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USAID withdrawal and the erosion of development assistance for health: Considerations for health system leadership in LMICs

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ABSTRACT

Development assistance for health (DAH) is entering a period of retrenchment, exemplified by the withdrawal of USAID from global health. This commentary examines, the implications of a declining DAH landscape for health systems in low- and middleincome, countries (LMICs). The loss of donor support not only creates significant funding gaps but also removes certain benefits that donors have provided - such as sustained financing for high-impact vertical programs (e.g. immunization and disease control) and coordination functions. At the same time, the reduction in DAH may alleviate some longstanding distortions, including the fragmentation caused by vertical initiatives and the internal "brain drain" of talent into donor-funded projects, opening opportunities for countries to reclaim leadership. The immediate challenge for health system leaders is to mitigate service disruptions through short-term measures, while pursuing long-term strategies to increase domestic health investment and strengthen system-wide capacities. We emphasize the need for renewed commitment to the principles of country ownership and alignment - now driven by domestic stewardship rather than donor conditionality. In a changing global context, new arrangements that complement national efforts are needed to ensure that global solidarity and support for shared health goals persist despite a reduced role for traditional aid.

Introduction

The withdrawal of USAID from global health engagement marks a significant shift in the landscape of international health cooperation. USAID's retrenchment is not - and will not be - an isolated development. It is part of a broader, longer-term decline in development assistance for health (DAH) that is now gaining momentum (Baeza et al., 2025) (Atun et al., 2017). While attention has largely focused on financial impacts, the broader consequences on health systems in low- and lower-middle-income countries (LICs and LMICs) deserve closer examination. For health system leaders, this is not merely a funding reduction - it is a shift in political economy, institutional priorities, and decision space.

Much of the earlier discourse around "graduation" or "transition" policies - framed as structured, managed exits from donor support - suggested orderly transitions and rising autonomy. This now seems like a luxury. In practice, many countries are facing fiscal and programmatic cliffs rather than carefully planned handovers. In today's environment, aid withdrawal is more often experienced as an abrupt exit - leaving countries to contend with structural gaps and unmet obligations (Shroff et al., 2024). The pace and shape of withdrawal often reflect donor priorities, not domestic readiness, with national systems left scrambling to sustain services without clear financing paths (Bharali et al., 2025).

Moreover, decades of overreliance on a handful of donors - especially from the U.S. which accounted for 40 % of global DAH in 2019 (Baeza et al., 2025) - has not only left many countries with short term contingent fiscal liabilities they are poorly positioned to absorb (Bharali et al., 2025), but also enabled a domestic politics that regards DAH as fungible and does not prioritize health spending (Hanson et al., 2022 May 1).

Importantly, the impact of this decline in DAH is uneven. LICs, with higher levels of aid dependence, are likely to experience sharper disruptions (Baeza et al., 2025). For MICs - many of which are already navigating transitions away from donor funding - the challenge is more about managing uncertainty, shifting influence, and increasing reliance on domestic political and market dynamics. This divergence underscores the need for differentiated, locally anchored responses.

Advantages of DAH that will be lost

The withdrawal of USAID - and the beginnings of the retreat of other

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major DAH actors (UK Parliament, 2025) (Euronews, 2025) - removes a set of benefits that, while uneven across countries and programs, have long played a prominent role in shaping national health agendas. DAH has funded vertical interventions featuring high-return technologies - such as vaccines - that have consistently received support and often delivered measurable results (Gavi, 2024) (The Global Fund to Fight AIDS, 2024). In some contexts, maternal and child health, and TB and HIV control have straddled the vertical–horizontal divide and seen sustained investment (Goldstein et al., 2023) (Kawonga et al., 2012). Humanitarian interventions, although episodic and politically constrained, have also served as buffers for fragile systems in times of crisis (Jamal et al., 2020).

