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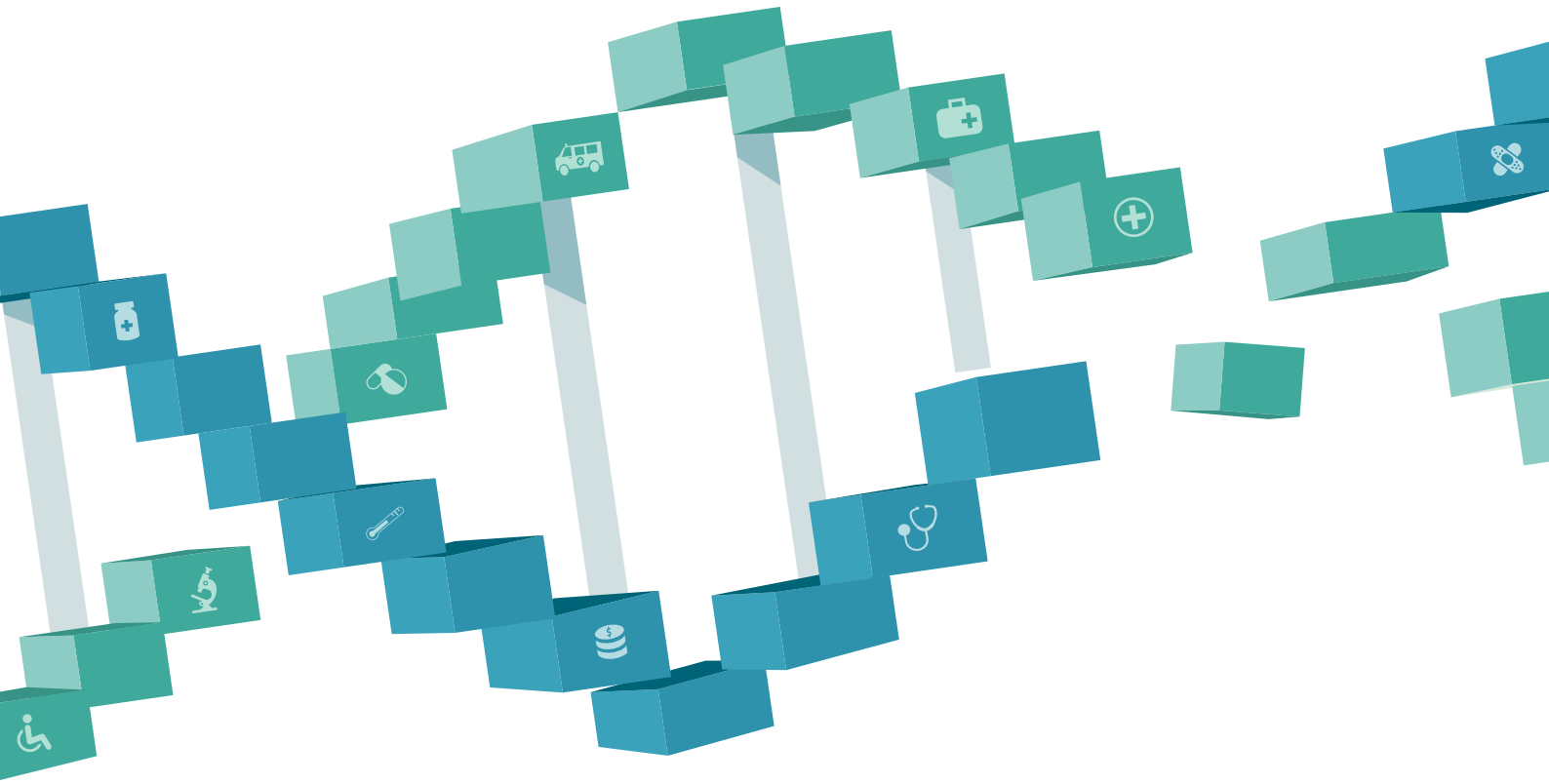
Beyond dependence: Understanding the impact of ODA cuts on Pakistan's health system



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Bismillah irr Rahman irr Rahim

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List of abbreviations

ABS	Annual Budget Statements
ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
BHU	Basic Health Unit
CBC	Complete Blood Count
CDC	Center for Disease Control and Prevention
CPI	Consumer Price Index
DAH	Development Assistance for Health
DHQ	District Headquarter Hospital
EAD	Economic Affairs Division
EAF	Equity Accelerator Fund
EPI	Expanded Programme on Immunisation
FY	Financial Year
GDP	Gross Domestic Product
GHI	Global Health Initiative
GHS	Government Health Spending
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
ICT	Information and Communications Technology
IMF	International Monetary Fund
IT	Information Technology
KP	Khyber Pakhtunkhwa
LMIC(s)	Low- and Middle-Income Country/Countries
MNHSR&C	Ministry of National Health Services, Regulations and Coordination
NHA	National Health Accounts

ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PBS	Pakistan Bureau of Statistics
PKR	Pakistani Rupee
PPP	Public–Private Partnership
RHC	Rural Health Centre
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBP	State Bank of Pakistan
SDG	Sustainable Development Goals
TB	Tuberculosis
TCA	Targeted Country Assistance
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WFP	World Food Programme
WHO	World Health Organisation

Executive Summary

Pakistan's health outcomes lag substantially behind regional peers. Life expectancy stands at 67.3 years, approximately four years below the South Asian average. Infant mortality remains at 50.1 deaths per 1,000 live births — more than double the rates in Bangladesh and Nepal — and maternal mortality at 155 per 100,000 live births sits well above comparators. These outcomes reflect a low-performing health system shaped by decades of policy choices, resource allocation patterns and system design, not unavoidable circumstance.

One of key structural causes is sustained underinvestment. Pakistan spends 2.91% of GDP on health. Public spending accounts for 0.9% of GDP, far below the WHO-recommended minimum of 5% for universal health coverage and lower than South Asian regional average of 5.83%. Between FY 2019–20 and FY 2025–26, nominal public health allocations increased by 155%, from PKR 530 billion to PKR 1.35 trillion. After adjusting for inflation, real financing expanded by only 25%. Per capita real allocations remain low across provinces, ranging from PKR 2,043 in Punjab to PKR 3,203 in Sindh — far below the USD 100 minimum estimated for low- and middle-income countries by 2030.

Within this constrained envelope, Official Development Assistance (ODA) plays a role disproportionately positive to its fiscal contribution. Pakistan has received an average of USD 4.9 billion per year in ODA since 2017, equivalent to 1.68% of GDP. On-budget ODA for health amounted to USD 1.07 billion between 2017 and 2025, just 2.4% of total ODA flows. Off-budget ODA channelled through Global Health Initiatives[i] (GHIs) — principally the Global Fund and Gavi — finances functions that public budgets for these programmes do not cover. Public budgets are personnel-heavy and fixed, financing salaries, facilities, essential medicines and routine operating costs. ODA is flexible and commodity-heavy, financing vaccines, diagnostic kits, supply chains, disease surveillance, technical assistance and outreach for TB, HIV-AIDS, malaria and immunisation.

Globally, Development Assistance for Health declined from USD 50.1 billion in 2019 to a projected USD 38.4 billion in 2025, driven by unprecedented cuts from the United States, United Kingdom, Germany, France and Japan — the first synchronised retrenchment by major donors since 1995. ODA cuts are manifesting through three channels:

- **Bilateral withdrawals** are producing abrupt programme discontinuities with no transition period and no institutional buffer.
- **Multilateral reductions** are diluting the functional capacity of vertical disease programmes — commodities, diagnostics and field operations — over successive grant cycles.
- **Global spillovers** are compounding both, disrupting pooled procurement, weakening disease surveillance and impacting the UN agency partnerships that underpin outbreak detection and inter-governmental coordination.

