world. While the Figure makes clear that the US is the largest provider of global health financing, European countries collectively stand out as the second largest source of funding. In 2021, in the peak of Covid-related financial support, the development assistance for health provided by these countries was on par with that emanating from the US. More broadly, the joint global health financing provided by the US and European countries accounts for approximately half of the total such financial flows. If current plans by the Trump administration to scale back its engagement in global health financing come to fruition, European countries could become the largest group of funders and faced with a large financing gap in attempts to meet the world's pressing health challenges. On health, the EU pays a lot with little coherent strategic influence, a contrast to security, where the EU has coherence but is viewed by other powers, especially the US, as paying too little.

Figure 1. Development assistance for health, European countries, the US, and the rest of the world



Note: EU14 refers to the countries that had data available: Austria, Germany, Greece, France, Belgium, Netherlands, Luxembourg, Ireland, Italy, Portugal, Spain, Denmark, Finland and Sweden.
Source: Authors, using data from the Institute for Health Metrics and Evaluation.

The EU itself has been seen as an 'actor in construction' in global health. Notwithstanding the centrality of global health financing emanating from European countries, and the frequent enrolment of European experts into global health initiatives pursued by others (such as the US's global health security narrative, see Kentikelenis & Seabrooke, 2021, 2022), the EU's own capabilities do not always translate into heft in shaping policy outcomes (Chang & Rollet, 2013). The key reason is the lack of a clear mandate for exclusive or shared competences of the EU in this policy area, thus leading to an ad hoc approach: depending on the aspect of global health under consideration, EU institutions partner up with interested member-states—collectively known as 'Team Europe'—to coordinate positions and pursue a unified approach. The 2022-approved EU Global Health Strategy set an ambitious agenda for the EU's ability to shape the emergent global health order, based both on leveraging existing multilateral structures and setting up new bilateral partnerships for health(European Commission, 2022).

This working paper takes stock of the recent state of play of Europe's involvement in global health, drawing on the NAVIGATOR methodology presented in Box 1. It does so with reference to institutions that vary according to two dimensions of the NAVIGATOR governance matrix: whether international organizations represent open or closed systems; and whether they have a predominantly technical or normative function. This approach is defensible given that most activities in which Team Europe participates in are highly formal in nature: they have clear legal backing and well-defined mandates, organizational bureaucracies that are there to deliver on these mandates, and a funding stream and policy ecosystem to support their operations.

Of course, this is not to say that there is no scope for more informal arrangements to also be relevant in this issue area, as is the case in international security or international migration. Rather, global health operations that rely more on informal mechanisms tend not to witness major involvement by countries, as opposed to philanthropic foundations or non-governmental organizations.

Box 1: The NAVIGATOR Methodology

NAVIGATOR launches the concept of "search costs" to understand the time and resources used in identifying, assessing and choosing between different forms of governance mechanisms for solving global challenges. To help develop and gain empirical insights on what this entails for the EU and individual European states, NAVIGATOR is mapping the variation in governance mechanisms across different issue-areas. We focus on the degree of formality (formal/informal), accessibility (open/closed), and normativity (technical/normative) of different governance arrangements (organizations and more informal arrangements). This, we submit, is important for assessing what type of legitimacy is likely to be vested, or not, in these organizations, which is of importance for considerations of what types of governance arrangements best matches the interests and values of the EU. In some areas we expect to find the persistence of multilateralism, while in others more private and informal governance arrangements will dominate. NAVIGATOR also hypothesizes that there will be variation in the strategies chosen in different issue areas, depending on path dependencies, sunk costs, and the availability of alternative arrangements. In so doing, the project aims to offer a more robust empirical basis from which to assess the evolution of governance mechanisms and how the EU can navigate them to advance its interests (Sending et al., 2024).

In this working paper we provide an overview of global health governance organizations, with special emphasis on decision-making structures and financial contributions. This sets the stage for outlining how Team Europe is already involved in these organizations. We conclude with a discussion of opportunities for further European engagement in aspects of global health governance. To pursue this analysis, we focus on four organizations that demonstrate a mix of technical vs normative and open vs closed decision-making, as summarized in Table 1.

Table 1. Overview of selected policy actors according to framework dimensions

	Informal/Formal	Closed/Open	Technical/Normative
World Health Organization (WHO)	Formal	Open	Mixed
UNAIDS	Formal	Open	Normative
Gavi, the Global Vaccine Alliance	Formal	Closed	Technical
UN Population Fund (UNFPA)	Formal	Closed	Normative

Source: Authors

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Analysis of cases

(1) World Health Organization

The World Health Organization is the world's leading global health governance institution, serving as a focal point for the development of health-related norms and regulations. Its varied areas of activity include the development of health policies to supports its members in meeting health goals, the monitoring of health status across the world as well as the implementation of the International Health Regulations (the only piece of legally binding international health legislation), and the administering health interventions in target countries (Chorev, 2012). In other words, for any issues that directly or indirectly affect health, the WHO is usually involved in conducting analyses and providing recommendations for how to deal them.

Formal	The WHO is a UN specialized agency with an established bureaucracy and offices around the world.
Open	The WHO's activities are regularly subject to external scrutiny and its member-states have regular opportunities to influence decision-making within the organization.
Mixed Technical and Normative	The WHO's activities demonstrate a mix of technical characteristics (e.g., designing health interventions in the Global South) and normative commitments to specific models of health policy (e.g., universal health coverage, 'health in all policies,' or 'One Health').