Broad fiscal support for system-wide strengthening was never a central mode of engagement for most bilateral donors - In the case of the United States, the share of its DAH directed to health systems strengthening fell from 34 % in 2000 to just 4 % by 2007, as nearly all aid was reallocated to disease-specific programs (Carroll et al., 2024). At best system wide support has been partial (e.g. limited investments in community-based programs, supply chains or information systems), even if the presence of aid has helped coordinate activities, sustain political commitment, and maintain a certain level of predictability. The absence of major donors now opens fiscal and strategic vacuums that neither multilateral institutions nor philanthropic actors are fully positioned to fill.

The biggest underlying challenge, however, is that many LMICs continue to underfinance health - and often do so inequitably (McIntyre et al., 2017). This moment compels a confrontation with that reality.

Problems of DAH that will be removed

At the same time, the retreat of donors such as USAID may remove some longstanding constraints embedded in the aid architecture. Chief among these is the distorting effect of verticalization. Disease-specific programs often operated through parallel systems, crowding out attention and resources from other health problems, notably, non-communicable diseases, action on the social determinants of health, and cross-cutting health system functions such as workforce development, governance, and public financial management. These vertical programs also fragmented service delivery, making it harder for countries to build coherent, resilient health systems. Additionally, DAH-funded initiatives frequently attracted top talent into donor-funded silos - creating internal "brain drain" that weakened national institutions (Biesma et al., 2009). With the reduction of these programs, there is now an opportunity to re-anchor leadership and expertise within the public sector, provided countries seize the moment to reinvest in domestic capacity and career pathways.

Without external mandates shaping and - in some instances - dictating priorities, countries may now have more latitude to pursue integration strategies and health programs that match their institutional readiness and strategic priorities. In other words, the exit of donors, while painful, creates political space to reframe national priorities and reclaim agenda-setting from external actors.

Thinking beyond the withdrawal

While the instinct may be to lament the erosion of global solidarity, for health system leaders in LICs and LMICs, this moment demands strategic focus. The retreat of DAH redirects attention away from one set of global influences, opening space to reframe national priorities and strengthen domestic governance.

In the short term, stop-gap measures will be necessary to avert service disruptions. But the long-term imperative lies in mobilizing more sustainable and equitable domestic investment in health. This includes strengthening primary care, fortifying horizontal systems, and addressing the political economy distortions that favor high-cost, low-access models. Countries must also confront the persistent underfunding of health and move toward domestic financing targets as have been benchmarked in the Abuja Declaration (Organisation of African Unity, 2001) and the recommendation that governments spend 5 % of GDP on health (McIntyre et al., 2017). This is a necessary precondition for strong and resilient health systems (Human Rights Watch, 2024a).

Greater domestic resource mobilization is essential not only for fiscal and political sustainability, but also to stimulate local innovation and strengthen learning cycles that are better attuned to country contexts and constraints (Sheikh and Abimbola, 2021). Technical leadership and learning capabilities within national systems will be central to this rebuilding effort - not just in the form of a resilient health workforce, but also through sustained investment in health systems research, policy analysis, and leadership development that can drive health system progress. Countries can take a leaf out of Thailand's book, which has demonstrated how strategic government support for training, recruitment, retention incentives, and clear career pathways can build and sustain nationally grounded expertise in the health sector (Tangcharoensathien et al., 2013). Learning must be re-centred at the country level - not just in implementation but also in defining the questions and shaping the terms of engagement.

Global solidarity still remains important. Interdependence in global health - made plain by COVID-19 and other cross-border threats - means no country is truly isolated in its risks or responsibilities. Public goods such as disease surveillance, pandemic preparedness, and equitable access to vaccines require sustained, coordinated investment beyond what any single government can manage. While traditional aid models are waning, the need for collective action remains. Proposals such as the Global Public Investment (GPI) framework offer one vision for a more inclusive, equitable financing system, grounded in shared benefit, mutual contribution, and joint governance (Mazzucato and Glennie, 2024; Cobham et al., 2025). These ideas are still evolving and will need to find their place in a rearranging global order. But they signal an important shift away from hierarchical donor–recipient models and toward approaches that complement national leadership with global support.

Separately, the idea of managing transitions from donor funding remains relevant - but must be grounded in present-day realities. Transition planning can no longer be treated as a technical exercise managed by donors. It must become a nationally owned process of resilience-building, especially in contexts where support is withdrawn abruptly and without guarantees.

