FACTSHEET 2026

Health Aid Cuts Are Putting Global Health Equity at Risk

A call to action for donors



Donors may keep calling health a priority, but the services persons with disabilities depend on are quietly disappearing from donors' budget and people's lives.

What gets protected is a choice, not an accident. Right now, donors are largely making these choices out of sight.

KEY NUMBERS[1]

–29% to –46%

Projected fall in net bilateral ODA for health and population, 2024-2026, representing a reduction of USD 5-8 bn

–13.8%

Fall in official-donor health ODA grant-equivalent flows, 2023–2024

1.1%

of total bilateral health ODA was recorded with disability inclusion as the principal objective in 2024

50%

more likely for persons with disabilities to face catastrophic health expenditures

86%

of OPDs report assistive-technology and rehabilitation services becoming less accessible due to aid cuts

3 times

more likely for persons with disabilities to be denied the needed healthcare

A general collapse with some exception on the cover page

Global health aid is contracting sharply. Net bilateral ODA for health and population is projected to fall by 29-46% between 2024 and 2026, equivalent to roughly USD 5-8 billion, following a 13.8% decline between 2023 and 2024.[2] Under the higher-cut scenario, health ODA in 2026 would fall to levels last seen around 2008: that is up to one-third below 2019 levels and 63% below the 2022 peak.[3]

Health aid is highly concentrated. In 2024, the five largest individual donors (the United States, the United Kingdom, Japan, Germany, and France) accounted for approximately 60.9% of official-donor health ODA grant-equivalent flows to developing countries. Decisions by a small number of donors can therefore materially alter the global health-financing landscape. While non-DAC donors increased their health financing by 33.3% in 2024, these gains were insufficient to offset the much larger reductions among traditional bilateral donors.

[1] sources: OECD DAC; WHO report on Global report on health equity for persons with disabilities (2022), Humanity & Inclusion (2026), "Funding cuts turn inequalities into permanent exclusion"

[2] OECD (2026), ODA Projections for 2026 and the Near Term; OECD Data Explorer, CRS: Creditor Reporting System grant-equivalent dataset; data extracted August 2026

[3] OECD (2026), ODA Projections for 2026 and the Near Term

The contraction is affecting specific health functions. In 2024, global ODA declined by 25.4% for health-personnel development, 25% for basic nutrition, 24.1% for basic health, 18.9% for infectious-disease control and 6.6% for medical services.[4]

Donor	Total health ODA, 2023–2024	A function collapsing within it
Canada	**−45.2%**	Health-personnel development −52.0%
France	**−34.5%**	Basic nutrition −91.2%
Germany	**−28.1%**	Health policy & administration −50.3%
EU Institutions	**+1.8%**	Health-personnel development −55.5%

Note: Even where overall health-related aid remains stable or increases - as for the EU institutions, where it rose by 1.8% - this can mask substantial cuts within specific subsectors. For example, EU institutions spending on health personnel development fell by 55.5%. Canada, France and Germany show similar patterns, with sharp declines in specific areas that far exceed changes in overall sectoral financing.[5]

Disability inclusion remains an afterthought in global health financing

Under Articles 25 and 26 of the Convention on the Rights of Persons with Disabilities (CRPD), States are legally obliged to ensure equitable access to healthcare, habilitation, rehabilitation and assistive technologies. At the same time, articles 32 and 11 require donor States to ensure that international development cooperation and humanitarian assistance support, protect and include persons with disabilities. Shrinking aid budgets are making these obligations increasingly difficult to fulfil.

Before the latest wave of aid cuts, progress on disability-inclusive health financing was encouraging but remained far from adequate. Between 2023 and 2024, health commitments with disability inclusion as a principal objective increased by 130.1%, rising from USD 38.3 million to USD 88.1 million. Commitments identifying disability as a significant objective also grew by 19.6%. While this growth is welcome, it started from an extremely low baseline. Even after more than doubling, funding with disability inclusion as a principal objective represented just 1.1% of total bilateral health-focused ODA.[6] This represents a negligible share of overall health spending.