Decision-making structures
The WHO's decision-making structures rely on the functioning of two bodies: the plenary World Health Assembly, where all member-states are represented, and the Executive Board, which receives its instructions from the Assembly and which is composed of 34 experts who are elected for a period of three years. This Board meets biannually, and its members are drawn from the WHO's different regions: for example, Europe currently has eight seats, while Africa has 7 seats. The experts elected to sit on the Board are generally senior national health policymakers—ambassadors responsible for global health issues, ministry officials and sometimes ministers themselves. Together, the Assembly and the Board set the strategic direction of the organization and ensure that it is living up to its mandate.

However, decision-making at the WHO is not exhausted at the headquarters level. While the meetings of the Assembly and the Board in Geneva have a formal mandate to make major decision on overall strategy and the budget, major decision-making power at the WHO resides with its six regional offices, each led by a Regional Director and governed by a Regional Committee. At this level, ministers of health by each member-state set the strategy for countries in their respective region and have broad power to both raise and spend funds beyond the WHO's core financing. This means that headquarters are only nominally superior to the regional offices, which have such extensive powers so as to beg questions about the degree of control that the headquarters can exert on them (Clinton & Sridhar, 2017).

The WHO's decision-making structures generally operate under a 'one country, one vote' principle, however particularly important decisions need a two-thirds majority of the member-states who are present in deliberations and do not abstain. These important decisions generally relate to major changes for the organization, like changes to the WHO Treaty, budgetary decisions, adoption of conventions, agreements with other international organizations, and the selection of the Director-General for the organization.

Financial contributions
The WHO's operations depend on the contributions by its member-states, as well as other organizations, including the European Union, philanthropic foundations, public-private partnerships and other international organizations (like the World Bank). These contributions are divided between mandatory membership dues—known as 'assessed contributions'—and voluntary contributions that these different actors make to help the organization in meeting pressing challenges. As Table 1 shows, the WHO's reliance on the latter type of contributions reached an unprecedented 88% of the final program budget in 2020-21, suggesting the scale of reliance on 'soft' financing for the organization and the corresponding problems in developing long-term strategic planning under conditions of financial uncertainty.

Table 1. Assessed and voluntary contributions as per cent of approved and final program budget

	2010-11	2012-13	2014-15	2016-17	2018-19	2020-21
Assessed contributions as a share of final program budget	25	21	19	20	17	12
Voluntary contributions to general fund as a share of final program budget	75	79	81	80	83	88

Source: Iwunna et al. (2023).

The fact that so much of the WHO's financial resources rely on voluntary contributions begs the question of where these funds are coming from. As Figure 2 shows, European countries and the EU have become—collectively—the largest contributors to the WHO. In 2016-17, the EU27 and the EU institutions (European Commission and European Investment Bank) added up to 61% of US contributions, as the country was—and remains (until its withdrawal from the WHO comes into effect)—the largest single donor, and to 10% of the total WHO voluntary contributions by all member-states.

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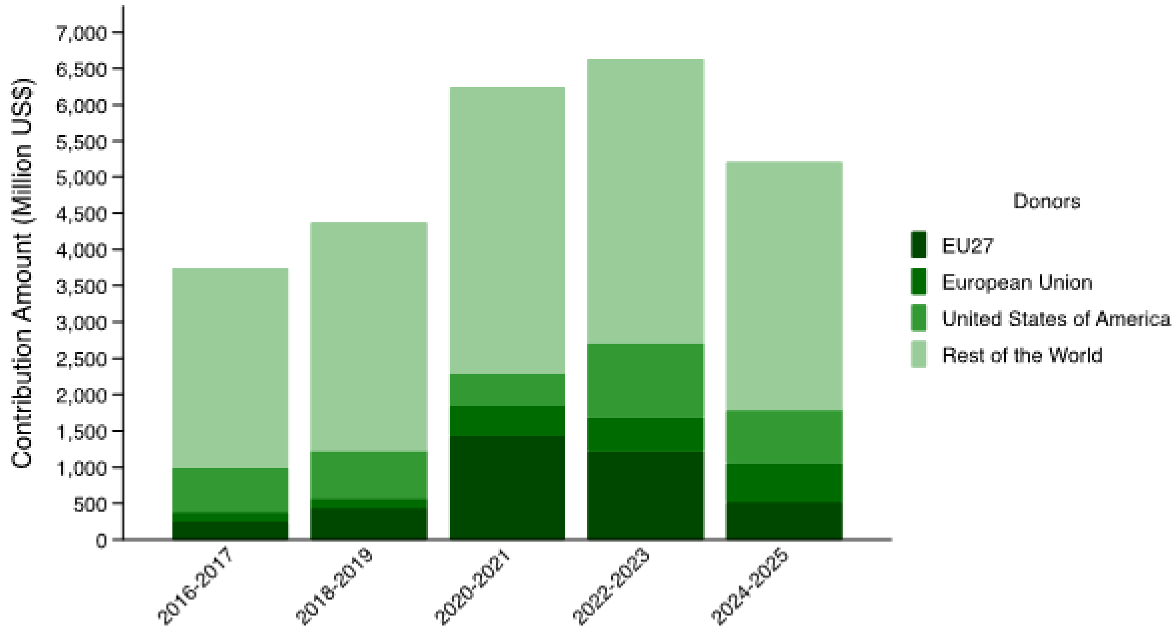
However, the most recent data on voluntary contributions commitments for 2024-25 reveal that the EU27 and the EU have become the largest collective backers of the organization: they now exceed US donations and account for 20% of total WHO voluntary contributions. Importantly, for the first time, the EU has become a larger contributor than the collective contributions by the EU27.