Competing forces, new risks

The vacuum left by the withdrawal of DAH will not remain empty. New actors -philanthropic foundations, middle-income donor countries, regional blocs, and commercial investors - are already asserting influence, often with different motivations and accountability structures (Bill and Melinda Gates Foundation., 2025). For countries on the receiving end, navigating this plural global health space will require robust regulatory capacity and political sophistication and stepped up capacity for integrated health policy and systems analysis.

These shifts are unfolding in a moment of profound structural transition for health systems in LMICs. Rapid urbanization is redrawing population-health maps and bringing both opportunities and disparities into sharper focus (Lilford et al., 2025). Cities are becoming not just demographic centres of gravity, but also emerging hubs of political influence, innovation, and resource mobilization (Li et al., 2023). Commercial actors are playing a growing role in shaping care delivery, and digital technologies are disrupting how health information, services, and trust are produced and circulated. With growing wealth and, in some cases, expanding fiscal authority, cities are increasingly able to set health priorities, experiment with new models of care and place-based approaches, and cultivate leadership. Urban health governance, if effectively harnessed, could become a driver of renewal and accountability for national systems - but if poorly integrated, it risks entrenching

fragmentation and deepening inequities (Elsey et al., 2019). Of particular concern is the risk of further skewing investment toward urban, hospital-based care - often more politically visible and commercially viable - at the expense of equitable, preventive, and primary health care and community-based services. This risk is exacerbated by weak regulatory systems and fragmented governance structures (Sturgis et al., 2021).

Intersecting shocks - climate change, pandemics, food insecurity, and displacement - now demand stronger intersectoral collaboration. These challenges require new governance and system leadership capabilities that can coordinate across traditionally siloed sectors and levels of government. These capabilities include shifts from purely hierarchical governance modes to embracing hybrid bureaucratic forms capable of adaptive and networked, collaborative governance (Kanon, 2024; Sheikh et al., 2020).

Yet heavy indebtedness and economic fragility, exacerbated by global economic realignments, are severely constraining the fiscal space many countries need to respond effectively and strategically (Human Rights Watch, 2024b). Equally pressing is the rise of misinformation and anti-science politics. From the era of HIV denialism in the 1990s to the present-day resurgence of vaccine skepticism, the erosion of scientific legitimacy has profound consequences for public health. Countries now confronting these challenges with diminished external support must find new ways to reinforce public trust and evidence-informed policy (Sturgis et al., 2021).

A fork in the road

The retreat of USAID is more than a donor's exit - it is a signal of a broader shift in global health financing. For health system leaders in LMICs, this is a moment of reckoning: with past dependencies, with current underinvestment and debt, and with the kind of leadership needed for the future. It opens the door to new models rooted in country priorities, political realities, and long-term system resilience.

The Paris Declaration (2005), Accra Agenda (2008), and Busan Partnership (2011) on aid effectiveness all enshrined these principles of country-led development cooperation (OECD, (2005); OECD, (2008); OECD, (2011)). While these accords may have faded from the headlines, the principles they articulated remain essential. In an era of shrinking DAH and greater uncertainty, the values of country ownership, alignment, and mutual accountability are not outdated - they are foundational. Their value remains clear - particularly in addressing shared risks, coordinating investment in global public goods, and reducing long-standing disparities - but the institutional pathways for realizing this vision are evolving and contested. The challenge now is to reanimate these commitments not through donor-led reforms, but through domestic leadership and country platforms (Calland, 2025).

At the same time, the future of multilateralism and global solidarity is uncertain. Whether new or renewed global arrangements can meaningfully support country-led priorities without reproducing older hierarchies will be a key test in the years ahead.

The coming years will undoubtedly involve struggle. But if used wisely, this shift can become an inflection point - toward greater sovereignty, coherence, and accountability in health systems worldwide.

CRediT authorship contribution statement

Kabir Sheikh: Writing – review & editing, Formal analysis, Writing – original draft, Conceptualization. **Helen Schneider:** Writing – review & editing.

Declaration of Competing Interest

The authors declare no competing interests.

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