[4] OECD Data Explorer, CRS: Creditor Reporting System grant-equivalent dataset; data extracted August 2026

[5] id

[6] OECD Creditor Reporting System, "OtherMarkers: Aid activities targeting the inclusion and empowerment of persons with disabilities; data extracted August 2026

2024: the disability-financing accountability gap

41.3% of bilateral health commitments were not screened against the disability marker. A further 41.6% were screened but recorded no disability objective. As a result, nearly 83% of bilateral health financing demonstrates no identifiable commitment to disability inclusion, while just 1.1% has disability inclusion as its principal objective.[7]

The recent contraction of health aid is therefore particularly concerning. As overall health budgets decline, the already limited resources dedicated to disability-inclusive health programmes are also shrinking. At the same time, existing aid-tracking systems do not provide sufficiently detailed data to assess how much funding reaches organisations of persons with disabilities (OPDs) working on health-related issues.

Put simply, acknowledging disability in project design is not the same as investing meaningfully in the rights and health needs of persons with disabilities and ensuring that they have meaningful influence over decisions about priorities and cuts.

Donor cutback and the rise of health security: the most vulnerable will pay the toll

For many donors, development cooperation is increasingly being reshaped around domestic political priorities, geopolitical interests and the pursuit of "mutual benefits". The result is a sharp contraction in health ODA, accompanied by shifts in sectoral priorities and funding modalities.

Recent budget decisions illustrate this trend. The French Development Agency (AFD) reduced funding for health and social protection by 24% in 2025, while increasing support for energy (+29%) and governance and migration (+75%). Germany's 2026 draft budget increases contributions to multilateral development banks by around €225 million but reduces funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria by €82 million.[8] These changes reflect a broader move away from earmarked health financing.

Within the health sector, some donors are prioritising global health security and broad health systems strengthening over direct service delivery. The United Kingdom, for example, has announced a shift towards targeted investments in health systems and selected multilateral institutions, including Gavi and the Global Fund, while reducing its overall health aid budget.[9] At the same time, health investments are increasingly expected to serve donors' strategic and economic interests. The European Commission has explicitly linked future global health investments to objectives such as strategic autonomy, competitiveness and economic security.[10]

While health systems strengthening is essential, its benefits often take time to reach communities. In the short term, aid reductions risk leaving underserved populations without access to essential

[7] OECD Creditor Reporting System, "OtherMarkers: Aid activities targeting the inclusion and empowerment of persons with disabilities", bilateral health commitments in constant 2024 USD; dataset updated 11 July 2026; data extracted August 2026.

[8] Agence Française de Développement (2025), AFD Group's 2025 results; German Bundestag (2026), Haushalt 2026: Entwicklungsausgaben werden weiter gekürzt.

[9] Health Policy Watch (2026), "Drastic UK Aid Cuts Hit Fragile African Health Systems", 7 April 2026

[10] European Commission (2026), Global Health Resilience Initiative, COM(2026) 197 final, 13 May 2026

services. Persons with disabilities are particularly exposed, as they are more likely to rely on externally funded healthcare, rehabilitation and assistive technology services.

These policy shifts are often justified by calls for greater domestic domestic ownership and increased domestic resource mobilisation. Yet many low-income and heavily indebted countries lack the fiscal space needed to replace declining external support. Rapid aid reductions can therefore create funding gaps long before sustainable alternatives are established. The risks are greatest in fragile, conflict-affected and displacement settings, where governments often lack the capacity to absorb the withdrawal of donor support. Donors are increasingly promoting transitions away from humanitarian coordination and response mechanisms despite the absence of adequately resourced alternatives. Without safeguards, these transitions can lead to reduced service coverage, interruptions in care, delayed investment in the health workforce and higher out-of-pocket costs for patients.[11]

The consequences are already visible. Community-based health services are being scaled back or discontinued, including mobile clinics that often provide the only affordable and accessible source of care for remote and marginalized populations. As donor priorities shift, he greatest burden falls on those with the least access to healthcare, including persons with disabilities.