Figure 2. WHO voluntary contributions by region, 2016-17 vs 2024-25



Source: Authors, drawing on the WHO Voluntary Contributions Database.[1]

The EU's involvement

The EU has a deep and multi-pronged engagement with the WHO, both on diplomatic and operational levels. On the diplomatic side, the EU delegation in Geneva seeks to coordinate the policies of European countries vis-à-vis major global health policy issues, like support for universal health coverage or the development of a pandemic treaty. On the operational side, there are multiple channels of collaboration between the WHO's Regional Office for Europe and its country offices, and various EU organizations and programs, including the European Centre for Disease Control and Prevention and the European Medicines Agency. Even so, the EU—as an international organization—is not a member of the WHO per se and does not have a seat on its major decision-making fora, thus relegating it to primarily seeking to influence policy behind the scenes (Bergner et al., 2020). This is surprising given the status of the EU institutions alone as the organization's second largest donor.

However, EU engagement with the WHO is not exhausted in providing voluntary contributions for earmarked interventions. The EU is actively supporting the WHO's efforts for improving global health security and combatting anti-microbial resistance. The most notable—and ill-fated—case of this is with the launch of so-called 'pandemic treaty' negotiations, which would reform the WHO's only piece of binding international health law: the International Health Regulations. The EU was the driving force behind the launch of these negotiations and kept a unified voice throughout them.

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However, major EU allies, like the US and the UK, refused to support proposals for a new treaty and promoted tweaks to the existing Regulations instead, systemic rivals like China or Russia rejected calls for enhanced monitoring and data sharing, and many Global South countries insisted on introducing measures, like relaxation of health-related intellectual property rights and technology transfers, seen by the EU as unacceptable (Bozzini & Sicurelli, 2024). Ultimately, this case of the EU seeking and failing to corale enough global support for its policy priorities at the WHO, despite bankrolling many of its programs and operations, points to its clear limitations as a geopolitical health actor in an era of growing international fragmentation.

(2) UNAIDS

The Joint United Nations Programme on HIV and AIDS (UNAIDS) seeks to coordinate the various strands of international action that are necessary to end the HIV/AIDS pandemic. It seeks to meet this mandate by providing developing strategies that guide multiple actors—governments, businesses and affected communities—in their efforts to combat the spread of the disease, and its data gathering and analysis informs the design and implementation of evidence-based solutions. To do this, the organization has most of its staff based in recipient countries, where they work on various programme areas, like HIV treatment and prevention, data gathering, community mobilization, and working towards the implementation of HIV-related Sustainable Development Goals.

Considered along the key dimensions of NAVIGATOR methodology, UNAIDS is classified as follows:

Formal	UNAIDS has a permanent bureaucracy and is overseen by the Programme Coordinating Board, which includes diverse representation from member-states and UN system partners.
Open	As the mandate of UNAIDS is broad, there is ample scope for the organization to define operational priorities. This allows for a degree of openness in the selection of specific projects to be pursued to fulfil this mandate.
Normative	UNAIDS is committed to ending the HIV/AIDS pandemic through the advancement of various goals related to gender equity, community mobilization, combatting discrimination, human rights promotion, and universal health coverage. These goals embed the activities of the organization in normative commitments, rather than the advocacy of narrow, technical solutions to combat the pandemic.

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Decision-making structures

As UNAIDS was established by the UN Economic and Social Council, its governance structure is uncommon in global governance, as it comprises multiple stakeholders. Its Programme Coordinating Board (PCB)—the main decision-making body—includes officials representing 22 countries, 5 non-governmental organizations, and the UNAIDS 'cosponsors.' The latter category refers to other organizations within the UN system that jointly support the operations of UNAIDS: the UN High Commissioner for Refugees, UN Children's Fund, World Food Programme, UN Development Programme, UN Population Fund, UN Office on Drugs and Crime, UN Women, International Labour Organisation, UN Educational, Cultural and Scientific Organization, the WHO, and the World Bank. Of the 22 PCB members that represent governments, five current members hail from EU countries (Finland, France, Netherlands, Poland, and Portugal), while another four represent other high-income countries (Canada, Japan, United Kingdom and the USA).

The PCB has a responsibility to develop the policies of UNAIDS, review their execution, assess financing questions, and—more broadly—set the overall future-oriented strategy. To do this, it generally meets twice per year and organizes field visits, when appropriate. The PCB is also assisted by an Independent External Oversight Advisory Committee, which evaluates UNAIDS financial reporting and governance structures and meets several times per year.

