Reshaping the Future of Global Health Governance

A Forward-Looking Exploration and Analysis of Global Health after the 2025 US ODA Cuts

Applied Research Project Prepared for the

Institute for Global Health and Development

Submitted on 12 May 2026

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9979 words

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ABSTRACT

In January 2025, the world's largest health donor walked out. The US withdrawal from the WHO and the dismantling of USAID undid in four months what decades had built: over 2,000 WHO redundancies, many USAID-funded staff displaced, PEPFAR's HIV treatment pipeline severed across Sub-Saharan Africa, and Gavi capping malaria vaccination coverage at 70%, previously its minimum target for countries. The global health system has been calculating the cost ever since.

Drawing on 27 semi-structured expert interviews conducted across Switzerland, the US, and Sub-Saharan Africa, this research triangulates institutional and country-level perspectives through a decolonial lens to ask how the withdrawal has reshaped global health governance—financially, structurally, and politically—and whether the adaptations underway constitute the decolonising shift the field has rhetorically promised for decades.

The findings cut against the rhetoric of rupture. Donor concentration, disease silos, and partnership discourse that obscures structural asymmetries had been the system's operating logic long before January 2025; the shock has ended the consensus that allowed them to persist. The substitutes hold less than advertised: innovative finance cannot match ODA's volume, and philanthropy faces financial, strategic, and legitimacy limits that prevent wholesale substitution. Most critically, bilateral instruments such as the Kenya–US Cooperation Framework trade away fiscal autonomy in exchange for the knowledge systems that autonomy requires. Nevertheless, African leadership is consolidating where the architecture's crisis has opened space: initiatives such as Africa CDC, the Accra Reset, and the Lusaka Agenda show that the decolonising agenda is no longer purely rhetorical.

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LIST OF ACRONYMS

Africa CDC	Africa Centres for Disease Control
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
AMR	Antimicrobial Resistance
AU	African Union
CDC (US)	US Centers for Disease Control
CCM	The Global Fund's Country Coordinating Mechanism
DIB / SIB	Development Impact Bond / Social Impact Bond
FCTC	Framework Convention on Tobacco Control
GHIs	Global Health Institutions
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
HICs	High Income Countries
HSS	Health System Strengthening
ICD	International Classification of Diseases
IHR	International Health Regulations
IOM	International Organization for Migration
LMIC	Low- to Middle-Income Country
MoU	Memorandum of Understanding
mRNA	Messenger Ribonucleic Acid
MRV	Monitoring, Reporting, and Verification
NGO	Non-governmental Organisation
ODA	Official Development Assistance
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

1.0 INTRODUCTION

Global health governance has long been shaped by a small number of powerful state and non-state actors. For decades, the US was the largest donor to the World Health Organization (WHO). Moreover, the US utilised the US Agency for International Development (USAID) to contribute official development assistance (ODA) toward health technologies, research, and service delivery. The US decision to withdraw its membership from the WHO and dismantle USAID (see Appendix A.2) marks a pivotal rupture in global health governance (Ortiz-Prado *et al.*, 2025). Global health governance refers to institutions, rules, and processes used by states, intergovernmental organizations, NGOs, and civil society to address cross-border health challenges like pandemics, infectious diseases, and the governance of "collective responses to such issues" (Lee & Kamradt-Scott, 2014: p. 5).

As a standard setter in global health, the WHO remains a central player within this evolving landscape, but this funding withdrawal poses significant challenges, which will cause severe disruptions to the support provided to strengthen health systems in low- and middle-income countries (LMICs) and threatens to undo progress made through years of persistent efforts. Thus, this research project empirically analyses how the WHO and other key global health institutions (GHIs) in Geneva are strategically adapting to evolving financial and governance dynamics.

The project will focus primarily on Geneva, Switzerland, and key US cities such as Washington, D.C., Atlanta, and Seattle. These locations host major GHIs—including the WHO, the Global Fund, and Gavi—as well as leading philanthropic organisations, such as the Gates Foundation. Because much of the strategic and institutional decision-making in global health governance occurs in these hubs, they provide a rich set of sites to analyse how

institutions respond to change, including adaptations in budget allocation, governance structures, and strategic narratives.

Furthermore, the fallout from this decision has disproportionately impacted LMICs, particularly across the African continent. The sudden funding vacuum left millions without access to essential treatment and placed immense pressure on African governments, many of which are struggling to compensate for the absence of US support. As the impacts of the US funding withdrawal are most acutely felt in LMICs, it is imperative that we compare the macro-level perspective of GHIs to the lived realities of those on the other end of health initiatives in LMICs, ensuring that alternative pathways of collaboration, governance, and funding are explored (Yazdi-Feyzabadi *et al.*, 2025).

Accordingly, we approach the research through the lens of the decolonisation of global health, which allows us to identify underlying assumptions, challenge existing power dynamics, and forge pathways toward more equitable and mutually beneficial global health governance. Drawing upon this framework, our research addresses the following questions:

1. How has the US withdrawal from the WHO reshaped global health governance—financially, structurally, and politically—and how are GHIs adapting their narratives and strategies in response?
2. How has this shift altered the balance of power in global health governance, and to what extent do these adaptations demonstrate a shift toward a decolonised global health system that empowers LMICs?

To answer these questions, we began with a literature review, identifying key tensions, trends and debates within global health governance, particularly regarding the pre-existing ODA landscape, the US politicisation of ODA, the immediate and long-term impacts of the funding withdrawals, and LMIC agency and autonomy. These themes informed the data

collection phase, where we gathered firsthand accounts of the 2025 US withdrawal through interviews with experts. From our nine months of research, six key findings emerge:

1. The US withdrawal reflects an acceleration of existing ODA trends
2. The funding cliff caused meaningful damage to global health
3. As ODA contracts, a menu of finance alternatives is emerging
4. Threats to disease-specific programmes underscore their continued relevance
5. US bilateral MoUs pose new governance challenges
6. LMICs can use the systemic changes to rethink and reclaim country ownership

After a discussion of these findings, we conclude by providing actionable recommendations for global health professionals and policymakers in both Geneva and LMICs to rethink country ownership, prioritise national sovereignty, and effectively decolonise global health governance.

2.0 LITERATURE REVIEW

In this literature review, we critically examine the underlying power dynamics, hidden assumptions, and dominance of Western thought already present in global health governance, namely within the following four thematic areas:

1. The financial and institutional processes embedded in the previous global health governance landscape, including funding, agenda-setting and research priorities
2. The politicisation and conditionalities attached to health ODA
3. The disproportionate impacts of funding withdrawals on LMICs
4. The shifting power dynamics within global health governance, including the potential for emerging leadership from LMICs

2.1 Pre-Withdrawal ODA Landscape: Patterns & Problems

The pre-withdrawal global health ODA landscape was structured by four interlocking patterns that shaped how funds flowed, what they funded and whose priorities they served. Table 1 summarises these patterns and the structural critiques they attracted (see Appendix A.1 for the full table):

PATTERN	KEY EVIDENCE	DECOLONIAL IMPLICATIONS
2.1.1 Phantom aid	*One-third of UK ODA (2005) absorbed by Western consultants' inflated salaries and travel; 86 cents of every US aid dollar tied to "Buy American" procurement under the 1961 Foreign Assistance Act (Morley and Morley, 1961; Elliott, 2005).*	Aid is accountable to donor economies rather than recipient need; fragmentation erodes LMIC planning capacity.
2.1.2 Disease specific over HSS	*3–12% of US health ODA went to HSS (2008–2019); 31% of USAID's 2024 budget concentrated on HIV/AIDS and malaria in Sub-Saharan Africa (Buffardi, 2018; Atkins, 2025).*	Vertical silos undermine long-term resilience and bypass locally defined systemic priorities.
2.1.3 Ideological imperialism	*Mexico City Policy ("Global Gag Rule") repealed and reinstated along US partisan lines since 1984, producing measurable declines in safe abortion access (Crane and Dusenberry, 2004).*	Recipient communities absorb donor political volatility, undermining local agency and sovereignty.
2.1.4 Philanthropy & legitimacy gap	*Gates Foundation earmarked elevated polio over primary healthcare on the WHO agenda; opposed the COVID-19 TRIPS waiver, delaying generic mRNA access (Blunt, 2022; Thambisetty et al., 2022).*	Private wealth wields asymmetric influence and unilaterally defines what counts as epistemologically legitimate knowledge.

Table 1: Structural patterns in pre withdrawal global health landscapes

(Authors' Own, 2026)

2.2 The US' Radical Politicisation of Aid & the "Trump Doctrine"

2.2.1 US Withdrawal & American Realism

The US has largely withdrawn from global health cooperation and health ODA, collapsing a system it created. Building on the coercive history outlined above, Smith wrote (2025: para. 9), "what we haven't seen to date is the concept of American Realism taken to this extreme,"

in which Washington, D.C., has almost completely revoked its international contributions to capture perceived economic and geopolitical gains. This retrenchment is not merely a structural or fiscal shift—it reflects a complete upheaval of the US' ideology on foreign assistance.

Under the Trump administration, aid has arguably become a geopolitical tool to pressure states in vulnerable positions to adopt morally-embedded American foreign policy objectives. Smith (2025: para. 1) argues that there is a new "Trump doctrine" in place, where aid is "no longer a lifeline but an ultimatum." For example, the administration is coercing African countries into conceding access to its health data system for 25 years in order to receive aid for five years" (Rigby *et al.*, 2025).

These approaches suggest that life-saving interventions delivering essential medicines, training, and supplies may also be treated as a zero-sum game, conditional on advancing American interests. For vulnerable countries lacking the geopolitical leverage to push back against these strong-armed conditionalities, this quid pro quo approach will have disproportionately more severe effects, especially when their national health systems have been incapacitated.

2.2.2 Possible Scenarios for US' Future Engagement in Global Health

A major question looms among researchers, policymakers, and practitioners in the global health space: Given the developments of 2025, who will lead and govern GHIs going forward? Haug *et al.* (2025) offer a critical discussion of the possible engagement strategies the US may pursue in this post-USAID era, setting out three possible scenarios regarding the future of official development assistance following the US retreat, depicted in Figure 1 below:

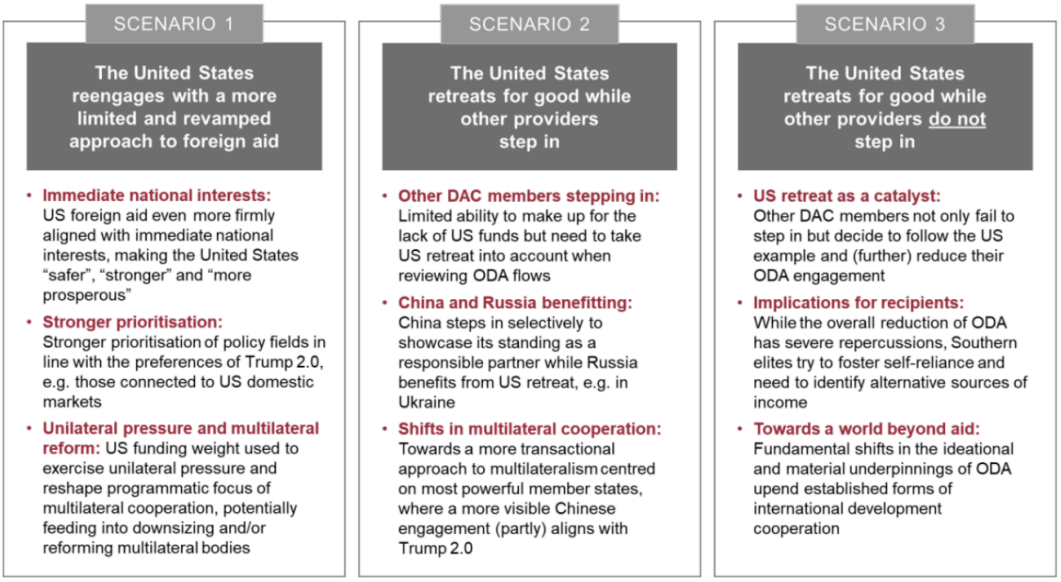

Figure 1: Three scenarios regarding the US and the future of international development cooperation (Haug *et al.*, 2025: p. 19)

We discuss and analyse the implications of these three scenarios in greater detail in Appendix A.3.