The functional consequences are already visible. The 2025 USAID suspension closed over 60 facilities and disrupted care for 1.7 million people; in Sindh's Shikarpur district, a tuberculosis control project reaching 1,500 families per month was halted, leaving over 100

[i] Global health initiatives (GHIs) are organised, large-scale, multistakeholder efforts that raise and channel financial, technical and political resources to address priority global health threats and reduce health disparities within and between countries. They commonly focus on areas such as HIV-AIDS, tuberculosis, malaria, and immunisation.

workers unemployed. A USD 27.2 million Global Fund reduction announced in July 2025 halved TB monitoring in Punjab and Khyber Pakhtunkhwa, cut diagnostic kit financing, and placed treatment for over 42,000 HIV-positive patients at risk. These are not system-wide collapses. They cause very specific gaps in critical system functions, exposing how deeply Pakistan's basic service delivery is intertwined with external finance. When ODA contracts, consequences on commodities, supply chains and specialist staff critical to vertical programmes are most pronounced. The risk is not a fiscal shortfall alone, but functional degradation in precisely the areas ODA supports.

The response to manage ODA withdrawals and reduced external financing for health requires a structural reform agenda, not a temporary financing shortfall. This transition agenda requires a sequential and structured approach with strong political, bureaucratic and technocratic commitment, consensus and coordination.

- **Convene a National Health Financing Forum,** chaired by the Federal Minister of Health, with parallel provincial forums chaired by Chief Secretaries. The forums should coordinate across federal and provincial agencies, GHIs, bilateral and multilateral partners, civil society and the private sector, without exercising parallel decision-making functions. Responsible: MNHSR&C, Provincial Health Departments.
- **Develop a national ODA registry** by enhancing EAD's existing development assistance platform to capture both on-budget and off-budget flows, mapped against programmes, agencies and functional activities. Responsible: Economic Affairs Division, MNHSR&C.
- **Design and operationalise a health financing risk matrix** that classifies every ODA-financed function against three dimensions — substitutability, absorptive capacity and systemic criticality — to produce function-level prioritisation across high-footprint programmes including TB, HIV-AIDS, immunisation and RMNCH. Responsible: Health Financing Forum, MNHSR&C, Provincial Health Departments.
- **Embed forecasting and integrated financial planning** through rolling ODA scenarios under gradual, accelerated and abrupt withdrawal pathways, and through explicit time-bound transition plans for TB, HIV-AIDS and EPI that feed into medium-term budgetary planning. Responsible: Health Financing Forum, MNHSR&C, Provincial Health Departments, Ministry of Finance, Provincial Finance Departments, Planning & Development Departments.
- **Reform the rules of the system** through reviews of laws, regulations and administrative directives that constrain market-rate hiring, flexible procurement and cross-government data sharing, sequenced as short-term executive orders, medium-term regulatory amendments and longer-term legislative reform. Responsible: Provincial Chief Secretaries, Public Procurement Regulatory Authorities, Law Division and Departments.
- **Mobilise domestic resources** through federal and provincial cabinet commitments to raise public health expenditure towards 3% of GDP, accompanied by an innovative financing roadmap covering pooled donor funds, impact bonds, Islamic finance, debt-for-development swaps, structured public-private partnerships and channelled diaspora and philanthropic financing. Responsible: Federal and Provincial Cabinets, Ministry of Finance, Provincial Finance Departments.
- **Accelerate technical and operational capacity** through a structured programme covering technical skills, institutional capacity and specialist human resources, sequenced so capacity builds in step with the functions being absorbed, with vertical

programmes progressively integrated through shared supply chains, laboratories and information systems. Responsible: MNHSR&C, Provincial Health Departments.

- **Establish oversight and adaptive governance** through quarterly operational reviews and annual strategic reviews at provincial forums, with authority devolved to the level at which decisions are made and accountability framed to encourage informed action under speed. Responsible: Health Financing Forum, Provincial Health Departments.

ODA cuts are exposing structural weaknesses rather than creating them. Managed well, this crisis can force overdue reforms. Systematic assessment, clear strategic direction and disciplined operational reform can move Pakistan from fragile dependence towards a more resilient, integrated health system.

About this report

Official Development Assistance (ODA) comprises of grants and loans from official agencies and public bodies. These funds are directed towards recipient governments to promote economic development and welfare in low- and middle-income countries (LMICs). [1]

Global ODA flows are declining since 2019 with an accelerated reduction in recent years. Reduced ODA will impact a wide range of sectors and priorities, however, such cuts in health financing for low- and middle-income countries will be significantly pronounced. Estimates suggest that aid cuts could result in approximately 22.6 million additional deaths, including 5.4 million children under five, by 2030.[2]

Pakistan is already affected by declining ODA flows. The scale and scope of such cuts are not fully understood across all nodes and tiers of the health ecosystem in Pakistan. It is imperative that a systematic and structured approach to understanding the implications of reduced ODA flows for Pakistan's health sector is shared across stakeholders - public, private, and development partners.

This report (i) maps the salience of ODA for health service delivery, (ii) tracks the impact of ODA cuts across the health system in Pakistan, and (iii) offers recommendations to help proactively mitigate the risks to health outcomes.

Framework and approach

ODA support, health programming and service delivery are deeply intertwined. This complexity merits the development of a clear framework to map and track the impact of shrinking ODA flows. While this framework is informed by Pakistan's health financing architecture, with contextual adaptation, it can be replicated by other countries and regions. ODA cuts stem from three sources:

- **Bilateral cuts:** A donor government reduces or suspends aid provided directly to partner governments or organisations (e.g. USAID).
- **Multilateral cuts:** A pooled international financing institution reduces its disbursements to recipient countries (e.g. the Global Fund).
- **Global knock-on effects:** Bilateral and multilateral cuts (treated as "primary cuts" in this framework) produce downstream disruptions that affect Pakistan through reduced support by global institutions or shared technical assistance modalities.

ODA supports specific health system functions — typically including procurement of commodities, logistics and supply chains, disease surveillance, and technical capacity in public offices. The impact of reduced financing available for system-wide functions must then be assessed using a function-based lens. This approach enables a clear risk assessment for services, geographies and beneficiaries. The framework below maps ODA flows from funders to recipient programmes and functions. This structure is aimed to:

(i) Support decision-makers in identification of high-exposure functions and services;
(ii) Prioritise interventions for transition planning and management; and
(iii) Eventually, design roadmaps for sustainable health system transformation.

ODA CUTS
TRIGGERS AND IMPACTS

1 TRIGGERS FOR GLOBAL ODA CUTS

POLITICAL SHOCKS

Shifts in priorities of donor governments: wide spectrum of responses from partial to complete withdrawal of foreign aid disbursements

BUDGETARY REPRIORITISATION

Pressure from rising defence and security expenditure across regions is redirecting resources away from development assistance

SYSTEMIC AND GLOBAL FEEDBACKS

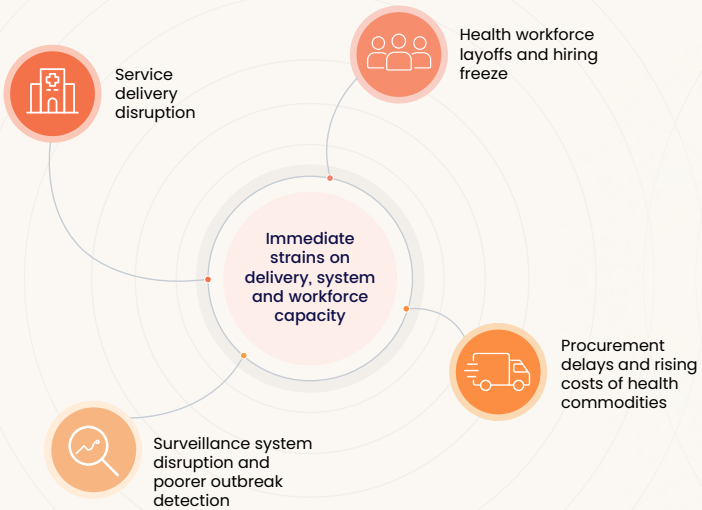
These political and fiscal shifts created ripple effects across major donor economies, tightening aid budgets globally and reinforcing a trend of declining ODA flows