Financial contributions

UNAIDS relies on exclusively voluntary contributions by its member-states. These can take the form of 'core' funds that finance the secretariat and offer catalytic financing for the work of UNAIDS' cosponsors that relate to HIV, and 'non-core' funds that are earmarked for use in specific programs or projects. The organization's financing has generally remained stable in the past decade at around USD 225mil, notwithstanding small spikes in 2020 and 2021, during the Covid-19 pandemic. According to UNAIDS' financial contribution data, the EU itself does not provide any direct financing through the EU budget.

Figure 3 shows the sources of the contributions that UNAIDS received, disaggregated by the US, the EU27 countries, and the rest of the world. While the US remains the largest individual contributor to the organization, its contributions have been gradually scaled back since 2020. As of 2023, US resources account for one-third of UNAIDS contributions. In contrast, EU27 countries have now become the largest collective donor to the organization: in 2016, EU27 contributions accounted for 30% of the total contributions received, while in 2023 they stand at 43%.

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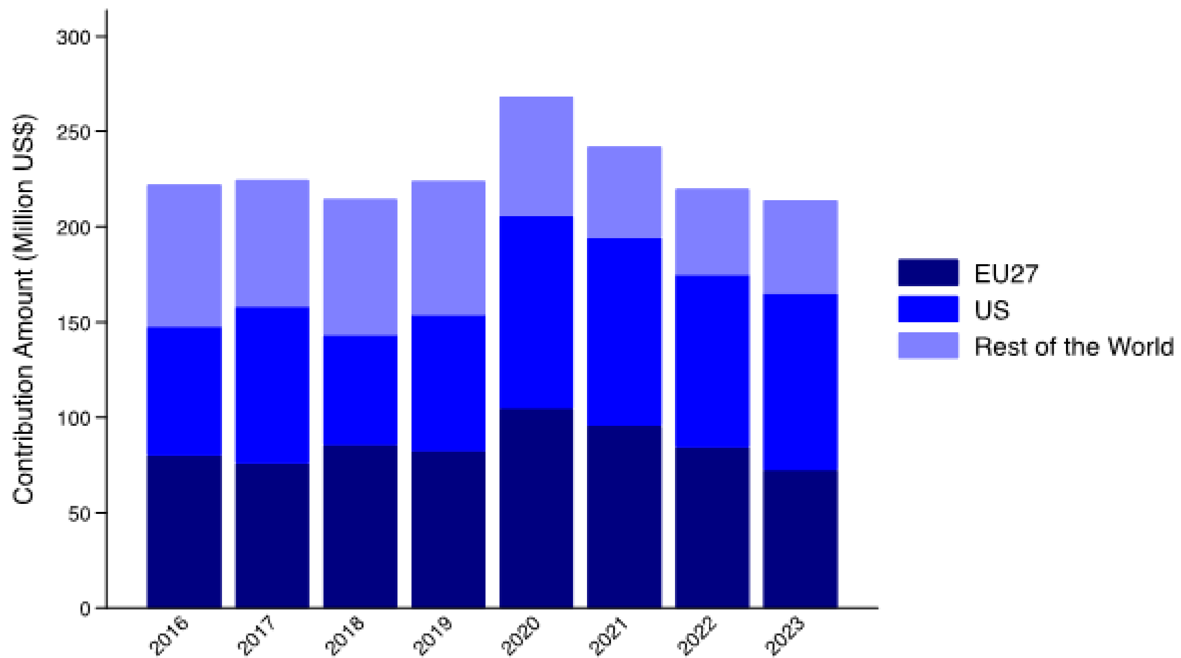
Figure 3. UNAIDS contributions by donor, 2016-2023



Source: Authors, using UNAIDS data.[2]

Importantly, there is great unevenness among EU27 contributions: the Netherlands alone nearly a third of those collective contributions, followed by Sweden, Denmark, Germany, Luxembourg, Norway, Belgium and Ireland. For example, France and Italy together—two of the largest economies among the EU27—provided $1.14mil in 2023, as opposed to the $2.68mil provided by Ireland, the seventh-largest donor among the EU27. Other large economies, like Spain or Poland, provided almost no funds whatsoever. This suggests that the engagement with the mission of UNAIDS is highly dependent on the political salience of the HIV/AIDS pandemic for different governments and the degree of attention they provide to this health issue. Indeed, most EU27 countries do not provide any contributions whatsoever.

The EU's involvement

The EU has engaged in ad hoc partnerships with UNAIDS, however none seem clearly formalized and durable. Indeed, beyond financing specific activities, the EU does not appear to have any meaningful role within UNAIDS, despite the centrality of EU27 countries in providing financial contributions to the organization. The existing areas of collaboration between the EU and UNAIDS are focused on data gathering and exchange. For example, the European Centre for Disease Prevention and Control has aligned with UNAIDS priorities and collects the data necessary for reporting progress on the targets set by UNAIDS.[3] The lack of EU-level coordination is surprising given that the EU is a major contributor to the Global Fund to Fight AIDS, Tuberculosis and Malaria, a highly-technical financial institution akin to Gavi (see case study below). Thus, even though EU funds are clearly channelled to support global efforts to end the HIV/AIDS pandemic, there is no coherent strategy that incorporates UNAIDS in the broader EU activities. Such strategies are, however, available at the national levels: for instance, Sweden[4] and the Netherlands[5] have clear global health strategies that outline their interest in scaling up their contributions to UNAIDS.