Regarding power dynamics, Bloom *et al.* (2025) propose that global health governance is shifting from US hegemony to multipolarity. They argue that COVID-19 has already redistributed power within global health toward the BRICS, transitioning from a US-centric system towards a multipolar order where no single actor dictates the global health agenda. Instead, collaborations across governments, civil society, the private sector, and regional organisations will create opportunities, encourage competition, innovation, and alternative sources of financing. Thus, the dismantling of USAID provides a unique opportunity for LMICs to develop more resilient health infrastructure and build effective multilateral partnerships grounded in equity.

2.3 Immediate & Long-Term Impacts on Global Health

With US funding accounting for 19.77% and 13.96% of the WHO's budget in 2022 and 2023 respectively (Institute for Health Metrics and Evaluation, 2025), the US withdrawal from the WHO and the dissolution of USAID have unprecedented and unparalleled impacts on global health outcomes (Auwal *et al.,* 2025).

2.3.1 Humanitarian Crises & the Human Cost

The deficit in health funds may push more than 5.7 million Africans into extreme poverty by 2026 and Africa CDC estimates 2-4 million deaths as a result of reduced global aid budgets (Kaseya, 2025). Over a five-year period (2025-2030), over 14 million preventable deaths are projected (Cavalcanti *et al.*, 2025). Additionally, a 25% reduction in funds threatens efforts to limit the spread of major infectious diseases such as HIV and malaria in Sub-Saharan Africa (Krugman, 2025). The Desmond Tutu HIV Centre suggests an additional 500,000 deaths in South Africa within the next decade due to cuts to HIV/AIDS programmes, and a 78% increase in HIV cases is projected in Zimbabwe by 2030 (Tsitsi *et al.*, 2025). Table 2 below outlines the projected death toll resulting from USAID funding withdrawal directly:

	Number of deaths at all ages	Number of deaths in children younger than 5 years
2025	1776539 (967604–2496308)	689900 (436368–911004)
2026	2499525 (1521410–3490070)	828970 (575089–1078316)
2027	2477031 (1507936–3458985)	798188 (553276–1039475)
2028	2454816 (1494286–3428201)	768294 (531228–1003073)
2029	2432809 (1480850–3396272)	739719 (513316–962867)
2030	2411030 (1467499–3366678)	712098 (494694–926596)
2025–30	14051750 (8475990–19662191)	4537157 (3124796–5910791)

Data are number of deaths (95% uncertainty intervals). USAID=US Agency for International Development.

Table 2: Mortality rate rations and numbers of avoidable deaths from the comparison of the forecast scenario of USAID defunding versus baseline, 2025-2030 (Cavalcanti *et al.*, 2025: p. 289)

As a consequence of disrupted health interventions for HIV treatment, malnutrition programs, and additional food aid, millions of people in Africa will be prone to extreme poverty and preventable deaths, jeopardising the decades-long progress made towards achieving health equity and exacerbating health infrastructure fragility. The funding withdrawal has thus created both a financial crisis and a humanitarian one, uncovering weaknesses in LMICs' health infrastructure and capacity to manage health crises.

2.3.2 Exposed Fragilities: Loss of Institutional Capacity, Expertise, & Data Infrastructure

The US funding withdrawal has debilitated health financing systems across Africa, evidenced by policy statements, budget data, and institutional responses (Farmer, 2025).

Fragile and conflict-affected states are particularly challenged with respect to sustaining health systems due to widespread corruption, public distrust in the government, and more urgent budgetary priorities (Bogale *et al*., 2024).

2.3.3 Long-term Epidemiological Impacts & Disease Proliferation

The effects of the US withdrawal can already be seen through increased transmission of HIV, decreased treatment and testing coverage, and higher mortality rates in LMICs (Stover *et al*., 2025), revealing how funding cuts have begun to reverse decades of progress and multiply disease burden. Hussein and Samet (2025) forecast significant negative impacts on infection and disease prevention interventions and nutrition programmes.

These disruptions also heighten susceptibility to endemic diseases like HIV, TB, and malaria, undermine response readiness for future pandemics, and weaken public health security. Moreover, the breakdown in cooperative financing impairs emergency response coordination and limits access to vaccines, diagnostics, and medicines necessary to contain disease spread (Cullinan, 2025). This combination of human suffering, institutional undermining, and increased transmission risks, reflects the broader destabilising effect of the US withdrawal on multinational cooperation in global health.

2.4 LMIC Agency & Autonomy

2.4.1 LMICs Dependence on Foreign Aid is Unsustainable

Foreign aid creates an unsustainable donor-recipient paradigm, enabling health ODA to substitute domestic health spending in LMICs and limit their resiliency against widespread disruptions (Nonvignon, *et al*., 2024; Aryal, 2025; Yach *et al*., 2025). As the recipient of 31% of USAID's foreign assistance in 2023, Sub-Saharan Africa is particularly reliant on health ODA (Atkins, 2025). However, now that global health organisations are reducing their own

budget allocations, it is critical that LMICs move beyond continued dependency, using this opportunity to rebuild national health systems in an equitable manner.

With this in mind, leaders in LMICs have called for greater independence and autonomy within their health systems. For example, the presidents of Zambia and Rwanda described the funding cuts as a "long overdue wake-up call," arguing that "the [African] continent cannot rely on the generosity of others forever" (Atkins, 2025: para: 13).

2.4.2 Increasing LMIC Agency, Equity, & Representation

The US funding withdrawal unveils the necessity as well as a concerted desire of LMICs to govern and finance their own health systems. A recent Africa-focused report outlines a strategy to boost domestic health financing. The proposal was examined by ministers, deputy ministers, and senior health officials from across the continent, and later received formal endorsement from the AU Assembly in early 2025 (Bloom *et al.*, 2025).

Core elements include domestic funding plans backed by multiple revenue sources, creditor and donor commitments to support health services, affordable access to medicines and diagnostics, active engagement in global pandemic preparedness and digital technology adoption (ibid.).

Equity should not be seen merely as a financial redistribution issue, but as a matter of governance design, questioning who makes decisions, whose knowledge counts, and whose priorities are institutionalised. Genuine transformation requires assigning authority to national and regional institutions in LMICs, allowing them to shape policies according to their lived realities (Aryal, 2025). A recent example that illustrates this shift is the Africa CDC 2025 continent-wide strategic plan, which aims to transform health financing and advance self-reliance (Edwin, 2025). After a 70% decline in external aid and rising disease outbreaks,

domestic resource mobilisation is the initiative's priority to protect Africa's health security (ibid.).

The initiative urges governments to meet the Abuja Declaration target of allocating 15% of national budgets to health. It also encourages innovative mechanisms to finance HSS interventions, including diaspora-linked financing and catalytic finance (Edwin, 2025). These strategies ultimately reflect the principles of ownership and equity for which Aryal (2025) advocates by placing African institutions, their priorities, and their resource needs at the centre of governance, which illustrates a practical move toward a decolonised global health landscape.

2.5 Research Gaps & Contributions

Global health research on the post-USAID withdrawal era primarily focuses on scenario forecasting and macro-level consequences, emphasising numerical projections depending on the level of future US engagement. The literature fails to empirically investigate the lived experiences of both global health workers and affected communities after the withdrawal. Moreover, the complex roles of innovative finance and philanthropic capital in global health are not fully explored, despite their potential to bridge gaps in global health finance. Insights regarding the potential for regional institutions (e.g., the African Development Bank) to replace US hegemony are also underrepresented in the literature.

Finally, more analysis is needed to assess whether new architectures within a multipolar system lead to equitable health governance or simply rearrange existing power centres. Our research contributes to the field by providing empirical data that fills three critical knowledge gaps:

- **Institutional Adaptation:** Examining internal operational adjustments (staffing cuts, operational restructuring, financial models,) in HICs
- **Field-level Realities:** Capturing the lived experiences and strategic shifts of implementing partners in LMICs
- **Decolonised Alternatives:** Providing a grounded analysis of whether adaptations represent genuine shifts toward LMIC-led governance or merely reformist adjustments, utilising a decolonisation of global health framework

By integrating multiple perspectives, this research evaluates the extent to which GHIs are reshaping their strategies and structures, and whether these changes are advancing global health governance toward more equitable outcomes rather than reproducing existing power hierarchies.

3.0 CONCEPTUAL FRAMEWORK & ANALYTICAL LENSES

3.1 Overarching Conceptual Framework

Our research is grounded in the decolonisation of global health, defined as a normative, critical framework that focuses on:

> Correcting power asymmetries, empowering Indigenous systems, reforming global health knowledge systems, and taking actions such as redistributing decision-making authority, integrating traditional healing practices, and ensuring equitable funding along with recognition (Mehjabeen, Patel and Jindal, 2025: p. 7).

With this approach, we analyse and evaluate the impact of the US withdrawal beyond budget cuts, workforce reductions, and policy reforms felt in GHIs. Though we do report on these changing dynamics, we delve more deeply into the underlying knowledge asymmetries, donor-recipient hierarchies, funding dependency, and other long-standing power structures that left GHIs and health systems—especially in LMICs—so vulnerable to a funding crisis in the first place.

Moreover, we use this framework to explore whether GHIs and LMIC governments perceive the withdrawal as an opportunity to reshape their strategic priorities and public health policies, eschewing the existing Western-led donor-recipient model (Ashcroft, Griffiths and Tiffin, 2013)—or if the emerging global health paradigm ultimately reproduces power dynamics under new names and programmes.

4.0 METHODOLOGY

4.1 Data Collection

As our research involves highly qualitative, nuanced, and subjective questions on the future thinking of global health actors, we relied on expert interviews to provide firsthand, nuanced insights. Through exploration of different cognitive framings of the US withdrawal, we aim to answer our two research questions with the following objectives in mind:

- Characterise the global health landscape before and after US withdrawal, focusing on institutional processes, funding priorities, and political power structures.
- Examine how GHIs are adapting to current changes, including staff perceptions of future operations and emerging governance shifts.
- Identify the regions most affected by US funding withdrawal.
- Assess how reductions in US funding have affected health outcomes, access to services, care priorities, and local perceptions of institutional responses in LMICs.
- Explore less visible factors shaping global health governance and outcomes, including unexpected themes and heterogeneous effects.
- Compare perspectives between institutional actors in Geneva and respondents in affected countries to identify similarities and differences in perceived impacts, funding priorities, and future visions for global health governance.

Between January and March 2026, we conducted and recorded 27 semi-structured expert interviews with global health professionals in various regions around the world.