2 REDUCED ODA AVAILABILITY

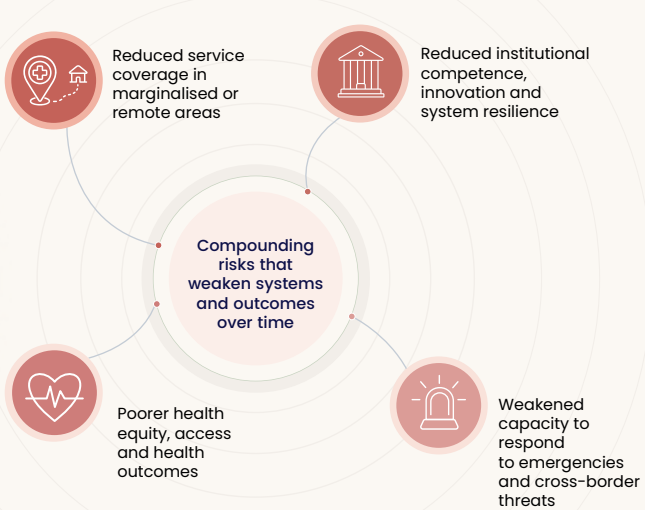
These political, security and fiscal shifts reduce the volume, predictability and flexibility of ODA

3 IMPACTS AND RISKS ON HEALTH SYSTEM

NEAR-TERM OPERATIONAL IMPACTS



MEDIUM- TO LONG-TERM SYSTEMIC RISKS



Focus on Global Health Initiatives

This report concentrates on ODA channelled through Global Health Initiatives (GHI) such as the Global Fund and Gavi, using cuts to USAID and UN agencies for contextual illustration. It does so because GHI flows are both large and highly concentrated in system-critical health functions. This focus makes it easier to build a clear and rigorous analysis. The analysis covers how GHI-financed ODA underpins key health functions in Pakistan and assesses implications of reduction in this funding pool for programme continuity and transition planning.

Limitations

This report uses published health data sources (Government Annual Budget Statements) and on-budget ODA records (monthly and annual EAD reports). GHI financial data, where used, is drawn from published aggregates. This reliance on official and published sources focuses the analysis to a defined subset of on-budget ODA flows in Pakistan. Limited financial reporting for off-budget support (e.g. funds routed through UN agencies and implementing partners are not available) does not allow for a comprehensive country-level ODA analysis.

1. Context

Pakistan's health outcomes lag behind those of regional and lower-middle-income comparators. Progress has been uneven, and key indicators still fall short of regional and global benchmarks. Despite recent increases in headline budgets, levels of public expenditure on health remain inadequate. Low domestic health spending limits the scope, scale and quality of services that governments provide.

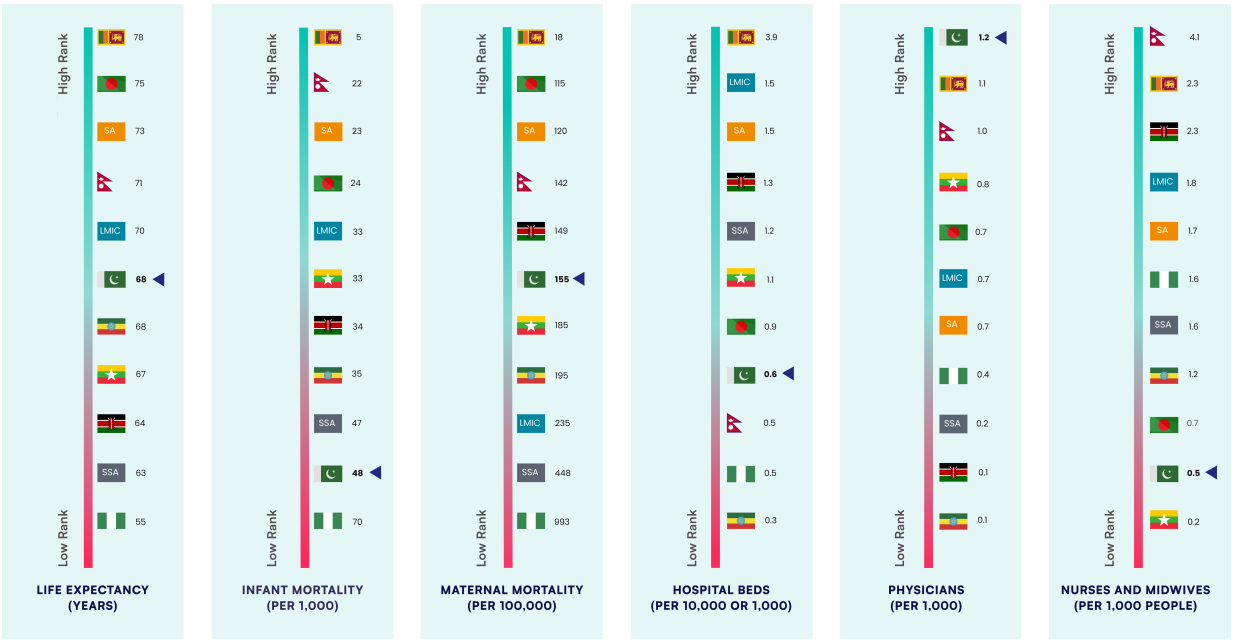
1.1 Health outcomes in Pakistan

Pakistan carries a high burden from both communicable and non-communicable diseases - tuberculosis, diabetes and cardiovascular conditions all show rising trends. Despite modest improvements in life expectancy, outcomes across key health indicators remain poor, with maternal and child health outcomes among the weakest in the region.

1.1.1 Key health indicators

Pakistan's health outcomes can be assessed against several standard indicators. Life expectancy stands at 68 years,[3] approximately four years below the South Asian average. Infant mortality at 50.1 deaths per 1,000 live births[4] — is more than double the rates in Bangladesh and Nepal. These persistently poor outcomes reflect a low-performing health system attributable to a mix of design and implementation gaps in policy, resource allocation, and governance.

Table 1: Health indicators benchmarks



Source: World Bank [5]

1.1.2 Low public investment

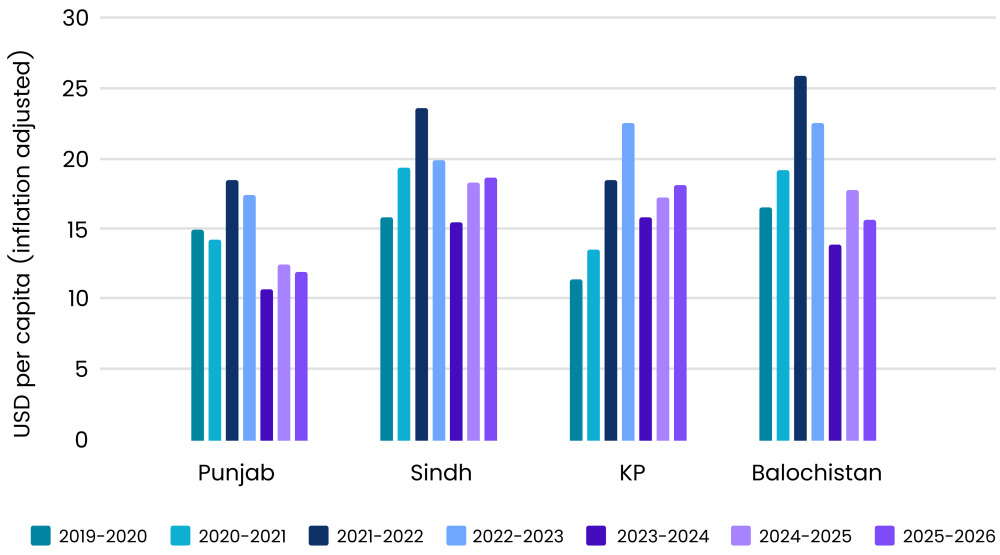
Pakistan's health expenditure remains well below international standards. According to the National Health Accounts, total health expenditure is only 2.9% of GDP[6]- including public, private, and insurance-based spending. The weighted average for South Asia is estimated at 4%[7] of GDP. [8,9] While the weighted OECD average is 9.2%.[10] Public health spending stands at only 0.9% of GDP,[11] far below suggestive levels that call for public health spending amounting to 5% of GDP for universal health coverage.[12] Over the last six years, federal and provincial health allocations have increased in nominal terms - from PKR 530.8 billion (USD 3.3 billion) in FY 2019–20 to PKR 1.4 trillion (USD 4.8 billion) in FY 2025–26. This represents an increase of 155%.[13]

This headline growth in nominal allocations is misleading. After adjusting for inflation, real allocations increased by only 25%. High inflation during FY 2021–24, with an average annual rate of 18.3%,[14] eroded the potential gains from increased health budgets. While the nominal increase depicts stronger political commitment, a real increase of 25% over six years does not bridge the inadequacy gap in health expenditure required to improve outcomes at scale.