(3) Gavi

The mandate of Gavi, the Vaccine Alliance, is narrow and clear: to ensure that children in the developing countries have access to crucial immunizations. To do this, the organization serves as a financing entity, rather than one with major operational presence. Indeed, the actual delivery of the vaccines is done by the United Nations Children's Fund (UNICEF), which is contracted by Gavi to perform the immunization campaigns. Instead, the power of Gavi lies in its 'market-shaping power,' as the organization—resourced with billions of dollars—seeks to shift the vaccines market to a high-value / low-cost dynamic and supports research and development activities around vaccines (Clinton & Sridhar, 2017).

Considered along the key dimensions of NAVIGATOR methodology, Gavi is classified as follows:

Formal	Gavi has a permanent secretariat that is focused on delivering on the organization's responsibilities for fundraising, coordinating disbursements, and monitoring and evaluation.
Open	Gavi is a financial institution with diverse representation of donors, recipients, industry and civil society, that narrowly focuses on its mandate.
Technical	The technical expertise of Gavi is in mobilizing and deploying financing for a sole purpose: increasing children's vaccinations in developing countries.

Decision-making structures

Gavi is peculiar in the broader field of global health governance as it takes the form of a public-private partnership, rather than being an intergovernmental organization. This is in line with the broader shift to special-purpose public-private partnerships in global health, like the Global Fund to Fight AIDS, Tuberculosis and Malaria or the Global Alliance for Improved Nutrition. What such organizations have in common is that they bring together governmental and non-governmental actors—like philanthropic foundations and pharmaceutical companies—around achieving very concrete and measurable outputs (Bartsch, 2007).

Gavi's main decision-making body is its Board, which is innovative in its composition. Of its 28 seats, only 10 are reserved for countries: five for donor governments and five for the governments implementing Gavi programs. Another eight seats are allocated to key stakeholders in the organization's activities: the Gates Foundation (which provided the initial funding to the organization and keeps supporting it), the WHO, UNICEF, the World Bank, representatives from the vaccine industry in high-income and developing countries, representatives from civil society and research institutes, and the CEO of the organization. The remaining nine Board spots are allocated to independent individuals, possessing specialized skills that are relevant to the organization's operations.

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Table 2 presents the current (2025) composition of the Gavi Board. The representatives of donor and implementing countries are—unsurprisingly—all senior officials, while there is also strong representation by the private sector, whether through the two seat allocated to vaccine industry representatives or through the seven independent individuals who have had extensive private sector experience. At the moment, three of the five Board seat allocated to donor countries are vacant. To be sure, this does not mean that there is no representation whatsoever, as there are also alternate members who can participate in Board deliberations. However, the lack of appointments limits high-profile representation for these countries in Gavi decision-making.

Table 2. Gavi Board composition

	Representation	**Board member**	**Position/affiliation**
1	Independent individual / Chair	José Manuel Barroso	Non-executive Chairman of Goldman Sachs International; Former Prime-Minister of Portugal and Former President of the European Commission
2	Independent individual	Yibing Wu	Joint Head of the Enterprise Development Group and Head of China, Temasek (Singaporean state-owned multinational investment firm)
3	Independent individual	Awa Marie Coll Seck	President, Forum Galien Africa
4	Independent individual	Anne Schuchat	Former Deputy Director, US Centers for Disease Control and Prevention (CDC)
5	Independent individual	Deena Shiff	Founder CEO, Telstra Ventures
6	Independent individual	Karen Sørensen	Former CEO, Philips Capital
7	Independent individual	David Sidwell	Member of the Board of Directors, Chubb Ltd
8	Independent individual	Ana de Pro Gonzalo	Former Chief Financial Officer, Amadeus IT Group
9	Independent individual	Anna Sedgley	Former Group Chief Financial Officer, Bauer Media Group
10	Gates Foundation	Violaine Mitchell	Director, Health Funds and Partnerships, Bill & Melinda Gates Foundation
11	World Bank	Juan Pablo Uribe	Global Director, Health, Nutrition & Population and the Global Financing Facility, World Bank
12	UNICEF / Vice Chair	Omar Abdi	Deputy Executive Director for Programmes, UNICEF
13	World Health Organization	Bruce Aylward	Assistant Director-General, Universal Health Coverage and Life Course, WHO
14	Implementing countries - Ethiopia & Ghana	Mekdes Daba	Minister of Health, Federal Democratic Republic of Ethiopia
15	Implementing countries - Indonesia & Bhutan	Budi Gunadi Sadikin	Minister of Health, Republic of Indonesia
16	Implementing countries - Somalia & Pakistan	Mohamed Jama	Senior Policy Adviser, Ministry of Health, Somalia

