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OPINION

Disrupting dependency: decolonising global health in the wake of aid cuts

ISABELLE MUNYANGAJU[1,2,3]

AFFILIATIONS:
[1]ISGlobal, Barcelona, Spain
[2]Facultat de Medicina i Ciències de la Salut, Universitat de Barcelona (UB), Barcelona, Spain
[3]Tinpswalo Association: Vincentia Association to Fight AIDS and TB

CORRESPONDENCE:
Isabelle Munyangaju
[1]ISGlobal, Barcelona, Spain
Email: imunyangaju@gmail.com

INTRODUCTION

The global health landscape is currently at a pivotal point. In recent years, significant reductions in foreign aid by historically dominant donors – most notably the United Kingdom and the United States – have led to abrupt disruptions across many health programs in low- and middle-income countries (LMICs)[1,2]. A recent modeling study warns that a U.S. PEPFAR funding freeze could severely undermine HIV control efforts across seven sub-Saharan African countries, potentially resulting in hundreds of thousands of additional infections and deaths by 2030. Mozambique could see over 130,000 more HIV infections and 80,000 deaths. At the same time, Nigeria is projected to suffer the highest absolute increase in HIV-related deaths, over 200,000, due to its large population and reliance on PEPFAR. Uganda, Zambia, Lesotho, Malawi, and Kenya would also experience sharp declines in ART coverage and significant health system disruptions[3].

In Malawi, nearly 4,500 health workers have been affected, and the collapse of sample transport and lab data systems threatens HIV diagnostics. Kenya risks losing over 41,000 donor-supported staff, while South Africa's Western Cape province reported the loss of a 365 million rands grant (approximately US $20–21 million), impacting HIV, TB, and community health services and putting 698 workers at risk[4,5]. While these aid cuts have left critical gaps in essential services, they also present an unprecedented opportunity to reimagine and restructure global health relationships. This essay argues that these sudden aid reductions, though destabilizing, may paradoxically catalyse the decolonisation of global health by disrupting entrenched dependencies and encouraging greater sovereignty and leadership by countries in the so-called "Global South".

The Colonial Foundations of Global Health

Global health, as an enterprise, is deeply rooted in colonial histories. Originating from tropical medicine and international health, the field has historically been shaped by priorities, knowledge systems, and leadership structures of the colonia and post-colonial powers[6,7]. Even today, global health initiatives are

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largely dominated by actors from the "Global North", who control funding flows, set research agendas, and define intervention priorities[8]. This dynamic reinforces patterns of dependency, where low-and middle-income countries (LMICs) often serve as implementation sites rather than co-creators or decision-makers.

Decolonising global health demands a critical interrogation of these power asymmetries. It calls for dismantling systems that perpetuate inequity and building structures that enable equitable partnerships, local leadership, and epistemic justice[9]. The decoloniality movement emphasizes shifting ownership of health agendas to countries themselves, amplifying indigenous knowledge, and addressing the structural legacies of colonialism embedded in health governance[10].

Aid Dependency and Its Discontents

Foreign aid has undeniably supported critical health achievements, from expanding immunisation coverage to scaling up HIV treatment. However, its architecture has also entrenched dependencies and undermined sustainable, sovereign health systems[11]. Aid has often been tied to donor priorities, political cycles, and conditionalities that limit national policy space. Moreover, accountability structures in global health frequently direct responsibility upward to donors, rather than downward to communities meant to benefit[12].

The COVID-19 pandemic and subsequent global economic downturns intensified these vulnerabilities. Abrupt cuts in aid, such as the UK's reduction from 0.7% to 0.5% of gross national income, left programs in countries like South Sudan and Sierra Leone scrambling to maintain basic services[1,2,13]. Similarly, the recent freeze and abrupt cuts in USAID and PEPFAR funding have had devastating effects across several sub-Saharan African countries, disrupting HIV, TB, and community health services. The loss of funding has led to mass displacement of healthcare workers, collapsed diagnostic systems, and threatens to reverse years of progress in HIV epidemic control in countries highly dependent on external support[4]. As Kyobutungi et al. 2025[13] recently questioned, with traditional aid actors pulling back, African nations must grapple with the urgent question: '*What now for aid and Africa?*'. These shocks highlighted the fragility and inequity of a system reliant on the shifting priorities of external donors.

A Potential Catalyst for Change

Paradoxically, the very disruption caused by aid cuts may create the impetus for transformation. The sudden loss of external funding compels countries to revisit their health financing models, mobilise domestic resources, and prioritise policy sovereignty[8,14]. It creates a necessary discomfort that breaks the inertia of aid dependency, pushing for innovation in local solutions, regional cooperation, and community engagement.