National aggregates mask variations between provinces and merit a more granular analysis at a per capita layer. Per capita allocations in FY 2025–26 (real terms) across provinces were: [15]

- **Punjab:** PKR 2,043 (USD 12)
- **Balochistan:** PKR 2,680 (USD 16)
- **Khyber Pakhtunkhwa (KP):** PKR 3,136 (USD 18)
- **Sindh:** PKR 3,203 (USD 19)

Figure 1: Inflation adjusted per capita provincial budgets (FY 2019-20 to FY 2025-26)



Source: Pakistan provincial Annual Budget Statements (ABS)

Compared to the required government spending of USD 100 per capita (annually in 2023-dollar values) till 2030, these allocations remain far below adequacy benchmarks to improve outcomes in lower-middle-income countries. This gap highlights the gross underinvestment in health services and has a direct consequence for stagnating outcomes.

Pakistan's low investment in health has direct consequences for outcomes. Budget constraints limit government's financing capacity, particularly for recurrent costs and essential system functions. Limited budgets restrict the number and distribution of health workers, the availability of medicines and diagnostics, and maintenance of facilities and equipment. They also restrict investment in primary care and preventive services, which are critical for reducing maternal and child mortality, and infectious disease burdens. Even where allocation has increased in nominal terms, inflation has eroded much of the potential gain in real terms. The result is a health system with weak baseline capacity and limited room to expand or improve services without new resources.

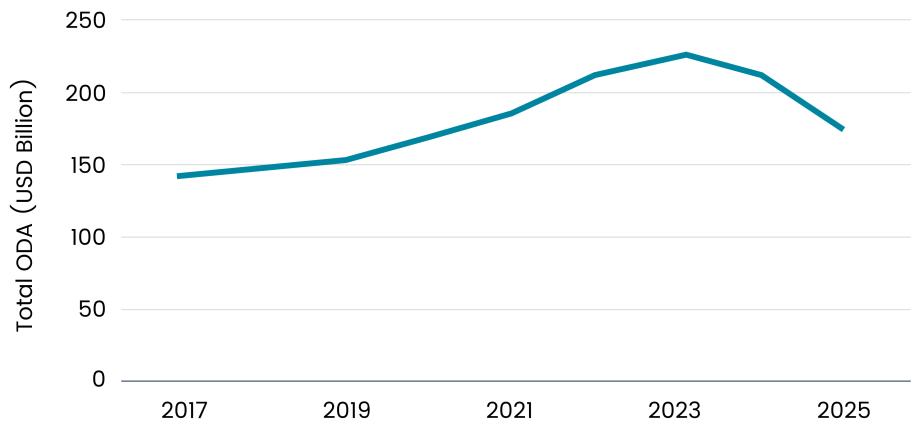
In this constrained fiscal space, external assistance plays a critical role in supporting Pakistan's public health system. While it accounts for a small share of total health spending, only a very small proportion of these resources flow into primary and secondary care. Within these levels of care, external assistance often finances critical system functions that domestic budgets only partly or inadequately fund. The next section examines ODA flows to Pakistan, key trends, and corresponding implications for health financing.

1.2 Pakistan's standing in the context of global ODA flows

1.2.1 Global aid retrenchment

Total global ODA flows stood at USD 174.3 billion in 2025, a decrease of 23% from 2024. OECD projections indicate a further 5.9% decline for 2026.[16] This declining trend is expected to continue beyond 2026.[17] Figure 2 shows that global aid declined following the 2025 aid cuts, falling from USD 215 billion in 2024 to USD 174 billion in 2025.

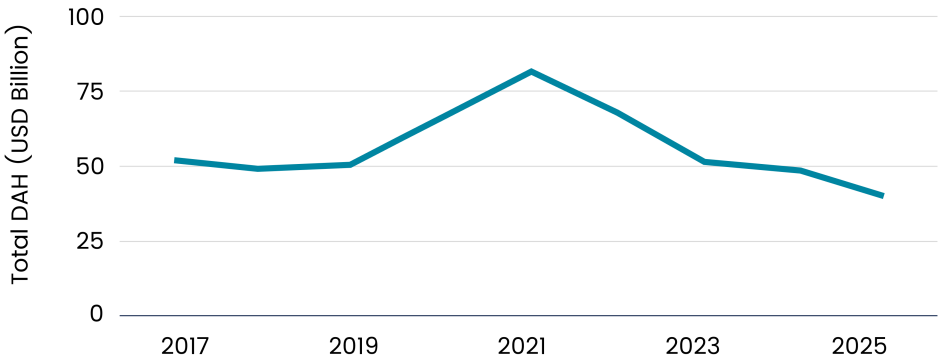
Figure 2: Global ODA trend (2017-2025)



Source: Organisation for Economic Co-operation and Development (OECD)

Similarly, DAH has also decreased. It accounted for 10–15% of total global ODA.[18] As noted earlier, DAH fell by about 22% between 2024 and 2025 in line with overall ODA declining trends.[ii]

Figure 3: Global DAH trend (2017-2025)



Source: Institute for Health Metrics and Evaluation (IHME)

This funding crisis has been driven by unprecedented budget cuts by the United States of America (USA) and major European funders.[19,20] While the USA cut 88% of USAID programmes in 2025, amounting to an estimated USD 60 billion,[21] Germany cut USD 9.2 billion, France USD 2.6 billion, and the United Kingdom USD 2.2 billion from their global ODA portfolios. All four major donors reduced their aid budgets in tandem for the first time since 1995.[22]

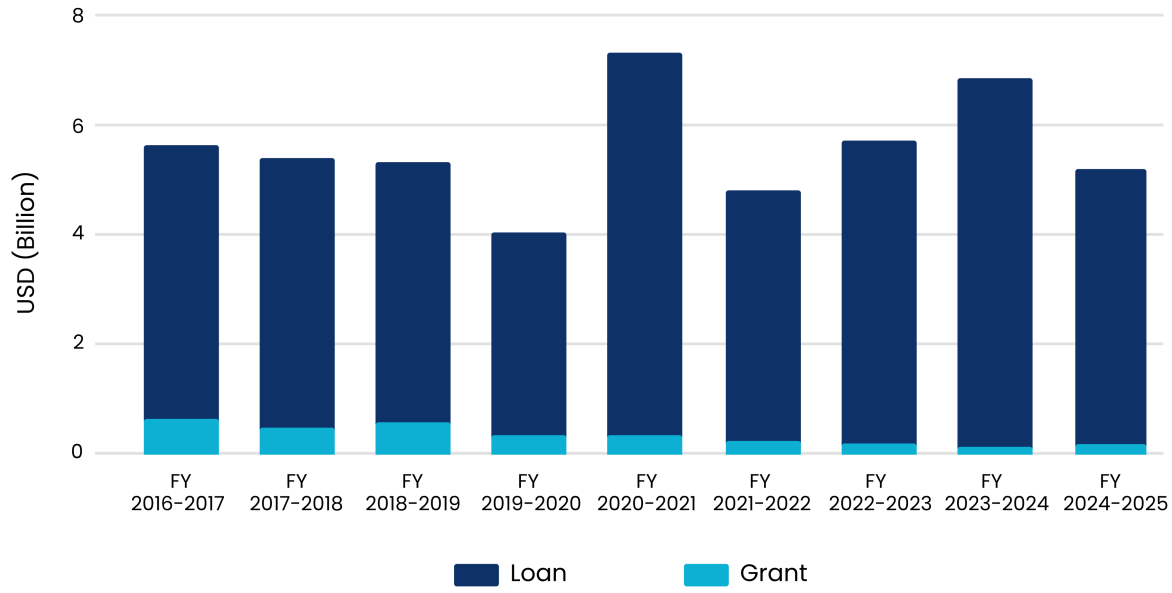
1.2.2 Pakistan's ODA flows

Pakistan has received an average of USD 4.9 billion annually in ODA From FY 2016-17 to FY 2024-25,[23] (1.7% of GDP over the same period). While the value of ODA flows to Pakistan depict a relatively stable flow (Figure 4), the composition of assistance has changed significantly – the proportion of grants has reduced whereas concessional loans have increased.[24] Over this period, grant-based assistance has contracted by 59% from USD 512 million (9% of total ODA) to USD 211 million (4% of total ODA). Concessional loans now comprise of 96% of all external assistance.[iii]

This is reflective of the changing global trends in development assistance where a clear emphasis on "shared responsibility" and "country ownership" has led donors to expect governments to finance a greater share of development through debt and co-financing rather than grants. Since 2015, financing frameworks for SDGs have reinforced this logic, encouraging blended finance and large loan-backed reform programmes over smaller, grant-funded projects.[25]

[ii] Updated figures for 2025 DAH were not available at the time of publication.
[iii] This means that Pakistan has been accumulating an average of USD 4.6 billion in loans per year.