17	Implementing countries - Honduras & Armenia	Brian Erazo Muños	Vice Minister of Regulation, Ministry of Health, Honduras
18	Implementing countries - Burkina Faso & Angola	Robert Lucien Kargougou	Minister of Health, Burkina Faso
19	Donor countries - Germany/ Belgium/ France/ EC/ Ireland/ Luxembourg	Alexandra Rudolph-Seemann	Senior Policy officer, Federal Ministry for Economic Cooperation and Development, Germany
20	Donor countries - Japan/ Italy/ New Zealand/ Spain	Vacant	
21	Donor countries - Norway/ Denmark/ Finland/ Netherlands/ Sweden/ Switzerland	Vacant	
22	Donor countries - United Kingdom/ Canada/ Qatar	Ruth Lawson	Deputy Permanent Representative for Global Health and UK Representative to the Global Health Boards, Foreign, Commonwealth and Development Office (FCDO), United Kingdom
23	Donor countries - United States/ Australia/ Korea (Rep. of)	Vacant	
24	Vaccine industry - Industrialised	Andrew (Drew) Otoo	President, Global Vaccines, Merck Human Health
25	Vaccine industry - Developing	Sai Prasad	Executive Director, Bharat Biotech International Ltd, India
26	CSOs	Bvudzai Magadzire	Director, Partnerships, VillageReach, South Africa
27	Research & technical health institute	Saad B. Omer	Founding Dean, Peter O'Donnell Jr. School of Public Health, University of Texas, Southwestern
28	Gavi CEO	Sania Nishtar	

Source: https://www.gavi.org/governance/gavi-board/members

While the Board is Gavi's plenary decision-making body it only meets in person three times per year. Many of the organization's policy decisions are instead made by sub-committees of the Board that meet frequently. For example, the Governance Committee has the responsibility to evaluate Gavi's governance practices, vet nominations to the Board, and assess the performance of the Board in meeting Gavi's mission.[6] Or the Market-Sensitive Decisions Committee is responsible for deciding on commercially sensitive decisions relating to the organization's supply and procurement strategy.[7]

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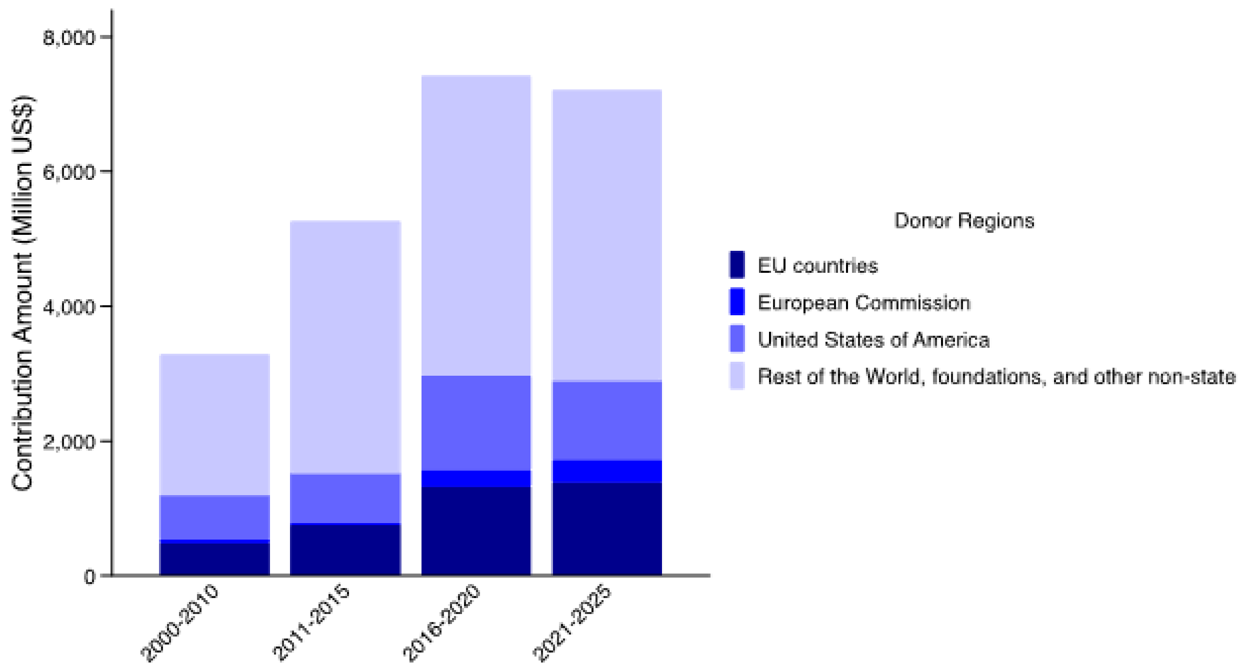
Financial contributions

Since its establishment, contributions to GAVI have steadily increased, reaching $7.4bn over 2016-20 and $7.2bn over 2021-25, as shown in Figure 4. Among this amount of financing, the role of Europe stands out. European countries and the EU went from offering 17% of contributions to the organization in the 2000s to nearly reaching a quarter of contributions over the 2021-25 period. For comparison, over the same period, US contributions dropped from 20% to 16%. Of course, the 'rest of the world, foundations, and other non-state' category includes the major contributions by the Bill and Melinda Gates Foundation, which was instrumental in setting up Gavi and continues to be one of its largest contributors.

Figure 4. GAVI Contributions by major donors, 2000-2025



Note: EU countries are only those that have directly contributed to GAVI: Austria, Belgium, Croatia, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovenia, Spain, Sweden.
Source: Authors, using contributions data from GAVI.