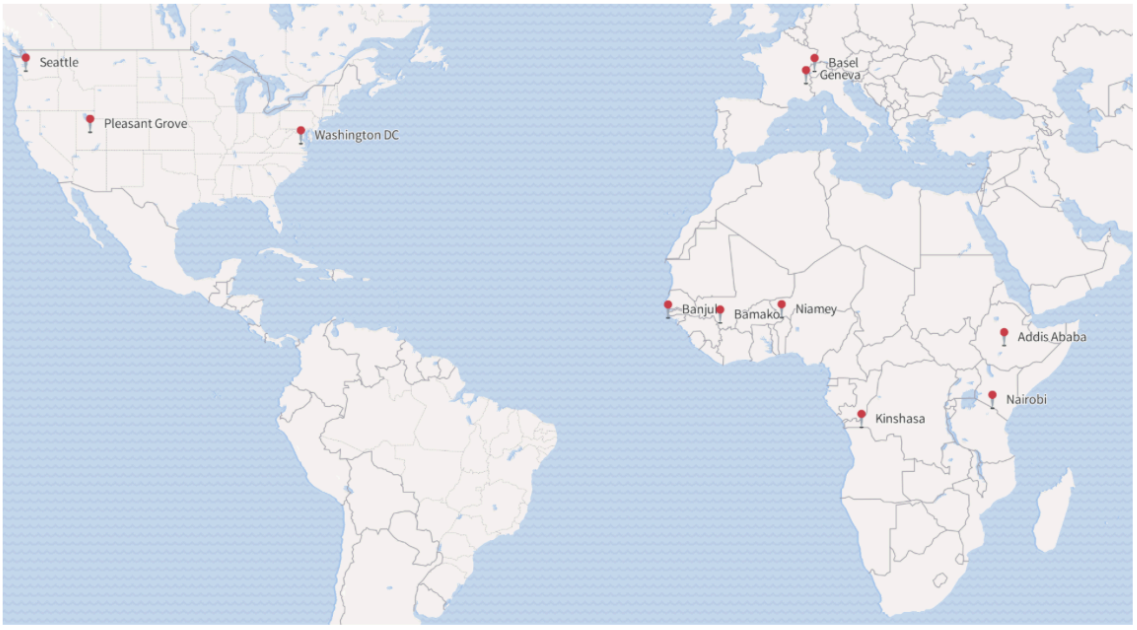

Figure 2: Interviewee locations (authors' own)

Data collection began with representatives from various GHIs and development institutions in Switzerland and the US, who were employed at organisations such as the WHO, Unitaid, Médecins Sans Frontières, Gavi, the Global Fund, USAID, the Center for Global Development, Pictet Wealth Management, and the Stirling Foundation (a family foundation with philanthropic operations in a number of LMICs).

Moreover, during our review of the literature and initial interviews, Sub-Saharan Africa emerged as the region most impacted by the funding cuts and became the primary focus for the LMIC-oriented research. We therefore spoke with health and/or development experts at UNAIDS Nairobi, former USAID professionals in Niger and Mali, The Gambia Country Coordinating Mechanism, and the Community Health Impact Coalition in the DRC to better understand the evolving situation on the ground.

In total, we interviewed 27 experts across 24 organisations and eight countries; however, most wished to remain anonymous due to the current political climate. Nevertheless, their

voices represent the diverse ecosystem of global health actors and institutions that were significantly affected by the US funding withdrawal.

We initially leveraged contacts at IGHD, the Geneva Graduate Institute, and our personal networks to contact our target informants, but a snowball sampling strategy was employed to identify further informants. Those who agreed to participate received an informed consent form explaining the purpose, use, and potential release of the research beforehand, and they could authorise disclosure of identifiable information. However, respondents' answers have been anonymised by default for ethical reasons. We interviewed respondents both in person and using video conferencing tools, and questions were sent beforehand to allow respondents to discern which questions they felt comfortable addressing.

The decolonisation of the global health framework was embedded in our interview questions, ensuring that we captured how global health professionals perceive the shifts in authority and decision-making, financing, and representation following the US funding withdrawal and dismantling of USAID.

4.2 Data Cleaning & Analysis

After the interviewing stage was completed, around 25 hours of audio recordings were collected. We transcribed the audio recordings into written transcripts using a secure, locally-run transcription AI software (see Appendix D), which we then manually cleaned. The initial analysis of the text was done manually, first identifying general themes and patterns, then organising ideas using qualitative coding. Codes included:

1. Initial impact
2. Evolving ODA landscape
3. Innovative finance

4. Future thinking
5. Country ownership
6. Policy recommendations

We manually coded the transcripts, categorised insights and quotes, and evaluated themes using decolonisation of global health as the analytic lens. Following the extensive manual coding process, we utilised an AI software (locally run and processed on a private computer, rather than cloud-based) to further analyse and group the interview data using the same coding categories and analytic framework. This allowed us to deepen our analysis of a large data set without compromising confidentiality.

Together, these methods ensured that our analysis not only documented institutional impacts and responses but also critically evaluated the extent to which institutional adaptations to the US withdrawal demonstrated a shift toward a decolonised global health system that empowers LMICs.

4.3 Limitations & Constraints

Although the research team used a comprehensive qualitative approach, unavoidable limitations persist. For instance, some interviews were conducted in French, which none of the researchers speak as a first language. Despite careful preparation and translation of questions aided by native speakers, some meaning may have been lost in translation or misinterpreted by both parties.

Additionally, the project is part of an academic requirement and is therefore limited to nine months, restricting the time invested into each stage of the research process. Moreover, multiple participants feared professional repercussions and were unwilling to disclose information or assert their opinions on certain topics. To mitigate risk and protect privacy and

confidentiality, the research team distributed consent forms, anonymised the data, and provided the option to edit or retract any answers given in interviews.

4.4 Assumptions & Biases

Since the team was based in Geneva, Switzerland, a place where the consequences of funding withdrawals in global health have been considerable, underlying and subconscious biases are also likely. Moreover, social desirability bias was also introduced in the data collection stage as respondents may have provided answers that they deemed socially laudable rather than their most honest opinions.

To mitigate this, the research team made an effort to write objective and non-leading interview questions. We also maintained openness and prioritised participants' perspectives over pre-existing ideas.

4.5 Alternative Approaches & Modalities

The partner and research team did not want to rely on quantitative approaches as these can conceal power structures and value judgements. As this research project involves deeply social and political decisions, it would be difficult to come to meaningful conclusions on the state of global health based on statistical modelling, as this depoliticises the decisions of key actors.

5.0 KEY FINDINGS & DISCUSSION

Our findings revealed that the US funding withdrawal, though abrupt and highly public, was a reflection and acceleration of existing ODA trends rather than an unforeseen systemic rupture. The emerging system poses certain threats for both multilateral institutions advancing global health initiatives and national governments seeking to construct stronger national health systems. Nevertheless, our interviewees provided promising thought leadership and future thinking to move global health forward.

5.1 The US withdrawal reflects an acceleration of existing ODA trends

When asked to describe their perceptions of the changes that took place in global health governance in 2025, most interviewees converged on one verdict: “The old system is dead—we have to build a new system.” This quote from a health professional in Geneva captures the sentiment across the workforce. The funding cuts, though abrupt and tumultuous, were, arguably, an acceleration of an existing trend. Western governments had been quietly reducing ODA for years, redirecting funds toward defence, energy and domestic constituencies; the invasion of Ukraine accelerated a reallocation already underway. Development, it turns out, has always been the first line item cut when the metropole’s priorities reassert themselves.

More critically, the system that collapsed in 2025 had not been an efficient one undone by political vandalism. It had functioned precisely as designed—extracting careers, salaries and discursive authority from “global health” while the labour of survival was performed elsewhere. As one interviewee put it:

> Global health had grown into this monster, which was not very efficient, was overlapping, wasn't well-coordinated—everybody fighting in the wrong

> corner, asking the same donors for more and more money, paying high salaries in New York and Geneva, not thinking about the focus, not on the countries, but on these global health institutions that were going to save the world.

Thus, despite the dramatic disruptions to GHIs and local populations, interviewees consistently implied that the US funding withdrawal was more a highly public manifestation and acceleration of existing ODA trends, than an unforeseen systemic rupture. As one practitioner noted, "USAID in some ways is really just one of a lot of different shifts that we're seeing" in the development landscape right now. Western donors such as the UK, Germany, or EU have also lowered ODA budgets relative to GNI; however, the only difference is that the US withdrawal was "done in a much more dramatic and traumatic fashion" than other governments in their more subtle "destruction of aid." Thus, this is not a Trump-specific phenomenon; it represents a broader structural shift in how HICs are adapting ODA budgets toward alignment with what they perceive as their national interests.

Many interviewees nonetheless cautioned: "I don't think the dust has settled—whether it's a catastrophic reduction or skeleton staff and minimum viable programming." But the framing itself bears scrutiny. Such comments from leading practitioners reveal the volatility, uncertainty, and complexity that define the current state of global health governance and underline why the findings that follow, on data sovereignty and alternative financing models, carry such urgency.

5.2 The funding cliff caused meaningful damage to global health

A key finding was that the consequences of the funding cuts for the global health sector were immediate, tangible, and long-lasting, particularly in their impact on the workforce. The funding cliff's reverberations were felt across the globe. In less than six months, the funding

cuts hollowed out a workforce of highly skilled practitioners in many of the world's leading GHIs. The US itself arguably experienced the greatest loss of experienced personnel, with one interlocutor estimating that around 200,000 federal employees were fired, while an additional 50,000 took early retirement because of the political situation and the 'Fork in the Road' initiative. A global health practitioner shared that only 30% of those who lost their jobs at USAID have secured new employment, and that:

> The market is completely flooded… For people starting their careers or mid-level career, it is very, very hard to find jobs in this sector. We will have to reinvent our lives completely—I want to be a dog walker!

Global health professionals continued to be disheartened in their search for new employment in early 2026, highlighting the severity of labour market displacement and showing that widespread unemployment in the global health and development sectors remains unresolved, with few other options on the horizon.

The dismantling of USAID also shrank the global health workforce outside of the US, as both on-the-ground USAID staff and the employees of the implementation partners were immediately terminated. In Sudan, USAID-funded partners were ordered to abandon their operations overnight, putting projects "at complete risk of collapse." An interviewee whose USAID funded project was suspended immediately and then terminated within weeks, recalls the exact chronology:

> We received [notice] on January 24th,.. four days after this new administration was sworn in, they ordered a pause. We got, technically, a suspension work order… suspend all of our activities immediately… we could no longer pay for anything. By the end of March, everyone had been laid off, and I was laid off in April.

Such comments illustrate the speed and depth of the US withdrawal from GHIs, with much of the chronology taking place over only a matter of weeks.

The reverberations of the US withdrawal were not confined to countries where USAID operated directly—they rippled outward to the multilateral institutions at the heart of global health architecture. The shifts in Geneva may have been slightly less abrupt, but still a shock to the system as hiring freezes, non-renewed contracts, and multiple rounds of layoffs characterised much of Geneva's multilateral ecosystem in late 2025 and early 2026.

The WHO, for example, has lost, or is in the process of losing, a third of its staff. One interviewee described the WHO consolidation: departments are merging and downsizing, the director headcount has been reduced from 70 to 30, and over 2,000 people across the organisation have been made redundant. These mass layoffs have also put immense pressure on the remaining workforce. Another global health professional reported that out of 15 operational branches at their organisation, seven had already been eliminated: “Everybody’s wearing two or three hats trying to do their jobs, but it is a very complicated environment to work in.”

A global health workforce built over decades and distributed across many regional contexts cannot be easily reconstructed. It carries institutional memory, specialised expertise, and the relational networks through which services were delivered; and that damage extends well beyond individual livelihoods.

5.3 As ODA contracts, a menu of finance alternatives is emerging

5.3.1 Inside perspectives on philanthropy reveal its limits

Many interviewees advised against putting “all your eggs in one basket,” arguing that this created the unstable foundations that led to the post-USAID funding shock in many GHIs and

LMIC governments. As a WHO employee stated, "We were relying heavily on a small number of donors—and it obviously created…fragility." Another echoed this sentiment, stating their greatest lesson learned from the withdrawal was that "over-reliance on one donor is bad… because if something changes in your main source of financing then it affects the entire capacity in an organisation."