Figure 4: Pakistan ODA composition (2017-2025)



Source: Economic Affairs Division (EAD) Pakistan

Sources of ODA have also shifted with annual bilateral ODA declining significantly from USD 2.3 billion in FY 2016–17 to USD 0.6 billion in FY 2024–25, an average annual decrease of 8%. Over the same period, ODA from multilateral institutions increased by 50% from USD 3.2 billion to USD 4.8 billion annually.[26]

1.2.3 Development Assistance for Health (DAH) in Pakistan

Health-related ODA to Pakistan amounted to approximately USD 1.07 billion between 2017 and 2025, representing only 2.4% of total ODA flows.[27] This represents ODA that flows to the government - on-budget assistance, recorded and reported by the Economic Affairs Division (EAD). It does not include off-budget GHI-ODA and donor implemented programmes, which contribute significantly to TB, HIV, and immunisation service delivery. A weak data regime for off-budget assistance, because of inconsistent and incomplete reporting by development partners, hinders the estimation of total ODA flows to health in Pakistan.

Box 1: Understanding 'on-budget' and 'off-budget' ODA

ODA flows to countries are directed and administered through different modalities. The distinction between on-budget and off-budget flows is essential for understanding the analyses and implications presented in this report.

On-budget ODA refers to funding that is recorded within government budget and financial management systems. It flows through the government treasury, and is subject to government planning, appropriation, execution, and reporting processes. This includes concessional loans from multilateral institutions such as The World Bank and Asian Development Bank, as well as bilateral grants and project financing routed through the federal or provincial treasury. In Pakistan, it is recorded by the Economic Affairs Division (EAD).

Off-budget ODA does not flow through or get recorded in government financial management systems. It is managed directly by development partners - multilateral and bilateral organisations, including UN agencies and international NGOs, and respective implementing agencies. These funds flow through their individual financial management systems. They are appropriated, expended and reported by the partners. Occasionally, these funds can be transferred to government entities for implementation. However, since government is not the primary recipient of the funding, this is still regarded as off-budget support.

In Pakistan, off-budget ODA often finances programmes such as TB treatment, HIV care, and immunisation outreach through partner-managed procurement and reporting channels. It is not included in federal or provincial health budgets, even where the assistance is used to finance services delivered through public facilities.

This distinction has direct policy implications. When off-budget ODA reduces, the resulting deficit does not automatically trigger a budgetary response. Governments may not immediately know which functions are impacted, in which programmes, or at what scale — making the risks less visible and harder to manage through standardised budgetary structure and processes.

DAH funding is highly concentrated in a narrow set of critical functions that enable the health system. These functions include medicines, vaccines, diagnostics, supply chains, technical capacity and, in the case of certain vertical health programmes, technical

human resources.[iv] This means that even modest cuts can create significant vulnerabilities in specific programmes (more details are covered in Chapter 3).

The remainder of this report focuses on a specific subset of this envelope: ODA coming through Global Health Initiatives (GHIs), focusing primarily on the Global Fund for TB, AIDS and Malaria and Gavi. The report uses the general "GHI-ODA" frame and discusses how it affects Pakistan's health system and what recent and expected GHI cuts imply.

Box 2: Global Health Initiatives and GHI-ODA

Global Health Initiatives (GHIs) are specialised international financing mechanisms that channel resources to priority health programmes across low- and middle-income countries. In Pakistan, the most important GHIs include the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and Gavi, the Vaccine Alliance. The GHIs typically finance disease-focused programmes, including the TB Control Programme, AIDS Control Programme and the Expanded Programme on Immunisation (EPI). For this report, GHI-ODA refers to Official Development Assistance that flows through these Global Health Initiatives to Pakistan's health sector. GHI-ODA represents a subset of total Development Assistance for Health (DAH).

The GHI-ODA is grant-based and mostly off-budget. Instead, GHIs generally route most of their funding through development partners (e.g. WHO and UNICEF), civil society organisations (including non-profits and academia) and private sector firms.

The flows from GHIs are substantial. Between 2017 and 2025, the Global Fund disbursed USD 825 million, Gavi disbursed USD 979 million to support health programmes in Pakistan. The GHI-ODA is concentrated in a very targeted set of health system functions. These include medicines and vaccines, diagnostics, surveillance, outreach, technical assistance and specialist staff.

Since GHI-ODA provides the funding lifeline to critical programmes, even modest cuts in GHI-ODA can create significant programme-level shocks for TB, HIV, immunisation, and related services. A clear understanding of how changes in GHI-financed support affect Pakistan's health programmes is essential to effective mitigation and transition strategies.

[iv] A notable example is Pakistan's TB Control Programme, where the Global Fund for TB, AIDS and Malaria currently supports 87% of the programme staff. Different programmes have varying degrees of exposure to ODA. Quite unlike the TB programme, the Expanded Programme on Immunisation (EPI) is supported by Gavi to cover payroll costs for frontline workers – with varying requirements over time and by province. This highlights the need for deep contextual understanding to analyse the impact of ODA cuts across two axes – functional, and programmatic.

Pakistan faces a compounding crisis. Poor health outcomes reflect decades of underinvestment in health. For years, ODA has partially offset underinvestment by financing critical health system functions. Global health assistance, including funding through GHIs, is decreasing with the implication that Pakistan's GHI-financed programmes must plan for reduced, more volatile grant envelopes over the coming cycles.

2. The role of ODA in Pakistan's health system

Pakistan's health system is financed through two distinct but connected sources: public funding (federal and provincial) and ODA. Public funding covers health expenditure for (i) recurring or operational heads, (ii) projects. Operational expenditure covers salaries, health facilities and infrastructure, and routine costs. Projects usually cover infrastructure development, capital expenditure and/or investments like training programmes, development of technology systems, procurement of equipment etc.

ODA, particularly through GHIs, typically finances commodities, supply chains, disease surveillance, tracing, technical assistance, and specialist staff. Government budgets contribute to some of these functions, but the most specialised and commodity-intensive elements remain heavily ODA-dependent.

This chapter maps expenditure supported by public funds and ODA, in particular GHI-ODA. The analysis identifies vulnerabilities and risks that emerge as ODA declines.

2.1 What public health budgets finance

Pakistan's public health budgets finance the recurrent and capital costs of keeping the formal health system operational: salaries, allowances, and pensions for health workers; utilities, repairs, and routine maintenance of facilities; the construction and renovation of hospitals, clinics, and outreach facilities; and the purchase of vehicles, equipment, and other operational assets. Table 2 sets out these categories in detail.

Table 2: Major categories funded by public health financing

	Budget category	Description
1	**Human resource costs**	Broad heading for all staff-related costs, including salaries and benefits.
	a. Salaries (officers, staff and support staff)	Basic pay for officers, regular staff and contract staff.
	b. Allowances (regular and other, excluding TA)	House rent, medical, risk and other allowances.
	c. Employees' retirement benefits (pension, etc.)	Pensions and related post-retirement obligations.
2	**Operating expenses**	Day-to-day non-salary running costs of health programmes and facilities.
	a. Utilities (gas, water, electricity, etc.)	Utility bills and related service charges.
	b. General operating costs	Stationery, printing, conferences, law charges and similar items.
	c. Repairs and maintenance	Upkeep of vehicles, equipment, buildings and other assets.
	d. Occupancy costs (rent, rates, taxes, insurance)	Costs of occupying offices and health facilities.

	e. Computer equipment (hardware, software, IT equipment)	ICT hardware, software licences and related equipment.
	f. Communications	Postal, telephone, electronic and courier communication costs.
3	**Purchase of drugs and medicines**	Procurement of pharmaceuticals and medical supplies for patient care.
4	**Buildings and structures/civil works**	Construction and major works for offices, hospitals and other buildings.
5	**Purchase of transport vehicles**	Capital spending on vehicles.
6	**Purchase of plant and machinery**	Capital spending on machinery and technical equipment.
7	**Purchase of furniture and fixture**	Furniture and fixtures for offices and facilities.
8	**Grants, subsidies and write-off loans**	Financial support to entities and loan-related subsidies/write-offs.
9	**Transfers (including scholarships and other transfers)**	Non-grant transfer payments such as scholarships and cash awards.
10	**Other stores and stocks /medical stores and consumables**	Drugs, medical supplies and other consumables.