The EU's involvement

The EU has been a major supporter of GAVI, not only in financial terms, but also through political support. On the financial side, the EU's already high commitments are increasing. For example, in late 2024, the EU pledged €260mil to the organization for 2026-27[8] to help support its immunization mission. On the political side, the EU has been a key driver or supporter of multiple Gavi initiatives. In the aftermath of the emergence of Covid-19, the EU supported the Gavi COVAX Advance Market Commitment programme, which sought to expand global access to Covid-19 vaccines, especially for low-income countries. Further, Team Europe has been supporting Gavi's efforts to accelerate vaccine manufacturing in Africa, a strategic initiative that promises to expand access to affordable vaccines for countries in the continent.[9]

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4) UNFPA

The United Nations Population Fund (UNFPA) is focused on sexual and reproductive health and is a subsidiary organ of the UN General Assembly. The organization's activities are centred around three targets that it has set for 2030: ending unmet need for family planning (absorbing 34% of 2023 programme expenses worldwide); ending preventable maternal death (27% of expenses); and ending gender-based violence (39% of expenses). To achieve these goals, the organization has extensive operations in over 150 countries and extensive partnerships with other UN system organizations, civil society and the private sector.

Considered along the key dimensions of NAVIGATOR methodology, UNFPA is classified as follows:

Formal	As a UN system organization, the UNFPA has a permanent secretariat and its leader is also a UN Under-Secretary.
Closed	UNFPA has a clear set of targets that guide organizational action, thus being narrow in its areas of focus.
Normative	The mission of UNFPA has strong normative commitments that go beyond merely technical approaches towards improving sexual and reproductive health.

Decision-making structures

UNFPA is governed by an Executive Board, which ensures that its activities are meeting its mandate, monitors its performance, and decides on programmes and financial plans. Unlike most international organizations that have their own governance structures, the UNFPA Executive Board is shared with two other UN system organizations: the UN Development Programme and the UN Office for Project Services. This Board meets generally twice per year in formal sessions and also hold a range of informal meetings as necessary. The Executive Board has representatives from 36 countries with broad geographical representation: as of 2025, 10 of these 36 members hail from EU member-states.

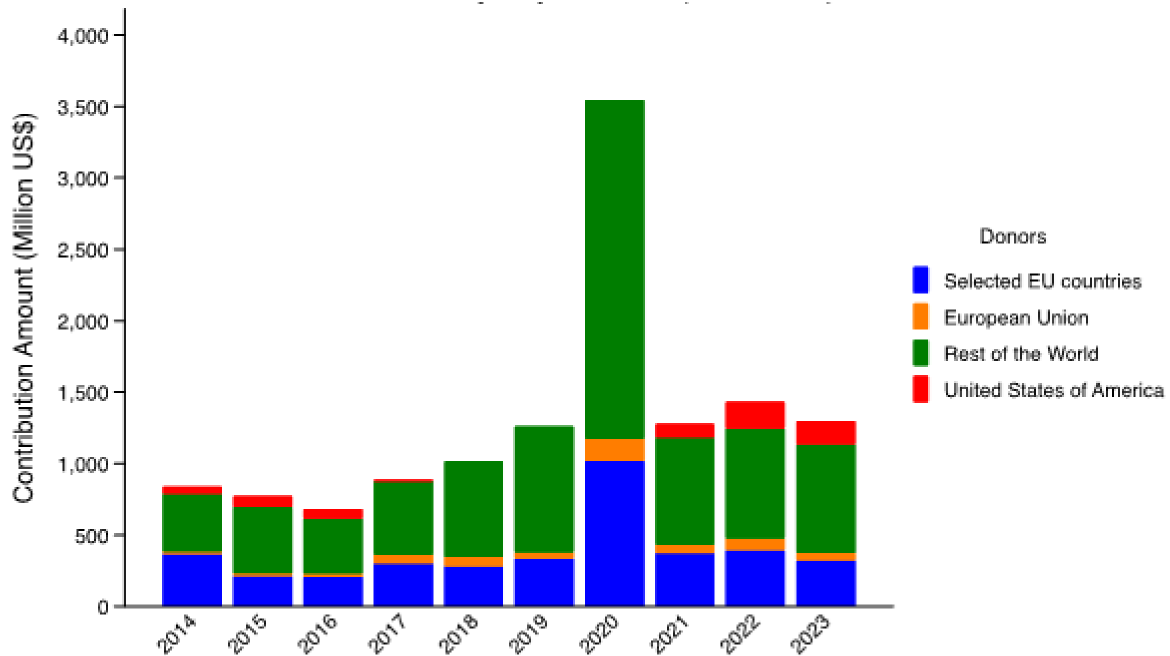
The Board is supported by a Bureau, composed of five Board members: a president and four vice-presidents. The responsibility of the Bureau is to prepare the agenda items for Board meetings, ensure inclusive decision-making, and settle on the teams that will participate in field visits by the Board. Two of the current Bureau members are citizens of EU countries.

Financial contributions

UNFPA is funded exclusively through the voluntary contributions of UN member governments. European countries—collectively—stand out for providing the majority of contributions to the organization. Even so, their relative significance has decreased: in 2014, European countries and the EU accounted for 46% of total contributions to the organization; by 2023, this this was down to 29%. Indeed, in nominal terms, they provided less money in 2023 ($376 mil) than in 2014 ($386 mil).