The shift towards “life-saving” humanitarian health responses leaves critical needs unmet

A growing consequence of humanitarian funding cuts is the increasing tendency among donors and humanitarian actors to prioritize the most immediate, life-saving interventions. In launching the 2025 Humanitarian Reset, OCHA, the UN body responsible for coordinating humanitarian response, acknowledged that, with humanitarian resources "slashed", the humanitarian community could no longer sustain all areas of work and would need to focus on saving lives first.[12]

While emergency life-saving assistance is essential, an overly narrow interpretation of humanitarian health risks sidelining a broader range of health needs that are critical for health outcomes, dignity, resilience and recovery. Programmes that do not always produce immediate life-saving results, including rehabilitation, mental health and psychosocial support, care for chronic conditions, SRHR services, disability-inclusive healthcare, and community-based health services, are often among the first to be reduced when funding contracts. In several crises, funding cuts have already led to health facility closure and the suspension of health and protection services, leaving affected populations with fewer pathways to access care.[13]

For many crisis-affected populations, particularly persons with disabilities, women and girls, older people, and people living with chronic conditions, the distinction between "life-saving" and "non-life-saving" services is often artificial. Disruptions to so-called “non-life saving” services can lead to deteriorating health, increased protection risks, loss of functioning, and preventable deaths.

While prioritisation is unavoidable when resources are constrained, the humanitarian principles of humanity and impartiality require assistance to alleviate suffering and be delivered solely on the basis of need. Humanitarian health responses should therefore be guided by the severity and

[11] World Health Organization (WHO) (2025), “WHO issues guidance to address drastic global health financing cuts,” 3 November 2025

[12] UNOCHA, “Humanitarian Reset,” 10 March 2025,

[13] UNOCHA (2026), Global Humanitarian Overview 2026

consequences of unmet needs, rather than by an overly narrow categorisation of services. Failing to do so risks leaving behind those facing the greatest barriers to health and protection, exacerbating inequalities and ultimately increasing humanitarian and health needs over time.

SRHR: A double threat for the most vulnerable

Sexual and reproductive health and rights (SRHR) are being squeezed from two sides: declining aid budgets and an escalating anti-rights agenda that challenges gender equality, bodily autonomy and reproductive rights. Services that rely heavily on external support, including family planning, maternal healthcare, comprehensive sexuality education, safe abortion care where legal, and prevention and response to sexual and gender-based violence, are particularly exposed to funding cuts.[14] Declining political and financial support for gender equality and SRHR may reinforce restrictive policies and barriers to care. The impacts are likely to be most severe for people already facing intersecting forms of exclusion, including for persons with disabilities, and during emergencies.

How cuts are operationalized on the ground: four countries, four mechanisms

Malawi. A donor exit is projected to remove family-planning access at scale.

FCDO expects to stop ODA programmes with health objectives in Malawi, projecting that around 250,000 adolescents a year could lose access to modern family-planning methods. The estimate is not disability-disaggregated, though FCDO's own Equality Impact Assessment does consider disability without quantifying the number of persons with disabilities affected.[15]

Senegal. A single donor financed almost half the national HIV response.

The United States financed 42.7% of Senegal's HIV response in 2023. Following USAID's withdrawal, the Ministry of Health began emergency mitigation measures while the national AIDS council warned of risks to HIV prevention, testing and treatment continuity for key and vulnerable populations.[16]

Multi-country. France cuts by three-quarter its flagship technical assistance and co-financing channel for the Global Fund.

The budget 2026-28 of "L'Initiative" is expected to fall by 75% compared with 2023–2025. Facing uncertainty over its 2026 commitment capacity, the programme did not launch its usual

[14] Singh, S., Sedgh, G., Sully, E. A., Owolabi, O. and Wittenberg, J. (2025), "Protecting global sexual and reproductive health and rights in the face of retrograde US policies and positions", The Lancet, 405(10490), 10 May 2025.
[15] United Kingdom Government (2026), The UK's modern development approach, July 2026; FCDO (2026), Multi-year Official Development Assistance Programme Allocations 2026/27–2028/29: Equality Impact Assessment
[16] Senegal Ministry of Health and Public Hygiene (2025), statements on mitigation of the cessation of USAID financing; CNLS (2025), "Le CNLS plaide pour un financement durable de la lutte contre le VIH au Sénégal"; Le Monde, 28 March 2025, field reporting on impacts of the US aid suspension

call for new projects, and only five of the six selected "Next Phase Projects" had secured funding commitments.[17]