Source: Authors' categorisation based on Pakistan Annual Budget Statements (ABS).

Public financing is characterised by two structural constraints:

(i) High fixed costs owing to the human resource expenditure categories – salaries and benefits. Once committed to, these are difficult to redirect.
(ii) Health facility-driven spending cover operating costs like maintenance of infrastructure and equipment, utilities, transports etc.

This leaves very limited cushion to finance the technical, commodity, and outreach functions that vertical disease programmes depend on.

2.2 What ODA finances

While public financing ensures core staffing and facility requirements, ODA finances programme-critical functions. GHI-ODA in particular concentrates on commodities, specialist staff, and technical capacity — the elements that keep TB, HIV-AIDS, immunisation, and related services running at primary and secondary levels. This works by complementing what governments already finance, and covering expenditure categories that domestic budgets do not provide for. Table 3 sets out these functions in detail.

Table 3: Major functions ODA supports

	Function
1	**Health products and supplies**
	a. Medicines, vaccines, and diagnostics
	b. Technical equipment such as X-ray machines, ice-lined refrigerators, and other devices
	c. Supportive equipment including laptops, tablets, and phones used for service delivery
2	**Systems and infrastructure for delivery**
	a. Logistics, warehousing, and cold-chain operations
	b. Information systems for commodities and programme monitoring
3	**Information systems for commodities and programme monitoring**
	a. Contracted programme staff and community workers
	b. Outreach activities, campaigns, and service delivery in underserved areas
4	**Technical and institutional support**
	a. Policy, planning, and data analytics expertise
	b. Data systems, analytics, and disease surveillance
	c. External professional services (e.g. surveys, evaluations, audits, IT and systems consultancy, etc)
	d. Targeted capacity-building for government and implementing partners

Source: Authors' categorisation based on a review of GHI funding categories.

Health products and commodities account for the largest share of GHI-ODA financing. This category covers pharmaceutical products, diagnostics, and health equipment (see Chapter 4). GHI-ODA also finances certain speciality medicines (e.g., HIV-AIDS treatments), which are generally more expensive. GHI-ODA also partially finances vaccines for the provincial EPI programme. Finally, it supports specialist and outreach staff that help maintain programme coverage and service continuity.

Procurement and supply chain management receive dedicated GHI-ODA funding. In fact, most of the funds the GHIs make available are dedicated to these functions. Provincial health budgets only partially cover these functions (in EPI/TB/HIV-AIDS), often indirectly. In practice, government contributions in these programmes appear mainly as payroll for procurement officers and infrastructure (i.e. brick-and-mortar warehouses, etc). GHI-ODA finances the rest of the delivery chain: tendering, vendor management, cost negotiation, demand quantification, stock management, and distribution. This division leaves domestic systems in such programmes dependent on off-budget donors for the most complex and market-facing elements of procurement.

Human resources financed by off-budget GHI-ODA in these programmes differ fundamentally from government payroll systems. The off-budget ODA pays for field staff, community mobilisers, and specialist consultants. In specific instances, such as the TB or

AIDS control programmes, GHI-ODA also supports administrative staff, even as this varies over time. These staff typically work on short-term, performance-linked contracts rather than permanent civil service posts. Many perform specialised roles for which no equivalent government-notified positions exist. A common example is IT specialists, such as full-stack developers, who design and operate digital health systems. Moving such personnel directly onto government payroll, against comparable positions, is rarely straightforward.

Technical assistance represents another structural divergence. GHI-ODA finances the expertise required for strategic planning, data systems management, epidemiological intelligence, and inter-governmental coordination. This expertise is typically delivered through consultants, civil society organisations, and external professional services firms. Public sector staffing rarely houses comparable in-house capacity across all these domains.

Finally, GHI-ODA supports programme-related costs such as targeted outreach campaigns, awareness drives, and coverage-expansion initiatives. While government contributions under these heads are substantial, ODA support is usually targeted towards underserved and/or hard-to-reach areas, or deployed during high-intensity efforts (e.g., province-wide vaccination campaigns). This makes ODA support system-critical to maintain coverage and reach high-risk populations.

Across all four functions — commodities, procurement and supply chains, specialist staffing, and targeted outreach, GHI-ODA finances precisely the elements that public funding systems are least equipped to assume at speed. These are not peripheral inputs but the operational core of vertical disease programmes: the commodities that make treatment possible, the supply chains that deliver them, the specialist staff who manage them, and the outreach that reaches the populations most in need. When this layer of financing contracts, facilities and staff are least affected. The consequences are most visible on critical programme functions that come to a halt. The next chapter outlines how this exposure is affecting service delivery as GHI-ODA cuts move from announcement to reality across Pakistan's TB, HIV-AIDS, and immunisation programmes.

3. The impact of GHI-ODA cuts on public health programming in Pakistan

The analysis presented in this chapter is informed by recently announced cuts to Pakistan's TB, HIV-AIDS, and immunisation programmes. Although the report's primary focus is on GHI-ODA, bilateral cuts are included where they illustrate the mechanics of donor withdrawal — most notably the 2025 USAID suspension.

The contraction of ODA is impacting Pakistan's health system through three distinct channels:

Bilateral donor withdrawals are precipitating cliff-edge effects, causing abrupt programme discontinuities and immediate shocks to service delivery. A single donor government abruptly reducing or suspending its programmes, produces the most visible system shocks. Since bilateral programmes are structured as discrete, time-bound projects delivered through direct implementation partnerships, the effects of suspension are immediate: facilities close, staff are laid off, and service delivery halts.

Reductions in **multilateral financing** occur when donor countries collectively reduce pooled contributions, which is then passed down to programmes. These effects typically unfold over longer funding cycles, mediated through structured reprogramming negotiations, and tend to impact system-wide functions rather than discrete projects.

Domestic pressures are compounded by **global spillovers** creating knock-on effects that reach Pakistan through shared systems and regional dynamics. These unfold through fragmentation in pooled procurement mechanisms, weaker regional coordination for disease control, and limited collaboration on critical technical assistance ecosystems.

3.1 ODA-only funded service delivery halted

Where donors directly fund frontline services in areas the public sector does not cover, withdrawal leaves no domestic programme to step in. Facilities close, staff are laid off, and service delivery halts — with no transition period and no institutional buffer. The 2025 suspension of USAID programming in Pakistan offers a clear example. In Sindh's Shikarpur district, a USAID-supported tuberculosis control project — launched in November 2023 and designed to run until 2029 — was abruptly halted, leaving over 100 workers unemployed and disrupting testing and treatment access for thousands of patients. At the time of closure, the programme was reaching 1,500 families per month.

3.2 Supply chain risks and disruptions

Multilateral funding supports procurement of an elaborate suite of health commodities required for Pakistan’s primary and secondary healthcare. Some key examples include vaccines, nutritional commodities, medicines and testing kits. Demand pooling offers lower unit prices — particularly for vaccines, TB drugs, and some diagnostics. Gavi, for instance, negotiates on behalf of 73 countries to secure discounts of 50–90% for routine immunisation vaccines. As pooled mechanisms shrink, unit prices rise, squeezing already constrained government budgets.

ODA-funded logistics, warehousing, and cold-chain investments – vehicles, cold rooms, temperature monitors, and associated maintenance and fuel are essential for smooth operations across the health system. When these inputs contract, the effects are gradual rather than immediate: domestically procured medicines may still reach warehouses, but distribution becomes unreliable, wastage increases, and programme credibility weakens over time.