Figure 4 shows the evolution of contributions to UNFPA. Unsurprisingly, 2020 stands out due to the major inflow of funds to help countries deal with the Covid-19 pandemic: contributions to the organization jumped from $1.64bn in 2019 to $4.72bn in 2020, and then reverted to $1.7-1.9bn in the subsequent years. Further, the role of the US is not as dominant as in other global health organizations. The country ceased contributing to the UNFPA during the years of the first Trump administration, a phenomenon that is likely to be repeated during the second Trump administration. In short, European countries and the EU were and remain dominant contributors to UNFPA. The plausible withdrawal of US support for the organization in the coming years would yield a shortfall that European countries may be called on to cover.

Figure 4. UNFPA Contributions by Major Donors, 2014-2023



Note: The data for selected EU countries represent the sum of contributions from Belgium, Finland, France, Germany, Ireland, Italy, Luxembourg, Netherlands, Spain, and Sweden; the other EU27 member states were not featured in the UNFPA contributions dataset.
Source: Authors, using UNFPA contributions data.

The EU's involvement

The EU has been among the largest contributors to UNFPA, both through the financial resources it has provided and through the political support for strategic UNFPA initiatives. Indeed, the EU is a strategic partner of UNFPA on various initiatives on sexual and reproductive health and humanitarian assistance. In this context, through the Gateway Team Europe Initiative on Sexual and Reproductive Health and Rights the EU is one of the major supporters of UNFPA actions to deliver on its mandate.

Conclusion and recommendations

Our aim here is to examine the evolving role of Europe in global health governance, with a focus on how the EU engages international organizations and the extent to which it has a coherent strategy in global health governance. One aspect is especially clear: EU countries are the second largest contributor to global health funding but there is a lack of overall strategy and ambition in how the EU seeks to influence global health governance beyond more ad hoc arrangements through Team Europe. The EU is also constrained by great power politics in pushing forward on health policies, including a particularly sensitive Trump administration. The EU's involvement in the WHO, UNAIDS, Gavi, and UNFPA show how financial commitments do not always lead to political leverage in the absence of a clear mandates and clarity on shared competencies. While the 2022 EU Global Health Strategy is a clear advance, there are both internal and external constraints to how the EU can navigate global health governance.

Externally, the second Trump administration is already erecting hurdles to global health governance. The first Trump administration withdrew from the WHO—later reversed by the Biden administration—and the second administration has strengthened the worldview that the US is a power interested in making better deals rather than universal progress on global health. The US leaving the WHO makes the EU the largest donor bloc, which will increase demands for funding to continue health policies, especially communicable disease treatment and prevention, vaccine access and health security. The defunding and demolition of USAID, which is responsible for three quarters of the US's global health bilateral assistance, makes matter much worse. A more isolationist and transactional US leaves the EU in a position as major funder but with little consensus among great powers on policy direction. The EU is likely to have challenges from both China and Russia, as well as from Global South countries.

In our view the EU has several opportunities in developing a more strategic approach to global health governance. They include:

1.Strengthening Team Europe's Coordinated Approach: the EU should strengthen its internal coordination to present a unified position to multilateral health fora. This requires policy direction from the European Commission that can be built into Team Europe as a mandate.

2.Strategically occupying US-funding gaps. With the decline of US funding, operations, and support, the EU can provide a united position to support core work in the WHO, UNAIDS, and UNFPA, all of which suffer from budget unpredictability. Such leadership would come with greater claims on policy direction.

3.Strengthen alignment with allied countries on global health governance. In the wake of the US's isolationist approach, the EU has more room for leadership in developing policies with Norway, Canada, and Japan, as well as progressive Global South nations.

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4.Deepen partnership with the Global South. The US's withdrawal on global and bilateral health provides an opportunity for the EU to build more flexible funding mechanisms with low- and middle-income countries. The African vaccine manufacturing initiative, supported by Gavi and the EU, provides a model for mutually beneficial cooperation (European Commission, 2022).

5.Enhance EU representation in decision-making structures. The EU should embrace a formal voice in global health governance, such as a dedicated seat at the WHO or a structured role within UNAIDS—should be pursued through diplomatic negotiations.

In sum, the EU can do more in global health governance than provide funding. It has an opportunity to be more assertive in providing policy direction based on a clearer internal sense of purpose that has more ambition than Team Europe. Through better internal coordination, dedicated financing, and deepening strategic partnerships, the EU can position itself as a key architect of a more stable and equitable global health governance system.

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Endnotes

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NAVIGATOR

NAVIGATOR is a 4-year research project set to examine how the EU shall navigate the increasingly complex – and conflict-laden – institutional spaces of global governance to advance a rules-based international order. What factors should be emphasized when considering which institutions to strengthen, which to reform, and which to by-pass when revitalising multilateralism? NAVIGATOR's main objective is to answer these questions and deliver a ready-to-use "search mechanism" and associated pathways of action that the EU and its member states can use as it seeks to strengthen a rules-based international order.

To achieve this, NAVIGATOR comprises a strong, global and inter-disciplinary team of researchers that explores institutional variation on six policy issues – climate change, digitalisation, finance/tax, health, migration and security – to identify what institutional mixes that enables the EU to have optimal impact in a given policy issue.

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