When asked to provide their future thinking on global health funding, some interviewees perceived traditional philanthropic organisations as the emergent leaders in global health funding, particularly the Gates Foundation (see Appendix C.1). However, it was noted by multiple interviewees that the foundation, given its planned closure in 2045, is "not here to fill the gap" left by US funding cuts. It was further noted that philanthropic foundations in general are being "inundated with requests to fill gaps and programmes that are collapsing" but are increasingly reluctant to absorb new responsibilities.

Notably, one philanthropic advisor described the imminent "Great Wealth Transfer," where an estimated 89 trillion USD will pass as inheritance from Baby Boomers to their children, and another 12 trillion USD will be left to philanthropic initiatives. In the past, the largest share of philanthropic assets (around 43%) targeted global health, particularly disease-specific programmes, reproductive health, and maternal/newborn wellness. However, according to a poll of 150 18-25 year olds administered by the interviewee's organisation, younger donors plan to direct future wealth toward conflict and peace, social justice, and climate change initiatives, with global health ranking lower on the list of target priorities. Thus, philanthropy "can make up some areas, but you shouldn't see that as a sort of wholesale replacement of the government reductions."

5.3.2 Innovative finance offers opportunities and risks

Beyond traditional philanthropy, our interviews revealed a growing ecosystem of alternative financing mechanisms that together constitute a credible, if partial, response to the ODA gap.

Innovative finance, which includes catalytic or blended finance, results-based financing, venture philanthropy, impact investing, development impact bonds, and social impact bonds, is rising among GHIs and governments as an alternative way to fund social programmes and development projects without using ODA or tax revenues (see Appendix C.2).

Venture philanthropy differs from both venture capital and traditional philanthropy. Rather than focusing either on financial returns or social impact, this type of capital identifies early-stage projects with high social or environmental returns that are too risky for traditional investors. Philanthropic investors then support and de-risk the projects (often through technical assistance) to encourage future investment from mainstream finance: “how can you use your pot over here to elicit a greater sort of investment from this bigger pot over here?” The size of philanthropic capital is considerable—one financial advisor we spoke with estimated its total market at around 2.5 trillion USD.

DIBs have also increased in popularity as one of many alternative finance tools to address funding gaps (see Appendix C.3). A former FCDO officer highlighted the success of a DIB for adolescent sexual reproductive health piloted by the UK government: an initial five million GBP tranche attracted private capital, bringing the project's total fund up twelve-fold without increasing taxpayer burdens. Table 3 below maps the key mechanisms that emerged from our interviews, the actors they apply to, and the outcomes they enable:

Finance Mechanism	Who it applies to	Finance instrument + What it enables	Current example in practice
Impact Investing	Private investors, development finance institutions (DFIs), IFIs	Issues debt or equity investment in health enterprises expecting both social and financial returns	IFC health sector equity investments in private healthcare providers; DFI investments in health commodity manufacturers in LMICs; African Development Bank health equity funds
Corporate Philanthropy/ Enterprise Foundations	Corporations and corporate-linked foundations	Deploys grants, in-kind contributions, and CSR-linked giving to scale early-stage health innovations	Novo Nordisk Foundation: controls Novo Nordisk, channels Ozempic profits into global health grants (now larger than Gates Foundation)
Blended/Catalytic Finance	IOs, NGOs, private sector, development banks	Uses concessional or philanthropic capital to unlock larger investment by improving risk/return profiles	Global Fund + World Bank TB loan buy-downs: ~$40M Global Fund subsidy unlocked a $400M loan in India; ~$20M unlocked $300M in Indonesia. Unitaid + Global Fund next-generation malaria nets: $30M + $60M = $90M joint project. Joint Unitaid/Gavi/Global Fund malaria vaccine project
Development/Social Impact Bonds & Results-based Financing	Governments, NGOs, private investors, outcome funders	Expects upfront investor to fund service delivery; outcome payer only reimburses if verified targets are met — transfers risk away from government	World's first adolescent SRHR Development Impact Bond, Kenya: FCDO as outcome payer, CIFF as upfront investor, Triggerise as implementer
Blockchain-based Finance	Governments, NGOs, private investors, individual donors	Disburses transparent, traceable payments and tokenised giving; attractive to younger, digitally-native donor base	MSF experimentation with crypto donations and NFTs; The Giving Block platform used by health-focused nonprofits; UNICEF CryptoFund (accepts and disburses crypto to early-stage technology projects)
Crowdfunding/Pooled Funding & Co-funding	LMICs, national governments, multilaterals	Shares risk across multiple funders; phased transition to domestic self-reliance with milestone-based co-financing requirements	Global Fund co-funding model (governments must fund ≥80% ARV costs, HR, and health infrastructure domestically); Gambia CCM co-financing agreement
Advanced Market Commitments (AMC)	Donors, multilaterals, manufacturers	Legally binds donor to subsidise purchase of a product at scale, guaranteeing manufacturers a viable market	Gavi pneumococcal AMC ($1.5B, 2009): brought vaccines to 60 low-income countries ~10 years faster than historical timelines; Gavi first response fund ($500M, 2024) for rapid pandemic deployment
Solidarity Levies	Governments, travellers	Hypothecates micro-taxes on transactions (flights, financial trades) generating recurring revenue	French air ticket levy (consumer tax of €1 for economy class and ~€10 for business) generated ~€500M/year, and Unitaid would receive around €85M

Emerging Menu of Alternative Financing and Governance Mechanisms in Global Health (Author's Own Work based on Interview Data, 2026)

However, private sector interviewees stressed that terms like innovative finance and impact bonds are often inaccurately cited as simple solutions, ignoring the nuances and complexities of various financial structures:

> These different people—the business sector, the government, the organisations, the philanthropists—all come from very different worlds. And we're expecting them to get around the table, shake hands, and pool their capital and work together—it's not straightforward.

In particular, innovative finance entails high volatility and regulatory risks that are yet untested at a global systemic scale. Additionally, innovative finance carries similar power dynamics to traditional ODA and philanthropy, where investors can set agendas and create standards that do not align with country priorities. As noted by one interviewee, “It wouldn't be proper to simply say, all right, things were funded in this way, let's just bring the money from somewhere else and fund them in exactly the same way.”

These warnings should not discourage GHIs or LMIC governments from exploring innovative finance solutions; however, they should be cautious and understand the differences between such financial tools and traditional ODA. If well structured and carefully managed, innovative finance can create resilient funding architectures that disperse risk, reduce single-donor dependency, and create more space for recipient-led decisionmaking.

5.4 Threats to disease-specific programmes underscore their continued relevance

One expert reported that the cessation of commodity distributions previously provided through USAID directly contributed to AIDS-related deaths, as patients began rationing medications that were essential to their continuous treatment regimens:

> The supply chain was impacted, so people already dying of AIDS started breaking their medications in halves to make it last longer, then they stopped taking the medications altogether.

HIV centres of excellence in tertiary care facilities were shut down abruptly, leaving thousands without access to care. These disruptions remain ongoing, and whether the outcome becomes a managed decline or catastrophic collapse, depends on whether the international community can establish an alternative model quickly enough. As one participant explained:

> The answer is not yet clear as to whether it's a catastrophic reduction in services or whether just skeleton staff and minimum viable programming and minimum viable service levels... I don't think the dust has settled on that.

The funding cuts directly tested the longstanding debate between vertical disease programmes and HSS. Existing literature frequently criticised disease-specific initiatives for diverting resources away from broader HSS priorities. However, interviewees consistently argued that life-saving treatment programmes for HIV, TB, and malaria remain essential and cannot be paused during periods of financial instability. One respondent emphasised that multiple GHIs were established specifically to intervene in these areas:

> Somebody still has to pay for the commodities. The reason we were set up in 2002 was because those three diseases were what people were dying for. And they're still dying. You can't take people off ARV treatment. You can't stop treating people for malaria.

Indeed, several interviewees stressed that reductions in vertical programming have immediate consequences for mortality and disease control, particularly where monitoring and

surveillance systems are fragmented: “30% makes a lot of difference when we're talking about trying to eliminate HIV, TB and malaria, especially in countries where these are the most deadly causes.”

The dismantling of USAID disrupted treatment supply chains across Sub-Saharan Africa, where high HIV prevalence already strained national capacity. Systems developed over decades through PEPFAR funding and coordination by the WHO were dismantled rapidly, exposing the fragility of externally dependent health systems. Patients lost access to medication, rationed treatment, or stopped taking medications altogether, while governments struggled to respond to fragmented service delivery systems.

Interview findings challenged the assumption that vertical programmes inherently weaken HSS. Instead, respondents argued that disease-specific interventions contribute substantially to system-building through investments in laboratories, supply chains, human resources, and service delivery systems:

> In reality, we do a huge amount of systems-building: supply chain, systems, human resources for health. So I tend to feel that we're a lot less vertical than people understand.

Another argument in favor of vertical programmes is their accessibility to smaller development organisations, which lack the financial resources, technical expertise, or institutional capacity required for large-scale systemic reform. One regional lead at a private foundation explained: “Health is one of our areas we focus on, but not as a primary implementation... we're not a well-equipped health-specific organisation.”

Although interviewees acknowledged that short-term donor investments can limit broader HSS initiatives, many rejected the idea that disease-specific programmes themselves were a

direct obstacle to HSS. Rather than representing mutually exclusive approaches, many interviewees viewed vertical programmes as essential components of health systems, particularly during crises. Thus, the critical issue is not whether vertical programmes should exist, but whether the knowledge, infrastructure, and operational systems involved are institutionalised within health systems.

5.5 US Bilateral MoUs pose new governance challenges

5.5.1 Data loss and externally controlled systems weakened global health governance

Governance of population data is a foundational component of health system resilience and continuity—not merely a component of a donor's technical assistance. One of the most concerning findings revealed by multiple interviewees was that, in addition to personnel and funding cuts, significant amounts of data were lost—quite literally overnight—amid USAID's abrupt withdrawal from LMICs. As one interviewee described:

> Lots of stories of USAID projects wrapping up and people basically taking their laptop with them—and with all the patient data on it—and the programme kind of falls apart. Even if the government has the resources to pick up the programme, they don't know who the patients are, how many, has this person been immunised? Part of this is about data systems and governments controlling the data systems.

Participants argued that this outsourcing of information on local population health, surveillance systems, and other programmatic records to USAID may have unintentionally weakened LMICs' ability to strengthen their health systems. The withdrawal resulted not only in a shortage of human resources—it destroyed a significant amount of analytical capacity, data interpretation, and institutional memory that had been built over decades.

The collapse of USAID may have exposed these systemic vulnerabilities, but this was not an isolated instance of governance failure—the withdrawal reflects a broader structural framework in global health where knowledge is produced and stored by donor institutions in HICs rather than localised. This dependence on externally managed systems created serious national security concerns for LMICs, as the ability to govern population data allows GHAs to shape national priorities, strengthen administrative capacity, design appropriate policies, and respond proactively to health crises.

Data sovereignty thus constitutes a form of epistemological power that is arguably underexplored in the current literature on decolonisation of global health, which primarily focuses on financial dependence and agenda-setting. By producing and storing data on foreign laptops, USAID limited the ability of LMIC governments to autonomously govern their health systems.

5.5.2 US Bilateral MoUs exacerbate asymmetries through data-sharing agreements

Despite the growing push for LMICs to govern their health systems, the rise of bilateral agreements between the US and LMICs may complicate or even undermine national autonomy and data sovereignty. As of April 2026, the US has signed 27 bilateral MoUs on health system funding with countries in Sub-Saharan Africa and Latin America (Hirschfeld *et al.*, 2026). The US Department of State, which has spearheaded the agreements, asserts that they will enable LMIC governments to gradually take ownership over health systems previously funded by USAID and scale domestic health budgets.