Information systems that track commodities and trigger resupply often depend on ODA, with funds supporting logistics management information systems, supervision, and data use. When these functions are scaled back, stock visibility falls and forecasting deteriorates, with manual workarounds likely to reintroduce the errors and delays that digital systems were designed to eliminate.

3.3 Loss of technical assistance and institutional capacity

The withdrawal of technical assistance represents a consequential effect of ODA cuts. Advisory teams, analysts, and specialist staff offer invaluable institutional capacity to enable planning, programme oversight, and inter-governmental coordination. Decreases in ODA funding will necessitate trade-offs that thin institutional capacity in favour of critical priorities like commodities and supply chain continuity.

3.4 Weakened regional coordination and technical support

Organisations such as WHO, UNICEF, and WFP support cross-border disease surveillance, outbreak response, and technical assistance platforms. With budget contractions, Pakistan may lose access to surge support, regional data, and specialised expertise that is absent locally. This can lead to low preparedness to manage shocks.

3.5 Amplified exposure to cross-border risks

Pakistan's disease surveillance, laboratory networks, and diagnostic systems depend on ongoing CDC, WHO, and multilateral partnerships, including GHIs. These partnerships are invaluable for outbreak detection, especially cross-border disease spread and internationally coordinated response. Instability in neighbouring health systems and resulting deterioration of services increases the risk of transboundary transmission and outbreaks. For example, TB, malaria, typhoid, and polio cases from Afghanistan. If ODA cuts weaken disease surveillance and response functions in Pakistan, undue burden on the health system will result in strain on local service delivery. Health management information systems, routine reporting, and programme evaluation capacity also require ongoing technical support.

3.6 Case-studies from flagship GHIs in Pakistan

Recent reductions in Global Fund and Gavi allocations illustrate how this plays out in Pakistan. As the country's two largest multilateral health funders, both finance commodities procurement, supply chains, and critical service delivery components — though their financing architectures are distinct. Gavi's support is concentrated primarily on vaccine procurement and vaccine supply infrastructure, while the Global Fund provides system-wide programme support across TB, HIV-AIDS, and malaria. Examining their financing modalities reveals functions that face immediate risk due to contraction of multilateral assistance.

In July 2025, Pakistan's Ministry of National Health Services, Regulations and Coordination (MNHSR&C) was notified of a USD 27.2 million reduction in Grant Cycle 7 allocations by the Global Fund.[v] While most of this cut was against the TB control programmes, it also included cuts of over USD 4 million to HIV-AIDS programmes (managed by the National AIDS Control Programme and UNDP Pakistan).[vi] Once in effect, the reduction in Global Fund funding for TB control programmes in Punjab and Khyber Pakhtunkhwa will significantly impact district monitoring, community interventions, availability of diagnostic testing kits, and capacity-building initiatives.[28]

[v] Global Fund cuts Pakistan's funding by USD 27 million for disease control programs amid rising health crisis

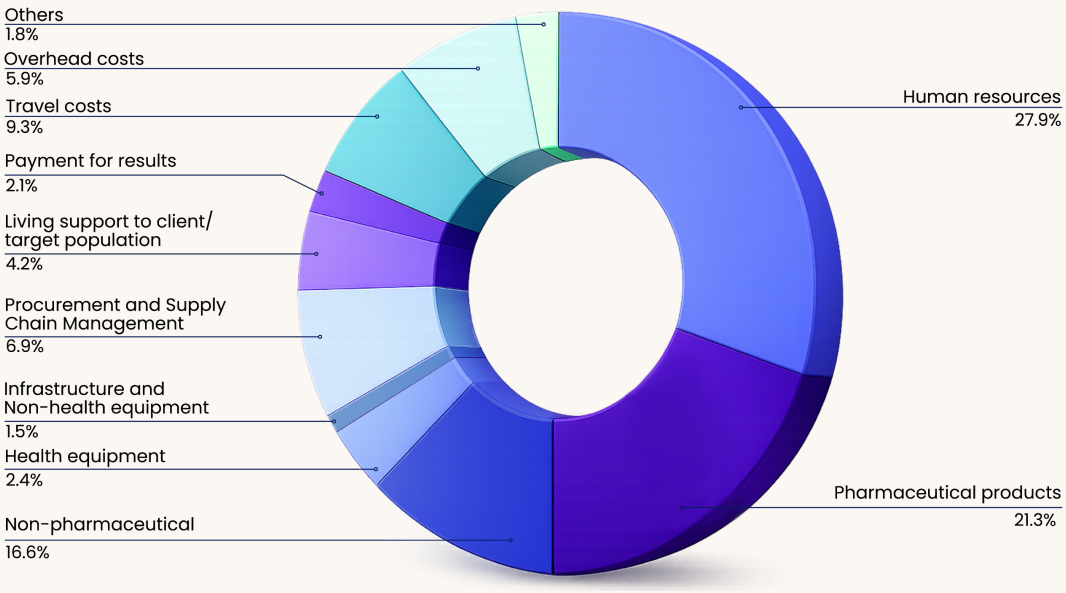
[vi] Global Fund cuts aid to Pakistan despite rising HIV, TB, Malaria

Box 3: Global Fund system-wide support and high dependency

The Global Fund supports critical functions across Pakistan's TB, HIV-AIDS, and malaria response - contributing USD 250.8 million (off-budget) in Grant Cycle 7. Of this, USD 118 million (47%) is used to finance health commodities, equipment, and supply chains.[29]

Figure 5 below presents expenditure categories under Global Fund support.[30]

Global Fund Components Pakistan 2023-2025



Source: Global Fund

For HIV-AIDS, the Global Fund spends eight dollars for every dollar spent by the government.[31] Given the multifaceted support provided by funding under this arrangement, risks and disruptions caused by a reduction in funding are not merely a financial substitution. The public sector would need to absorb functions across the delivery chain — from procurement to community outreach and follow-ups — ensuring capacity to maintain coverage and quality. Projected cuts place treatment for over 42,000 HIV-positive persons at risk, reducing both the capacity to detect new cases and the ability to sustain treatment for diagnosed patients.[32]

Analysis of immunisation programmes financed by Gavi between 2022 and 2024 also reveal similar findings. Gavi disbursed USD 395 million to Pakistan - an average of USD 132 million per year.[vii] Vaccine financing accounts for 88% of this funding. Over time, Gavi has shifted support from general programmatic financing towards specific gaps in government budgets, particularly in outreach to underserved and hard-to-reach regions. Cuts in Gavi funding over 2024–2025 resulted in the layoff of over 200 outreach staff in Lahore District alone.[33]

Box 4: Gavi's vaccine-centric architecture and narrowly targeted support

Gavi funding (USD 395 million, from 2022 to 2024) is off-budget and flows directly through its implementation partners. This funding supports the following critical functions:

- **Vaccine financing:** USD 347 million (88%) covering procurement and logistics of vaccines.
- **Health System Strengthening (HSS):** USD 21.5 million (5.4%) directed towards institutional capacity-building.
- **Targeted Country Assistance (TCA):** USD 9.1 million (2.3%) in technical expertise provided to government stakeholders.
- **Equity Accelerator Fund (EAF):** USD 9.77 million (2.48%) specifically earmarked for reaching zero-dose children in marginalised geographies.

These funding priorities cover gaps in government operations. As an example, hundreds of outreach staff deployed in underserved or hard-to-reach communities are financed through Gavi support.[34]

The potential contraction of Gavi support poses a multidimensional challenge. While it will primarily affect vaccine procurement, it could also undermine critical functions such as community outreach in underserved and high-risk areas adversely impacting immunisation coverage.

Together, these knock-on effects increase the probability of local service disruptions, higher costs, and lower system resilience. ODA cuts should be treated as a direct financing shock and a source of wider systemic risk that requires coordinated monitoring and contingency planning.

[vii] Years 2022-24 were taken because 2025 is ongoing; its financial reporting was not final at the time of this writing.

3.7 Implications of GHI-ODA cuts

ODA cuts are more than a reduction in spending — they are functional shocks, with impact visible in disrupted supply chains, eroded surveillance capacity, and breakdowns in service delivery.