Multi-country. Reduced donor contributions contribute to a significant contraction of Global Fund resources

Germany pledged EUR 1.0 billion to the Global Fund for 2026–2028, down from EUR 1.3 billion previously. Across all donors combined, country allocations for the new grant cycle are 17.9% lower than in the previous period, reducing available resources for health programmes across most Global Fund-supported countries, irrespective of their individual performance or needs.[18]

The triggers are all different. The outcome is the same: a full donor exit, dependence concentrated in one donor, a multilateral pipeline losing its next round of calls. In every case, the decision to cut was made before anyone assessed what it would do to persons with disabilities.

> *"Our work has been significantly impacted and is now at risk of closure, which would deprive 60 children of essential services they have been receiving consistently over the past five years." A local OPD working with children with Down syndrome, Syria*[19]

What donors must commit to now

- **Protect and ring-fence financing for inclusive health services**
  Safeguard investments in primary healthcare, community health systems, the health workforce, SRHR, nutrition, infectious disease control, rehabilitation, assistive technology, and emergency preparedness. Financing decisions should be guided by equity and need. Humanitarian responses should move beyond a narrow life-saving approach and support comprehensive, accessible and disability-inclusive health services throughout crises and recovery.

- **Finance disability-inclusive health equity through a twin-track approach**
  Systematically mainstream disability inclusion across all health funding while maintaining dedicated funding for disability-specific services. Require all health programmes, including health systems strengthening, SRHR, global health security and humanitarian responses, to demonstrate how they can reach persons with disabilities, identify and remove barriers and ensure accessibility and reasonable accommodation. Financing must respond to intersecting needs: gender, disability, displacement or extreme poverty, rather than treating disability as a single, undifferentiated category.

[17] French Senate, Finance Committee (2026), *L'aide publique au développement de la France en matière de santé*, Report No. 827, 1 July 2026; Expertise France – L'Initiative (2025/2026), *Information on the 2026 Calls for Proposals*; L'Initiative (2026), *2025 Activity Report*

[18] Global Fund (2026), Germany donor profile, pledges and contributions; German Bundestag (2026), federal development budget 2026; Global Fund Board (2026), *Sources and Uses of Funds for the 2026–2028 Allocation Period* and GC8 allocation information

[19] Humanity & Inclusion (2026), "Funding cuts turn inequalities into permanent exclusion"

No health investment should be considered successful unless it contributes to health equity for all.

- **Prevent harmful aid exits and ensure responsible transitioning**
  Ensure that funding reductions do not disproportionately affect persons with disabilities and other marginalized populations. Any programme reductions should be preceded by impact assessments, stakeholder consultations and transition plans to sustain essential services. Strengthen domestic health financing while maintaining predictable ODA commitments, recognizing that domestic resource mobilization cannot replace external support where fiscal space is constrained by debt, economic shocks or conflict.

- **Strengthen financing accountability and disability data**
  Apply the OECD-DAC disability marker consistently across health ODA and publish data on allocations, disbursements and marker scores. Require disaggregation of health outcomes *a minima* by disability, sex and age, and report on progress towards reducing health inequities. Track funding in support of rehabilitation and assistive technology where none currently exists.

- **Sustain civil society capacity and OPD participation**
  Establish predictable, multi-year, flexible financing accessible to local organisations and OPDs. Ensure their meaningful participation in the design, implementation, monitoring and evaluation of health programmes and health financing decisions.

THE BOTTOM LINE

Aid cuts to health are not neutral. Every donor that reduces its health budget is making a choice, whether explicit or implicit, about which services, populations and rights will be protected and which will be sacrificed. Health priorities are redefined through political and economic considerations rather than needs and equity. No donor can credibly claim that such decisions are equitable while failing to assess, measure and publicly report who is being left behind. Accountability for aid reductions must extend beyond budget figures to their real-world consequences for the people who depend most on essential health services.

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