However, this emerging bilateral system, according to interviewees, creates multiple new power asymmetries that reproduce colonial governing structures. For example, one informant reported that US negotiators pressured LMIC governments to sign these health agreements under strict deadlines and conditions:

> One of the things that has been problematic is that information is barely public. So we don't have eyes on agreements except in a very limited number of cases... there's a lot of secrecy and... the US government has established that these are bilateral-only agreements and that they are confidential agreements... It's very difficult to interact with such a degree of confidentiality.

The lack of transparent disclosure prevents local policymakers from thoroughly reviewing the terms with legal counsel and working with experts to establish critical safeguards, restricting local autonomy and voice.

Moreover, when asked about the bilateral cooperation agreement between the US and Kenya, one interviewee declared:“I think it's a lopsided agreement because my understanding is the US will have access to the data for up to 25 years, yet the money is only for five years.” The temporal mismatch highlights a concerning trade-off in the pursuit of data sovereignty: short-term funding for HSS would be traded for unilateral data access that outlasts the financial relationship by two decades (see Appendix C.4 for the Cooperation Framework between Kenya and the US)

By bundling funding with practically unrestricted access to local population data—including clinical health records, pathogen genetic sequences, financial accounts, and supply chain information—LMICs risk losing even more control over their data, as conveyed by one concerned health professional:

> We already, through PEPFAR, had data-sharing agreements… and now it's like they want all the identifiable information of every person, and I think that's wrong… I don't think that's a fair approach.

Thus, LMICs should be cautious in their approach to bilateral MoUs with the US, as the asymmetric data-sharing terms may reproduce colonial structures.

Interviewees also cited broader sovereignty concerns within the health MoUs, particularly terms regarding access to critical mineral resources:

> These agreements have other elements in them that have to do with access to data… But there are also other trade conditions, mineral agreements, that I cannot speak to because we haven't seen them. We have only heard about them, but I think it would be good that the objectives of global health prevail in agreements about health impact."

The short-term provision of funding in exchange for long-term access to both population data and critical minerals presents one of the most troubling dimensions of the emerging global health system: bilateral deals can exacerbate resource extractivism as wealthy governments pressure LMICs to bundle together and concede strategic geopolitical assets in order to maintain basic public health support.

As Geneva's multilateral global health system struggles with funding cuts, labour shortages, and strategic uncertainty, LMICs are encouraged to become more financially self-sufficient and to take ownership over their health systems. However, this has created a paradox: by increasing their financial capacity through closed-door negotiations with the US, LMICs may forgo the autonomy and control over their data that is needed to strengthen national health systems. This dynamic is reshaping, rather than eliminating, external influence over national health by turning data into a geopolitical tool and institutionalising resource extractivism.

5.6 Decolonising the Rhetoric of Country Ownership and National Sovereignty

5.6.1 National agenda-setting through the "à la carte" model

The push to decolonise global health is no longer theoretical, it is a practical acceleration of sovereignty, triggered by shifts in international funding. Yet, a persistent gap remains between the "rhetoric of country ownership" and the structural realities of national agenda-setting. As one participant noted, "the person who is paying… is the one who sets the agenda"—donor priorities often override the identified needs of recipient nations. Even where national health frameworks exist, countries must typically adapt their needs to fit funding envelopes rather than the reverse, creating an environment where ownership is constrained and alignment is reactive rather than sovereign. Partnership language obscures this underlying transactional logic, in which consultation is offered but the terms of engagement are set elsewhere.

Programmatic pressures, donor-driven deliverables, and tight deadlines further limit negotiation space, producing implementation oriented towards compliance rather than contextual relevance. Agenda-setting remains partially externalised even where formal commitments to country-led processes exist.

Historically, GHIs have operated on a "fixed menu" of donors who set disease targets. However, there are indications of transition. Initiatives such as the Gavi Leap signal a shift towards an *"à la carte"* model, allowing countries to prioritise their own intervention areas and increasingly, to select their own delivery partners. But these shifts unfold within persistent structural inequalities. As one respondent characterised the donor-recipient

relationship, “there are some that have power, money and decision-making and even if it's negotiated, even if it's in dialogue, there's always a power imbalance that's not going away.”

The diagnosis runs deeper than aid modalities. For two decades, “the incentives were not very strong for countries to prioritise domestic spending… resources were taken as a very important contribution, and domestic money was used for other purposes.” The architecture itself disincentivised sovereignty. Decolonising national agenda-setting is therefore not simply about transferring responsibility, but about restructuring the financial and knowledge structures that underpin it.

5.6.2 Overcoming the Audit Paradox: Local Accountability vs. External Control

A primary obstacle to country-led leadership is what we term the "audit paradox"— rigid donor MRV and accountability mechanisms constrain the very local leadership that ownership requires.

Donor audit functions—parliaments, independent auditors, philanthropic compliance regimes—drive how programmes operate, leaving aid ministries with little flexibility, “completely inflexible”, in one respondent’s terms. Concerns about recipient corruption further reinforce external control, though the asymmetry was directly challenged: “there’s corruption in the Western world too”.

The practitioner's objection, however, is not reducible to neocolonial reflex. Ownership cannot be unconditional where states have criminalised the populations a programme exists to serve—the donor representative who refused, “in good conscience”, to hand HIV funding to a government criminalising men who have sex with men was naming a real ethical limit, not a paternalist preference.

The audit paradox is structural: limited trust justifies increased MRV and control, which constrains the development of domestic accountability through learning-by-doing, which in turn sustains the capacity gap that justified control in the first place.

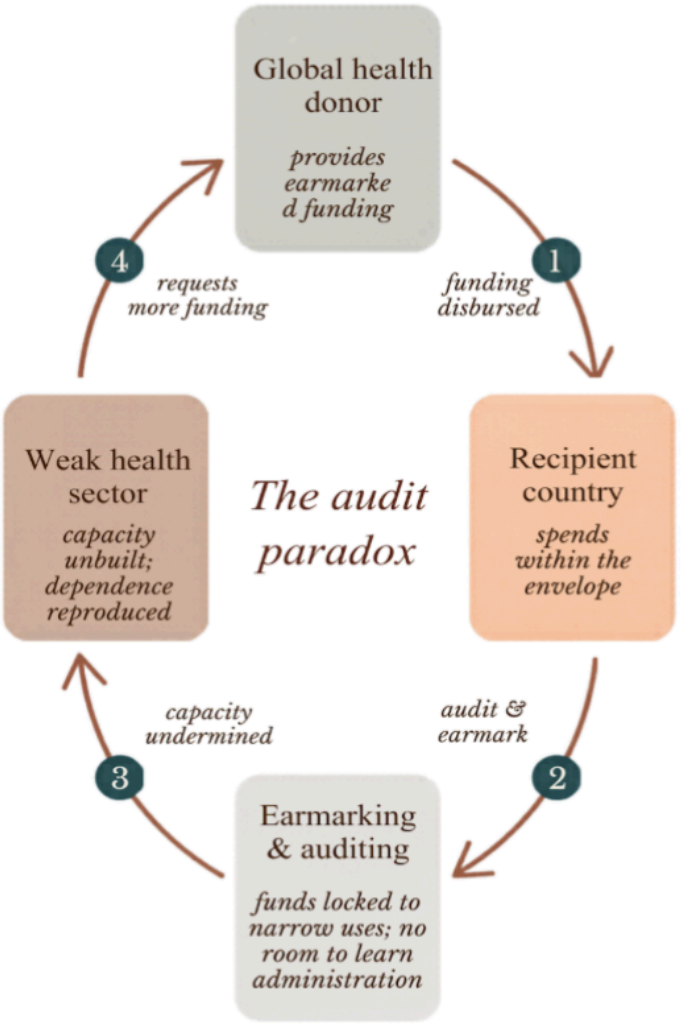

Figure 3: Patterns of donor distortion in global health ODA (Author's Own)

5.6.3 Shifting power dynamics: African leadership and the transition underway

African leadership is increasingly establishing itself as a foundational architecture of contemporary global health governance, not merely a response to HIC retrenchment. While funding shocks have accelerated visibility, the institutions and political work underpinning

this shift predates and exceeds them. The Africa CDC, repeatedly cited as a marker of growing regional autonomy, is more accurately read as a standard-setter in its own right—designed around continental epidemiological realities, regional accountability structures, and a vision of health sovereignty that HIC led architectures have historically failed to deliver. As one interviewee put it, "the last thing we want now is some colonial mentality coming back."

Initiatives such as the Accra Reset—a Ghana-led process now drawing in regional partners and connecting with international actors—and Lusaka Agenda formalise this shift, emphasising domestic resource mobilisation, HSS and the transition from donor managed to government managed funds. As one global health professional framed it, sovereignty operates on two levels at once: " improving health system, improving transparency, improving efficiency at domestic level", and "securing that the declining money from donors moves rapidly to be managed through government structures." UNAIDS now supports countries in developing HIV sustainability roadmaps aligned with national financing plans, helping them "have clarity on what's the expected self-reliant model in five years time". The Global Fund is "rebalancing the relationship across the major public donors and private constituencies" while strengthening CCMs to preserve country oversight of grant implementation. Even contentious US bilateral agreements, while being conditioned on donor terms, are now being signed on multi-year terms, one interviewee noted, because they allow countries to "think in a phased way of what needs to be filled in, what will have to drop, what needs to transition from donor structure into a country structure."

The political work, however, is incomplete. The Accra Reset, one Global Health Professional observed, was largely shaped by previous heads of state and ministers: "right now, it does not have broad credibility." The Somalia case illustrates the limit of

unconditional ownership: “When the government of Somalia controls more than 12 kilometres of Mogadishu, then we'll talk about accountability there? No, it's not there. The governance there? No, it's not there. The systems? No, not there.” And while the direction of travel is clear, the financial flows have not yet caught up: “we are already seeing a lot of this, but we are not seeing yet the results and the financial flows.”

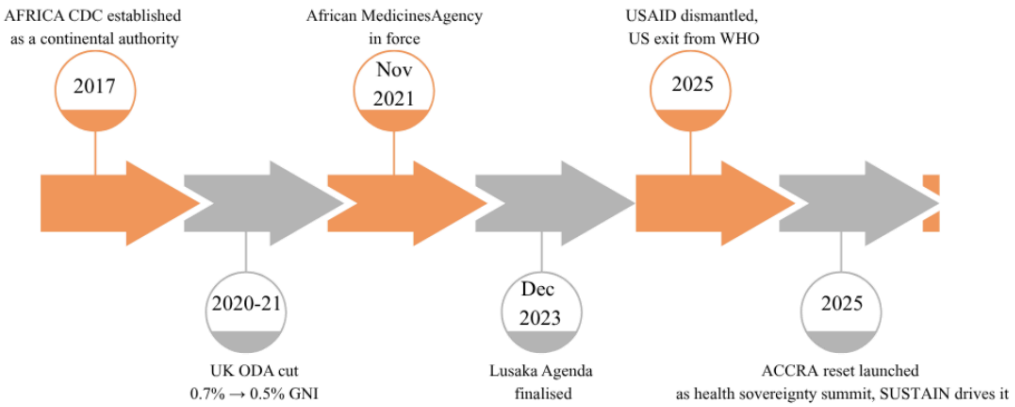

Figure 4: Decolonising global health: African leadership amidst HIC retrenchment, 2017–2026 (based on 27 key informant interviews).

African leadership is actively reshaping global health governance, yet its consolidation rests on three conditions: sustained domestic investment, institutional capacity, and partnerships renegotiated on more equal terms. Decolonisation cannot stop at redistributing authority; without the fiscal, epistemic, and administrative infrastructure to operationalise it, that authority remains nominal.

6.0 SUMMARY & CONCLUSIONS

Building on our six core findings outlined above, this section summarises how the 2025 US withdrawal has reshaped global health governance and what this implies for future architectures.