The type of functions impacted by ODA cuts can create differing pathways for adverse impacts observed in service delivery. In some cases, early phases of ODA cuts can appear manageable because only a few cost components shift at once. As more components converge on domestic budgets and systems, pressures intensify. This pattern creates a false sense of stability in the early stages of ODA cuts and delays necessary reforms. However, in other cases, disruptions from ODA cuts can manifest immediately. This creates structural instability where existing arrangements lack the capacity to absorb these shocks.

Limited technical expertise and weak institutional capacity for procurement and supply chain management limit the pace and sophistication of risk mitigation. Governments cannot rapidly and easily replace ODA-funded roles in complex, commodity-intensive programmes. In particular, planning, tendering, quality assurance, and distribution require capacity within government structures.

4. Recommendations: Charting the path to sustainable health financing

For countries like Pakistan, the withdrawal of ODA funding pipelines risks a sharp escalation in disease burdens and a deterioration in health outcomes. The downstream consequences extend well beyond the health sector, eroding the human capital on which Pakistan's long-term development rests. Global outlook for continuously declining ODA flows, particularly for health services, requires an urgent, proactive and dynamic response system. The recommendations below are aimed at enabling decision-makers at the federal and provincial level to undertake targeted actions to understand, prepare and implement mitigation measures.

Establishment of a 'National Health Financing Forum'	
Convening of a multi-stakeholder forum chaired by Federal Minister of Health to develop a Health Financing Framework that aligns allocations with disease burden, equity, and ODA trends. The forum's primary mandate is to serve as a strong convening and coordination mechanism across respective federal and provincial agencies without parallel decision-making functions. Provinces should establish their respective forums in parallel, chaired by the Chief Secretary or comparable office with substantive authority. Khyber Pakhtunkhwa's Interdepartmental Committee on Health Financing provides the working precedent for such a forum. These forums should include senior representatives from Economic Affairs Division (EAD), Ministry of Finance, Ministry of Planning, Development and Special Initiatives, major GHIs, bilateral and multilateral partners, civil society, and the private sector where it holds significant delivery roles.	Ministry of National Health Services, Regulation & Coordination (MNHSR&C) Provincial Health Departments

Development of a national ODA registry	
The development assistance platform at EAD should be enhanced and augmented with strong governance to convert into a comprehensive National ODA Registry. In addition to on-budget ODA being currently recorded, this registry should include all off-budget ODA flows with regular updates. Details for all ODA flows should be mapped against programmes, federal and provincial agencies, and detailed records of programmatic activities and functions support through all ODA to enable generation and use of high-granularity reporting and analytics.	Economic Affairs Division Ministry of National Health Services, Regulation & Coordination (MNHSR&C)

Design and implementation of a health financing risk matrix

Utilisation of the ODA registry by the Health Financing Forums (national and provincial) should lead to the design of an ODA Risk Matrix to develop a clear view of health system exposures that will adversely impact operations and outcomes. The output is a function-level prioritisation across Pakistan's high-footprint programmes — including TB, HIV-AIDS, immunisation, and RMNCH — identifying which functions face the highest risk and why.

The matrix should classify every ODA-financed function against three dimensions:

(i) Substitutability — how readily the function can be absorbed into domestic systems;
(ii) Absorptive capacity — the readiness of provincial procurement, hiring, and supervision systems to take over the function; and
(iii) Systemic criticality — the consequences of substitution failure for population health.

Each provincial health department should also contribute to tailored risk profiles for priority programmes reflecting the specific functions ODA supports there and the readiness of provincial systems to absorb them.

Health Financing Forum

Ministry of National Health Services, Regulation & Coordination (MNHSR&C)

Provincial Health Departments

Forecasting and integrated financial planning

The ODA Registry and Risk Matrix can provide the analytical toolkit for the Health Financing Forum to convene key stakeholders and devise a robust plan for transition management. Key actions on a periodic basis should include:

- Rolling ODA forecasts with detailed scenario planning: gradual, accelerated and abrupt withdrawals
- Projected financing gap assessments and timelines for the high-priority functions.

The forecasts should be produced jointly with federal and provincial finance departments, refreshed each grant cycle, and made available to the forums to inform decisions by the respective offices.

For TB, HIV-AIDS, and EPI, the forums should oversee the development of explicit, time-bound transition plans setting out the sequencing of function transfers, co-financing arrangements, milestones, and triggers for emergency action - aligned with the relevant Global Health Initiative's own transition framework.

Health Financing Forum

Ministry of National Health Services, Regulation & Coordination (MNHSR&C)

Provincial Health Departments

Ministry of Finance

These forecasts and plans should feed directly into Pakistan's medium-term budgetary planning, so that each annual budget round considers projected ODA contractions alongside domestic revenue and expenditure pressures. Without this integration, governments will have to manage withdrawal impacts as a sequence of fiscal adjustments within the year rather than a well-planned and phased health financing arrangement.	Provincial Finance Departments Planning & Development Departments

Reform the rules of the system

Review of all relevant public laws, regulations and administrative directives that govern: • Hiring of market-rate technical staff • Public procurement frameworks to allow for 'pay-as-you-go' and 'pooled-tender models' under which GHI-financed programmes operate • Data governance frameworks to allow for cross-government coordination for disease surveillance and supply chain management. A tailored suite of updates and reforms should be initiated based on the review and identified constraints: • Short-term administrative changes by executive order • Medium-term regulatory amendments • Longer-term legislative reforms. Reforms should be anchored in law to ensure continuity beyond political cycles. Without legal grounding, gains made under one administration risk being unwound by the next.	Public Procurement Regulatory Authorities Provincial Chief Secretaries Law Division / Departments

Domestic resource mobilisation

Commitments by federal and provincial cabinets to increase public health expenditure towards 3% of GDP with a time-bound roadmap. Additional funding should prioritise resources for functions currently financed by ODA: medicines, vaccines, diagnostics, supply chains, disease surveillance, and technical expertise. The commitment should be translated into annual milestones for budget planning and accountability. Development of an innovative financing roadmap that complements public sector funding through new instruments and modalities to crowd-in additional sources of health financing:	Federal and Provincial Cabinets Ministry of National Health Services, Regulation & Coordination (MNHSR&C)

• Pooled donor funds, impact bonds, Islamic finance, and debt-for-development swaps each offer modalities for mobilising non-traditional resources. • Strengthening and expanding public-private partnerships — particularly for primary care, diagnostics, logistics, and facility management — anchored in clear service standards and enforceable equity clauses. • Diaspora and philanthropic financing to be channelled through structured platforms that direct resources towards high-priority, under-served functions and geographies.	Provincial Health Departments Ministry of Finance Provincial Finance Departments

Accelerate technical and operational capacity enhancement

Design and implement an accelerated structured capacity-building programme across the priority functions identified by the risk matrix, covering: • Technical skills (procurement, logistics, surveillance, data analytics) • Institutional capacity (planning, contracting, supplier management) and human resources (recruitment, retention, and remuneration of specialist staff). Training and reform should be sequenced so capacity builds in step with the functions being absorbed. Where appropriate, delivery models developed under high resource ODA projects should be adapted for fiscal realism — streamlined to run within current resource constraints while preserving core functions. Vertical programmes should be progressively integrated where feasible, with shared supply chains, laboratories, information systems, and supervision platforms.	Ministry of National Health Services, Regulation & Coordination (MNHSR&C) Provincial Health Departments

Oversight and adaptive governance

The transition will unfold over multiple budget cycles, electoral terms, and grant cycles. Sustaining it requires continuous administrative and political ownership, not periodic attention when crises emerge. The provincial forums must hold this ownership through structured periodic reviews: (i) quarterly at operational level, (ii) annually for strategic redirection — in which progress against transition plans, registry updates, and risk matrix reassessments are presented, debated, and acted upon. Authority must be devolved to the level at which decisions are being made. Decision-makers at operational level need enabling	Health Financing Forum Provincial Health Departments

conditions to act in an informed manner, with speed and with fair and consistent measures of accountability.	

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[8] The 4% figure is based on the authors' calculations. It includes South Asian countries such as Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka, while excluding Afghanistan. Afghanistan was excluded due to its prolonged conflict situation and comparatively weaker health infrastructure, which could have lowered the regional average and affected the comparability of the analysis.

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