Indeed, we may argue that this moment is an opportunity—a disruptive opening to advance the decolonisation agenda. Without the cushion of predictable aid flows, countries may be forced to build more resilient and self-reliant systems. This can foster greater investment in local research capacity, stimulate south-south collaboration, and create space for health policies better aligned with local needs and realities[7].

Toward a Decolonised Global Health

To seize this opportunity, deliberate action is required. A decolonised global health paradigm must be built on key principles:

1) Sovereignty and leadership – countries must lead their health agendas, with donors acting as supporters rather than directors[11]. For example, Zimbabwe introduced a 3% AIDS levy in 1999, a tax on individual income and corporate profits specifically earmarked for HIV/AIDS programs. This innovative domestic financing mechanism has played a critical role in sustaining treatment and prevention efforts, particularly during periods of declining donor support[15].

2) Equitable partnerships – international collaborations must be grounded in mutual respect, shared decision-making, and accountability to affected communities[12,16]. For example, Gavi, the Vaccine Alliance, funded by high-income countries, partners with WHO, UNICEF, and LMICs to expand access to life-saving vaccines. Since 2000, it has helped

vaccinate over 1 billion children in low-income countries, preventing more than 17 million deaths. However, its impact could be further improved by strengthening local vaccine manufacturing capacity and increasing the involvement of recipient countries in decision-making processes[17]. Similarly, the Global Fund to Fight AIDS, Tuberculosis and Malaria, funded by high-income countries and private donors, supports programs in over 100 countries and has saved more than 59 million lives by financing prevention, treatment, and care services[17]. Its effectiveness could be further improved by strengthening country ownership and better aligning funding with national health priorities and strategies.

3) Local knowledge and innovation – health systems must elevate and integrate indigenous knowledge, local expertise, and context-specific research[18,19]. A strong example of integrating local knowledge into health systems is South Africa's Traditional Health Practitioners Act (2007), which formally recognized traditional healers as part of the national health system and established a regulatory council to oversee training and safety. This has enabled collaboration between traditional and biomedical practitioners, particularly in rural areas. In India, the AYUSH ministry has institutionalized traditional systems such as Ayurveda, Yoga, Unani, Siddha, and Homeopathy within public health, supported by the Traditional Knowledge Digital Library to protect indigenous knowledge. Brazil similarly integrates indigenous health through Special Indigenous Health Districts, combining biomedical care with traditional Amazonian healing practices. These approaches demonstrate how valuing local knowledge can strengthen and diversify national health systems[20].

4)Sustainable financing – domestic resource mobilisation and regional solidarity mechanisms should replace over-reliance on external aid[14]. The Abuja Declaration (2001), in which African Union member states committed to allocating at least 15% of national budgets to health, remains largely unmet. As of 2025, only Rwanda, Botswana, and Cabo Verde consistently reach this target, while over 30 countries still allocate less than 10%, some as low as 5 – 7%. To address this gap, there is a pressing need to enforce accountability mechanisms, link health budgets to measurable outcomes, and integrate health financing into broader economic planning. The Africa CDC's 2025 guidebook, Africa's Health Financing in a New Era, underscores the vision of building resilient, self-financed health systems capable of withstanding shocks such as pandemics and climate-related crises[21,14].

5) Epistemic justice – knowledge production in global health must reflect diverse perspectives, centring voices from the Global South[9]. South Africa's Research Chairs Initiative (SARChI), launched in 2006, aims to build world-class research capacity by funding South African scholars to lead studies in national priority areas, including public health. It empowers local researchers to generate context-specific evidence on HIV, TB, and health systems, directly informing national policy and shifting research agenda-setting to those with deep understanding of local realities. Similarly, Qatar's National Research Fund (QNRF) supports health research led by scientists in the MENA region, using local data to address region-specific issues such as diabetes and genetic disorders. This approach counters Global North dominance in authorship, promoting independent, locally driven research and publication[22].

CONCLUSION

The recent aid cuts are a stark reminder of the volatility and inequity of current global health structures. Yet, they also provide a rare chance to disrupt the status quo and chart a more just, equitable, and sovereign path forward. Decolonising global health is not a passive process but an active, transformative endeavour—one that requires reimagining partnerships, funding models, and governance structures. By embracing this disruption as an inflection point, countries in the "Global South" can assert greater leadership and ownership over their health futures, shifting global health from a paradigm of charity and control to one of solidarity and shared humanity.

CONFLICT OF INTEREST

The author declares no competing interests.

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