The US withdrawal arguably has not in itself ruptured global health governance and architecture; rather, it exposed trends and vulnerabilities that were already defining the landscape. In particular, unsustainable reliance on donors, conditional financing, and strained trust in partnerships were already embedded in the system long before 2025. Our 27 interviews with experts across Geneva, key US cities, and major African capitals revealed the unclear trajectory of global health governance, as GHIs continue to rethink their programming, staffing, and funding priorities under new constraints in 2026. Across Geneva's global health ecosystem, mergers, consolidations and relocations are being considered as possible consolidation options.

Financially, GHIs are moving away from reliance on few donors toward mechanisms of diverse and innovative finance, specifically blended finance, DIBs, and philanthropic capital platforms. They may be scaling up, but not with the same priorities that traditional ODA once delivered, bringing volatility and regulatory risks. Furthermore, philanthropy cannot fill the gap left by the US withdrawals, and the emerging generation of donors may prioritise funding climate projects and social justice over health initiatives. A system "dictated from Seattle" cannot remedy these issues.

Regarding the decolonisation of global health, our research findings both validate and complicate the path to country ownership. On one hand, the Africa CDC, the Lusaka Agenda, and the Accra Reset offer new possibilities for the African continent to determine its own strategic priorities. Moreover, the traditional donor-based model can be transformed into an

"à la carte" model, as exemplified by the Gavi Leap. Finally, The Global Fund gives national governments genuine, if still constrained, agenda setting authority, through co-funding models.

However, the impacts of funding withdrawal, particularly in SSA, reveal the asymmetric consequences of the funding cuts: interrupted ARV therapy, disrupted supply chains, and the collapse of a global health workforce that cannot be easily rebuilt. In addition, the 27 bilateral agreements between the US and LMICs signal a shift away from multilateralism but not necessarily toward multipolarity or equitable distribution of decision-making authority. The Kenya-US Cooperation Framework exemplifies the risk of national data sovereignty and resource wealth being traded for health finance. LMICs are encouraged to "own" their health systems but are simultaneously pressured to surrender the epistemic infrastructure upon which ownership depends, illustrating the complexities and trade-offs LMICs must navigate to overcome dependence on donors. Thus, the balance of power may be reallocated toward new HIC actors rather than equitably distributed between global health actors.

The global health architecture is changing—the key question now is who is designing what system is emerging and on whose terms. In the following section, we share recommendations as to how HIC GHIs can adapt resiliently under new constraints. We also propose strategies for GHAs and policymakers in LMICs to strengthen autonomy in the evolving system of global health governance.

7.0 RECOMMENDATIONS

Taking into account the insights received from 27 interviews with diverse voices in global health, this section outlines the actions needed to ensure that global health governance is strengthened and more resilient than before the US withdrawal, rather than weakened and more fragmented. Our recommendations are aimed toward:

1. Health professionals and decision-makers within Geneva-based GHIs (e.g., WHO, Gavi, the Global Fund, and UN health agencies)
2. Policymakers and global health thought leaders in LMICs, particularly Sub-Saharan Africa

7.1 Reorienting HIC-based Multilateral Institutions

7.1.1 Decentralise Operational Functions

Geneva-based GHIs should retain only the functions that cannot be performed elsewhere and decentralise the rest. The WHO holds functions no other actor can substitute for: administers the IHR, sets normative standards on which global health practice depends (ICD, AMR framework) and stewards treaty instruments from FCTC to the Pandemic Agreement. Other Geneva institutions hold comparable functions in their respective domains. Thus, the job functions that remain in Geneva should be highly specialised —such as infectious disease experts, genomic epidemiologists and global supply chain experts.

Beyond this core, decentralising administrative and operational functions is important for multiple reasons. First, Geneva is one of the most expensive labour markets in the world; hiring consultants or contractors in Geneva for tasks that can be performed locally is neither economically sustainable nor defensible to donors and member states. Second, programme delivery is stronger when planned and executed closer to the context it serves. Proximity to health ministries and affected communities improves accountability and overall impact.

Moreover, decentralisation aligns with the localisation agenda that recipients, donors and global health community have explicitly endorsed. Thus, decentralising operational functions would not only reduce pressure on GHI budgets—it would also critically ensure that regional or national institutions can build systemic capacity and localised expertise.

7.1.2 Implement Time-Bound Capacity Transfers

To decentralise global health governance responsibly, GHIs should establish and enforce formal, phased, time-bound plans to transfer functions like project leadership, data management, finance and administration to national or regional actors, such as Africa CDC or national ministries of health. A participant shared an example of this: a co-funding agreement which requires a government to financially contribute to a grant (such as the Global Fund) by covering certain costs such as staff salaries, health infrastructure, and local procurement. The government must include these costs in its national budget and prove they were actually spent through a yearly report. All of this government spending combined counts as their share of the partnership with the international donor.

7.1.3 Streamlining Mandates

Finally, where it is not possible to decentralise functions, GHIs in Geneva must streamline. Our research made clear that many back-office tasks could be merged or shared between organisations, drawing on the precedent of the UN's Common Back Office model, which consolidates finance, procurement and HR across all UN agencies. Gavi and the Global Fund, for instance, could operate shared platforms (e.g., one robust Africa Team), to streamline service delivery to the region. This would eliminate duplication, maximise operational efficiency and ease budget pressures. It would also ensure that LMICs are receiving neither conflicting advice nor conditions, which has in the past increased their administrative burdens. Most importantly, consolidating shared functions would allow each GHI to focus its

funding, programming and staff efforts on its unique mandates, increasing its relevance in global health governance.

7.1.4 Reorient Funding towards Sustainable, Country-Led HSS

GHIs should replace short-term, volatile funding cycles with predictable, multi-year commitments that allow recipient nations to perform reliable health system planning and investment. Funding should shift from earmarked, donor-defined technical fixes toward unearmarked contributions aligned with domestically-defined systems-strengthening priorities, in line with the Lusaka Agenda's commitments on country-led financing (Mwangangi & Røttingen, 2023). Philanthropic actors and bilateral donors should align their instruments with these same principles.

7.2 Strengthening African and other LMICs' Leadership and Agency

LMIC actors, particularly in African countries most impacted by the funding cuts, can shift from passive recipients to active agenda-setters through governance strategies such as strengthened data ownership, domestic resource mobilisation, administrative accountability, and regional cooperation.

7.2.1 Standardise Bilateral Negotiating Frameworks

LMIC institutions, like the AU, should create and promote transparent national protocols for bilateral agreements on external health funding. For instance, one guideline could recommend that MoUs decouple critical infrastructure and health funding from long-term data extraction or policy conditionalities or require duration parity between funding and data access granted under such agreements (e.g., 25 years of funding for 25 years of critical mineral access). Additionally, they should enforce strict data governance policies that prevent donors from holding exclusive access to national health data, ensuring that raw data and

analysis remain under local ownership and that data residency stays within national borders unless mutually beneficial secondary use is specifically negotiated (Africa CDC, n.d.).

A decolonised global health system must prioritise data sovereignty and local knowledge production, where data is generated, stored, and analysed within national borders, unless it is mutually beneficial to share with an external actor.

7.2.2 Local Content Requirements, Ownership and Accountability

LMIC governments should require some degree of local content requirements for projects or initiatives with foreign donors or investors involved. This would ensure that external investments embed local labour, supply chains, and training components and keep capacity-building and learning-by-doing in the country rather than relying on imported technical staff. Regarding anti-corruption and MRV measures, accountability should be dual: auditing can be led domestically through national institutions, then supported externally through donor-country feedback mechanisms. This approach recognises that many LMICs currently lack the institutional capacity to sustain robust accountability mechanisms independently, but with structured knowledge transfer, they can gain the capacity needed to lead such processes.

7.2.3 Institutionalise Regional Knowledge Hubs & Invest in Local Private Sector

LMIC institutions should capitalise on the current shifts in global health governance and ODA funding cuts to reposition themselves not simply as local experts or recipients of support, but as chief architects of global health governance. In the case of Sub-Saharan Africa, major cities such as Addis Ababa, Accra, Johannesburg and Nairobi can invest in creating their own GHIs—not as competitors to hubs like Geneva, Brussels and Washington, D.C.—but as complementary centres of authority in an emerging multipolar architecture.

To advance locally nuanced research, international organisations such as the Africa CDC should serve as primary producers of continent-wide health data and as experts on the continent's public health policies. The private sector also has a critical role to play—African sovereign wealth funds and impact investing funds should direct capital toward health-oriented companies in other African countries such as health-tech start-ups, medical device manufacturers, university laboratories, and private research institutes to encourage knowledge spillovers and create competitive advantages.

By creating regional health clusters, multiplying South-South investment, and prioritising local knowledge production, actors across LMICs can strengthen health systems, spark local innovation, and establish authority in global health governance.

7.3 Recommendations for Future Research

Having explored future thinking among global health professionals in the wake of the 2025 ODA cuts, we recommend that future researchers, including Geneva Graduate Institute students undertaking applied research projects, expand on this research area, which is critical for equitable global health governance. For instance, researchers can analyse how Sub-Saharan African countries are now adapting their health financing strategies and governance structures in response to the funding cuts and the rise of bilateral health agreements. In addition, it would be interesting to evaluate what conditions have enabled or constrained meaningful country-led response through a comparison of 3-4 country case studies, resulting in a list of best practices for country-led health governance and financing.

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APPENDIX A

Supplementary Data from Literature Review:

Appendix A.1: Structural patterns in the pre-withdrawal global health aid landscape

Pattern	Mechanism	Key Evidence	Decolonial Implication
2.1.1 Phantom aid & internal spending	A substantial percentage of ODA never reaches the target recipient, absorbed instead by institutional costs, meetings, events and administrative fees (Spicer et al., 2020).	ActionAid, an international NGO, found that one-third of British ODA in 2005 was spent on Western consultants' "inflated" salaries and business-class flights (Elliott, 2005) 86 cents of every dollar is virtually phantom aid as it is allocated to the purchase of American goods and services under the 1961 Foreign Assistance Act, which incorporated "Buy American" provisions that require a considerable proportion of ODA to be spent on US contracts for goods and services, effectively subsidising American companies (Morley and Morley, 1961).	The system is more accountable to donor-country economies and outcomes than to recipient need; LMICs cannot plan reliably when funds are fragmented and directed away from local systemic priorities.
2.1.2 Disease specific over health systems strengthening	Western donors pretend to prioritise disease specific interventions over long term investments in HSS interventions (Carroll et al., 2024).	Between 2008 and 2019, the US only earmarked 3-12% of health ODA funds toward HSS interventions (Carroll et al., 2024), and in 2024, 31% of USAID's budget was allocated toward HIV/AIDS and malaria interventions in Sub-Saharan Africa (Buffardi, 2018; Atkins, 2025). As time-bound programmes with measurable outputs, Disease-specific interventions have greater political visibility for donors and the public (Steele, 2017).	Systemic reforms, by contrast, have abstract targets that require long time horizons to show impact, and results are not easily attributable to a single organisation, making HSS interventions less appealing to donors. However, by allocating funding in vertical silos, Western health ODA systematically undermines long-term resilience and ignores local systemic needs.

2.1.3 Ideological imperialism masked as foreign assistance	Aid conditioned on donor political and strategic objectives, with allocation skewed towards strategic and political considerations as opposed to country need (Spicer et al., 2020); Historical roots in colonial resource extraction and protection of the colonial metropole from "exotified" tropical illnesses (Farber et al., 2025).	The US' Mexico City Policy—often referred to as the Global Gag rule—prohibits NGOs receiving US funding from providing or referring for abortion services, leading to a substantial decline in safe abortions as pregnant women turn to risky alternatives (Crane and Dusenberry, 2004). Since its introduction in 1984 under President Reagan, the policy has been repeatedly repealed by Democratic administrations and reinstated by Republican ones, causing frequent shifts in access to reproductive health services.	Local communities must absorb the aftershocks of a volatile American political system in order to maintain funding (Skuster et al., 2024). By imposing partisan ideologies on foreign health systems, the US imperialistic manner undermines local agency, stability, and sovereignty.
2.1.4 Philanthropy and the legitimacy gap	Earmarked private capital shapes multilateral agendas without democratic mandate or transparent accountability, presenting political mechanisms as neutral technical fixes (Ferguson and Lohmann, 1994; Moran, 2023).	The Gates Foundation's use of massive earmarked funding to elevate polio eradication to the top of the WHO agenda, diverting the institution's resources away from more urgent primary healthcare needs such as maternal and child health (Blunt, 2022: p. 2054); During the COVID-19 pandemic, the Gates Foundation opposed a TRIPS intellectual property waiver that would have allowed countries to manufacture generic mRNA vaccines, reinforcing pharmaceutical protections and contributing to preventable delays in vaccine access (Thambisetty et al., 2022).	This reflects philanthropic preferences for a market-driven approach to global health and knowledge dissemination. Philanthropy is thus a double-edged sword: it is capable of mobilising critical resources and driving impactful outcomes, but it simultaneously permits private wealth to buy influence and wield asymmetric power over collective health priorities, unilaterally defining what knowledge is considered epistemologically legitimate and which ideas will underpin global health policy (Harman, 2016).

Table A.1 Supplementary Data from Literature Review: structural patterns in pre withdrawal global health landscapes (Authors' Own, 2026)

Appendix A.2 Dismantlement of USAID by the Trump Administration

In January 2025, the Trump administration issued Executive Order 14169, titled "Reevaluating and Realigning United States Foreign Aid," in which it declared that "no further United States foreign assistance shall be disbursed in a manner that is not fully aligned with the foreign policy of the President of the United States" (The White House, 2025: para. 3). Soon after, Congressional bill *H.R. 5108* abolished USAID, the world's largest foreign aid organisation. 86% of the organisation's funding was immediately terminated, representing US$27.7B in multi-year aid funding that had been earmarked but not yet distributed to fund international development projects (US House of Representatives, 2025; Atkins, 2025: para. 1).

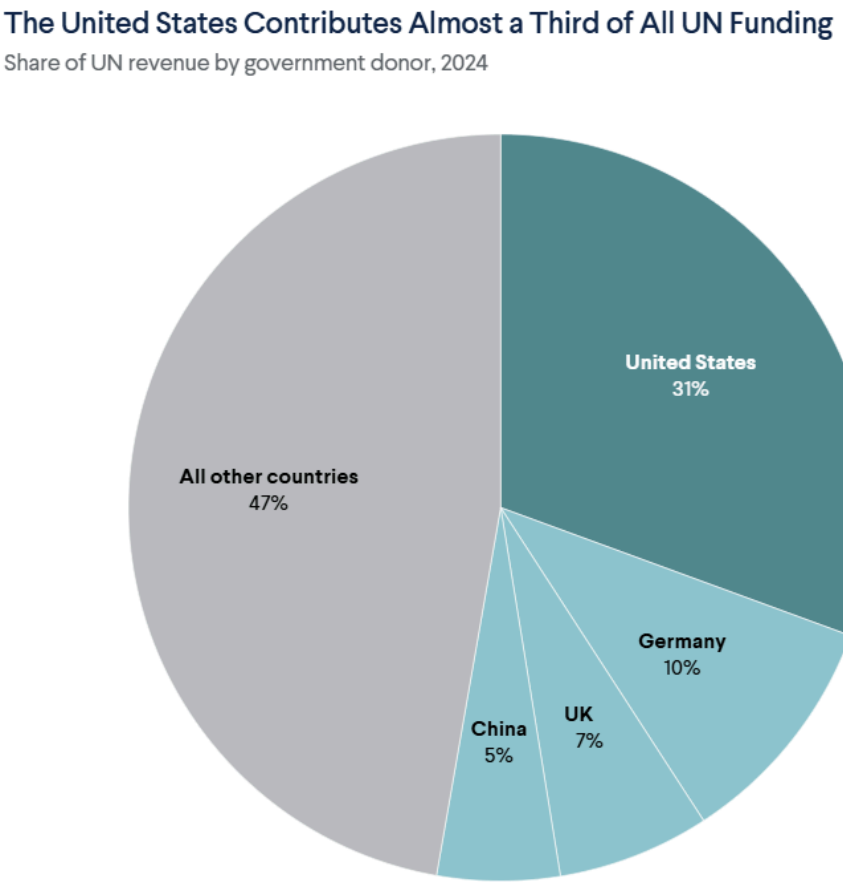

Figure A.2a US Share of Contributions to International Organisations & Proposed FY26 Budget Cuts

Figure A.2b: The FY26 Presidential Budget Proposed Deep Cuts to the UN (*Ferragamo & Roy, 2025*)

Appendix A.3: Future Scenario Analysis of US Involvement in ODA

In Scenario 1, the US only directs development funding toward areas that immediately serve the country's strategic priorities; for example, USAID food programs have retained their funding because it is US farmers that supply the food as a way to manage overproduction (Haug *et al.*, 2025). Additionally, to replace USAID supply chains, the current Trump administration announced its decision to provide US$150 million toward an American drone company to deliver medical supplies to five African nations (Kent &

Hansler, 2025). However, by remaining active in global health assistance, the US would likely continue using its economic brawn to pressure and influence multilateral institutions, which may limit their ability to adapt to the complex and evolving needs of fragile member states.

Scenario 2 entails the US retreat creating a power vacuum that the OECD's Development Assistance Committee (DAC) members, such as Germany, Japan, or the UK, could fill, potentially replacing the critical funding gap left by the US in areas such as education, research, and health governance (Greer *et al*., 2025). This structure could create an opportunity to critically reflect on promising reforms within the global health sector, such as a greater focus on strengthening national health systems. However, these states have also cut their foreign aid budgets, signalling a limited capacity and/or desire to henceforth govern the immense global health system.

Paradoxically, China could benefit most from Scenario 2 by providing strategic alternatives to traditional aid models (Huang, 2025). For instance, through its Health Silk Road Initiative, Beijing offers its partners health assistance and capacity building by providing medical and pharmaceutical research, sharing information and technology, training medical professionals, and providing emergency aid in areas such as "maternal and child health, disability rehabilitation, and major infectious diseases, including AIDS, tuberculosis, and malaria" (Rolland, 2024, p.4). By governing global health without the "ideological strings" tied to US assistance (Haug *et al.*, 2025: p. 18), Beijing could amass considerable soft power and geopolitical influence on the global stage.

Finally, Scenario 3 depicts a situation in which the US withdraws from global health assistance entirely, and other advanced economies follow suit. Such an exodus would undoubtedly cause distressing short-term consequences, such as fragmented service delivery

and haemorrhaging aid budgets. However, the Global South could emerge from the disorder having upended the traditional, Western-led donor–recipient model (Haug *et al.*, 2025), instead shifting to a multipolar system. This has been praised in the literature as an option, but the assumption that multipolarity will naturally foster more inclusive governance feels optimistic. Our ARP examines shifting power dynamics through a decolonial lens and, while emerging powers may challenge Western dominance, they can still replicate hierarchical practices that marginalise local needs.

APPENDIX B

METHODOLOGY & INTERVIEW DOCUMENTATION

Appendix B.1: Interview Questions

1. **Biographical information**

To help contextualize your insights, could you share a 1–2 sentence bio? For example:

- Current role / title:
- Organisation:
- Years in global health / international organisations:
- Geographic focus of work:
- Key expertise (optional):

Feel free to skip any/all questions (your anonymity preference will be respected in any case).

2. **Overall impact**

Since the US withdrew from WHO and dismantled USAID in 2025, how has this affected the funding your organisation (or organisation(s) that you work with/advise) receives for its global health work, if at all?

- If yes: Can you give one concrete example of a programme or budget line that changed as a result?
- If no: What are the main reasons your work was not meaningfully impacted?

3. **Financing strategies**

In response, has your organisation (or organisation(s) that you work with/advise) started to look more seriously at new ways of raising money beyond traditional aid (for example, private investors, blended finance, results-based financing, or other tools)?

- If yes: Can you describe one initiative you know well?

4. **Partnerships**

Since 2025, have you noticed a change in the role of private companies or philanthropic actors in your organisation's (or organisation(s) that you work with/advise) health programmes (for example, in funding or decision-making):

- If yes, have these changes been viewed as mostly positive, negative, or mixed?

5. **Governance**

In the wake of the US withdrawal from WHO and the effective collapse of USAID, how has your organisation (or organisation(s) that you work with/advise) adjusted its governance structures and/or relationships with major donors?

- What concrete changes in internal decision-making and power dynamics have you observed as a result?

6. **Local ownership and equity**

Since the U.S. withdrawal, have you observed any concrete changes in who holds decision-making authority in global health initiatives—who has gained or lost influence?

To what extent are local or national health priorities now shaping programme design, as opposed to donor or external institutional preferences?

7. **Disease-specific aid versus holistic health development**

With the shift in decision-making power and gaps in capacity, how is your organisation (or organisation(s) that you work with/advise):

- Moving beyond single-disease focus?
- Helping build holistic health systems?
- Preparing for health threats more resiliently?
- Doing this without relying on traditional Western models of development?

8. **Looking Forward**

What lessons has your organisation (or organisation(s) that you work with/advise) drawn from the US funding withdrawal when planning for future partnerships and institutional resilience?

Appendix B.2: Data Analysis Coding Themes

Themes								
Diversifying Donors	Eggs in one basket	shift toward philanthropies	private sector being approached					
Shrinking traditional aid and staffing	reduced grants	lowered ODA	reduced national aid budgets	Europe ODA budgets shrinking discreetly	reduced technical assistance	loss of jobs	Program adaptations	
Innovating Finance	Blended finance	new funding from private sector	Social impact bonds	Co-financing	Impact investing	Private sector is not a charity		Great wealth transfer
Increasing Country Ownership	Self reliance	Capacity building	Domestic health financing	Corruption	empowering local health centres	New opportunities		
Ensuring Global Health Security	Health system strengthening	Disease specific	Earmarked funding					
Identifying Key Actors	Philanthropies	Regional banks	Health ministries	Religious institutions/Charities	Countries (China, India)	Africa CDC	NGOs (MSF)	
Recognizing New US Strategies	Bilateral agreements/MoUs	Funding shifts	Not complete withdrawal	Shifting funds to state				
Shifting Governance Structures	Merging departments		Change in Geneva ecosystem	Induction of local staff				
Analysing After Effects	Human impact (mortality & morbidity)	HIV & ARV programs	Newborn & maternal health	Sexual and reproductive health	Family planning	Financing instability	Accra reset	Lusaka Agenda
Thinking About the Future and Lessons Learned	New world order	Increase in defence budgets	Decolonisation of global health	Sustainable models	Bilateral Vs Multilateral aids	Increased efficiency	continued investment in communicable diseases	

Table B.2: List of Parents Codes and Child Codes used for Data Categorisation and Analysis *(Author's Own Work, 2026)*

This table displays a screenshot of our 10 coding themes that were used to categorise and analyse the interview data, which contained over 25 hours of audio recordings. We also identified child codes, which allowed us to be more precise in our identification and classification of key themes. This ultimately allowed us to gather a very rich set of quotes that together told a complex story of the current state and future thinking of global health governance.

APPENDIX C: ADDITIONAL RESEARCH FINDINGS

Appendix C.1 Philanthropic Capital as a Replacement to ODA

The idea of using philanthropy as a possible substitute for traditional ODA emerged as a key debate among interviewees, particularly given the scale of the US withdrawal. The philanthropic sector holds enormous potential: the US alone held 890 billion USD in philanthropic assets in 2018, and between 2016 and 2019, over 43% of total philanthropic funds targeted health and reproductive health. A philanthropy advisor at Pictet Wealth Management described an imminent 'Great Wealth Transfer,' noting that 89 trillion USD will pass between the Baby Boomer generation and their children by 2040, with an estimated 12 trillion left to philanthropy.

However, many interviewees remained highly sceptical. A managing director at GAVI noted that the philanthropic sector was 'nowhere near as big as governments, so philanthropy can make up some areas, but you shouldn't see that as a sort of wholesale replacement of the government reductions.' A philanthropy advisor at Pictet Wealth Management described how his clients had expressed interest in scaling funding but felt inadequate: *'Okay, so what do I do now? Do I just let it all collapse? I can do a little bit, but I can't do enough to replace USAID.'* Furthermore, large actors such as the Gates Foundation—already the largest donor to the WHO—are keen to reduce increased reliance on their capital, especially given the foundation's planned closure in 2045.

Beyond financial constraints, interviewees raised strategic and ideological limits. Some philanthropies asserted early on that they *'are not here to fill the gap—US policy is not determining our policy.'* One philanthropy professional questioned the power imbalance in the whole arena, where decisions are often 'dictated from the Gates Foundation in Seattle' rather than placing ownership within the countries where philanthropies operate. Younger generations of donors were also found to prioritise climate change and biodiversity over health, marking a generational shift in philanthropic priorities.

Appendix C.2: Details on Blended Finance

As a systemic issue, HSS in LMICs does not need to merely need to be fortified to mitigate impacts—it must be fundamentally adapted and transformed; however, a lack of access to capital poses obstacles for LMICs. To finance significant HSS needs, LMICs must attract and mobilise capital beyond ODA. One of the most promising avenues to do so is by employing outcome- and impact- driven catalytic finance mechanisms, such as blended finance.

Blended finance differs from traditional aid by combining public funds and philanthropic contributions to finance the initial tranche of investment in large-scale interventions at below-market interest rates, absorbing upfront costs and attracting additional private-sector capital that would otherwise find the investment too risky (Onabowale, 2024). Figure 6 below provides an overview of common blended finance models and their relevance to improving HSS:

Blended Finance Model	Sectoral Applications	Mechanism of Risk Sharing	Healthcare Relevance
Concessional Loans	Infrastructure, agriculture, clean energy	Public or donor-backed loans at below-market rates	Supports financing for primary healthcare facilities, equipment procurement, and rural clinics.
Guarantees and Risk Insurance	Renewable energy, transport, SMEs	Public sector absorbs partial credit or political risk	Encourages private capital into fragile health markets, reducing perceived investment risks.
Impact Bonds (Social/Health)	Education, workforce training, healthcare	Returns tied to pre-agreed measurable outcomes	Funds maternal health, vaccination drives, and chronic disease management based on verified health outcomes.
Equity Co-Investments	Start-ups, venture capital, digital innovation	Shared ownership with concessional or philanthropic capital	Scales digital health platforms, telemedicine tools, and AI-driven diagnostics.
Pooled Funds	Climate adaptation, education, cross-sector infrastructure	Aggregates donor, public, and private resources	Facilitates large-scale, multi-country healthcare initiatives such as pandemic preparedness funds.
Results-Based Financing (RBF)	Water, sanitation, healthcare	Disbursement linked to achievement of specific targets	Ensures accountability in vaccine delivery, maternal mortality reduction, and rural healthcare expansion.
Hybrid Instruments	Multi-sector projects involving ESG financing	Combination of equity, loans, and grants	Tailors financing to integrate sustainable hospitals, renewable-powered clinics, and cross-border health projects.

Table C.2: Comparative overview of blended finance models across sectors, highlighting healthcare relevance (Onabowale, 2024, p. 790)

For instance, UBS has created the Optimus Foundation, an impact investing and philanthropic finance group committed to strengthening and scaling people-centered, integrated primary healthcare in LMICs. One of its HSS projects is a 5-year impact loan of US$400,000, directed toward Hewatele, a social enterprise that provides life-saving medical oxygen solutions to healthcare facilities in East Africa (UBS, 2022). The loan's interest rate is determined by the number of beneficiaries reached (see Figure 7 below), which encourages Hewatele to achieve its stated targets.

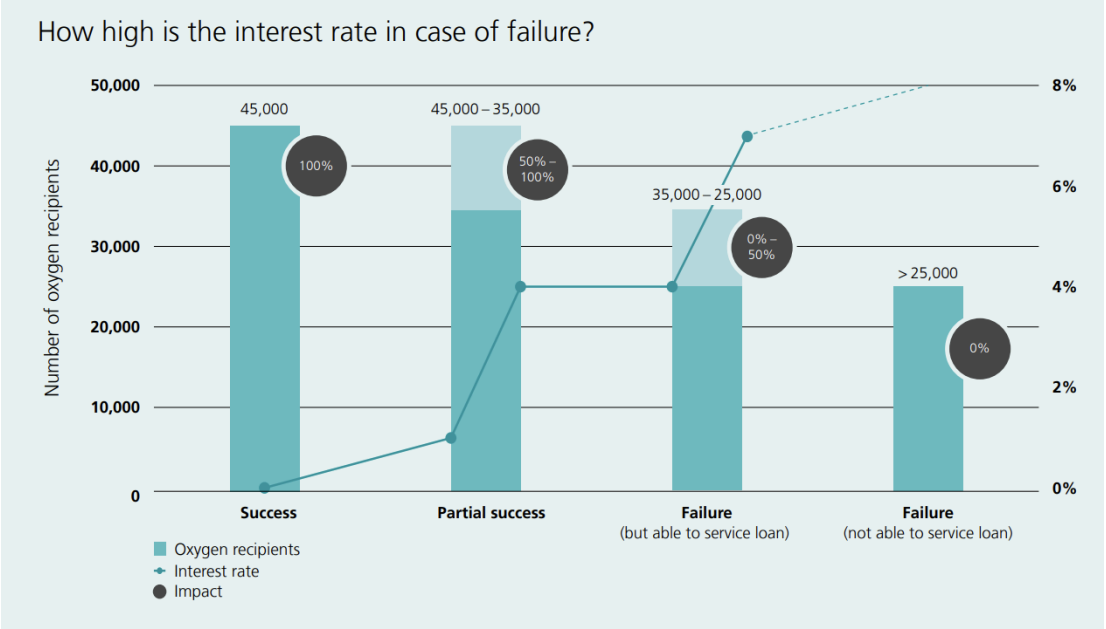

Figure C.2: Outcome-driven interest rate on impact loans in East Africa (UBS, 2022: p. 75)

However, to ensure that the success of outcomes is not determined by Western actors—thus perpetuating the existing model—catalytic finance must be paired with local public-private partnerships. Not only do these arrangements increase decentralised knowledge and input, they also ensure that interventions are sustainable, aiming to publicly institutionalise or privately monetise health services at the local level, while avoiding the subsidisation of private profits (Onabowale, 2024). Additionally, despite its benefits, catalytic finance should be seen as an outcome of good health governance rather than a starting point. Political and

government-led HSS reforms (e.g., private sector development, public financing interventions, and policy roadmaps) must precede investment attraction as investors rarely supply non-aid capital in a country without holistic government and market support . Onabowale outlines key HSS reform strategies for LMICs (ibid).

Ultimately, when employed in tandem with governance reforms and effective local partnerships (outlined in Figure 8 below), catalytic philanthropy can offer LMICs a holistic, whole-economy approach to HSS finance, ensuring that capital is directed toward systemic needs rather than short-term solutions.

Appendix C.3: Definition of Development Impact Bond

A Development Impact Bond, or DIB, is a results-based investment instrument that involves three parties: a private investor, an outcome payer, and an implementing partner/service provider. In practice, a DIB can have more than one of each type of partner. The private investor—usually a fund or group of investors—gives money to carry out a development project that promises certain social outcomes.

Appendix C.4: Cooperation Framework between Kenya and US

Link to the Kenya-US Cooperation Framework:

Cooperation Framework- Kenya- U.S.pdf

Appendix C.5: The Nuances of the Current Global Health Landscape

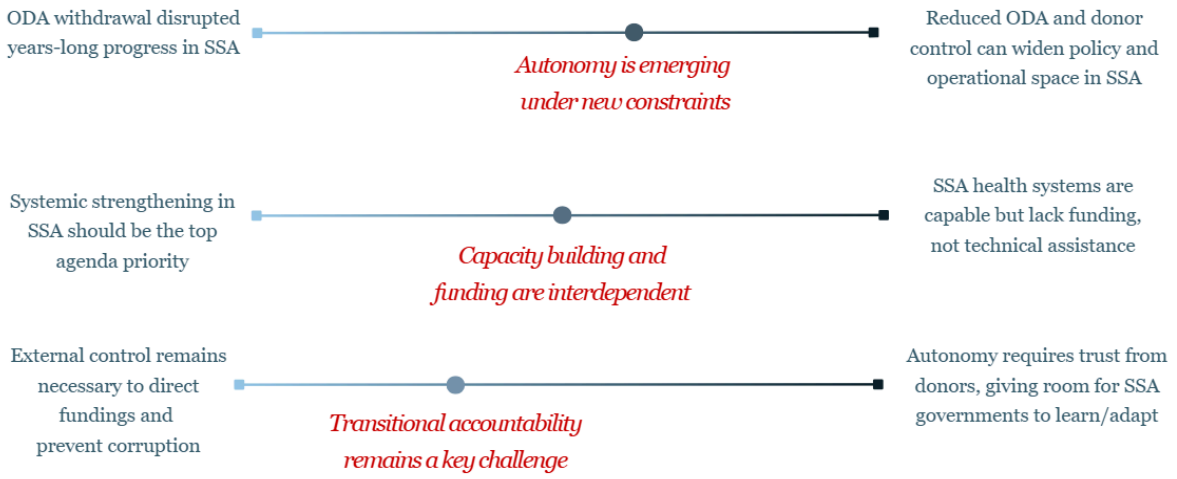

Figure C.5: The Nuances of the Current Global Health Landscape (Authors' Own Work, 2026)

This spectrum demonstrates how the current global health landscape is defined not by black and white dynamics but rather ambiguity, complexity, and uncertainty regarding its direction. Through our interviews, we came to understand that the discourse and future thinking of top global health experts tends to be rather nuanced, emphasising qualifications and caveats rather than absolute assertions.

APPENDIX D: USE OF ARTIFICIAL INTELLIGENCE

AI Disclosure Statement

In line with the IHEID *Rules and Good Practices for Ethical Use of Artificial Intelligence in Academic Work*, artificial intelligence tools were used at several stages of this research project. TurboScribe was used to transcribe audio recordings of interviews. A locally-run AI language model—operated on a private computer rather than a cloud-based platform—assisted with a second round of qualitative data analysis, including suggesting additional coding themes for review. As the model ran entirely offline, all data was processed locally and immediately deleted after use, with no transmission to external servers. Claude (Anthropic) was used to strengthen the literature review process by identifying additional sources and themes to the research question, to support translation work, to aid in the construction of tables and charts, and to guide administrative aspects of the research project.

In all cases, AI-generated outputs were critically reviewed, verified, and refined by the research team. All analytical reasoning, interpretation of findings, and formulation of the research question remain entirely our own. AI was not used to generate substantive arguments or conclusions. Where AI suggested coding themes or retrieved literature, these were independently assessed before inclusion. We take full responsibility for the accuracy and integrity of the work presented in this report.