MEASURING THE GLOBAL IMPACT OF PEPFAR DISRUPTIONS

FINDINGS FROM THE PEPFAR PULSE STUDY

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EXECUTIVE SUMMARY

Since 2003, the President's Emergency Plan for AIDS Relief (PEPFAR) has been the backbone of the global HIV response, saving over 26 million lives in over 50 countries. In 2025, a series of United States government executive orders, the dissolution of the United States Agency for International Development (USAID), and the termination of thousands of global health awards severely disrupted PEPFAR implementation. While publicly released PEPFAR data have shown notable drops in service delivery, there has been no official accounting of the current status of the organizations and institutions implementing the PEPFAR program. Documenting what happened to PEPFAR's service delivery partners is a key question to understand what was lost, what remains, and how these changes reshaped HIV service delivery. The PEPFAR Pulse Study was designed to answer this question.

Between November 2025 and April 2026, the PEPFAR Pulse study team conducted a global electronic survey of PEPFAR implementing partners (IPs)—the organizations that received PEPFAR funding to deliver HIV services in 2025. In addition, the study team examined PEPFAR program expenditure data for 2024 and 2025 to compare how cuts to funding aligned with IP-reported service disruptions. Overall, 166 organizations from 46 countries responded to the survey, representing 23% of all PEPFAR IPs. IPs provided information on what happened to their organization's funding, staff, and service delivery in 2025. Across countries, the data reveal deep and uneven damage to HIV services including destabilized HIV treatment programs, a breakdown of HIV prevention work, and the collapse of services for the world's most at risk populations.

KEY FINDINGS

- **Disruptions affected the entire PEPFAR system.** Over 77% of IPs had at least one award terminated or payment delayed during 2025. These terminations contributed to the closure of at least 1,700 service delivery sites (clinics, drop-in centers, etc.) and the termination of over 16,000 full-time staff. Almost no organizations were able to replace lost funding from other funding sources.

- **Even protected services suffered collateral damage.** While the U.S. government directed HIV treatment, testing, and prevention of mother-to-child transmission of HIV (PMTCT) services to continue despite award terminations, 63% of partners still reported a disruption to service delivery as their funding for staff, commodities, and partners were impacted.

- **Cuts were concentrated on services for populations most impacted by HIV.** 73% of IPs previously serving key populations (KP), defined as sex workers, men who have sex with men (MSM), transgender populations, and people who inject drugs (PWID), reported permanently ending a KP service. Among IPs previously providing each service, 67% of IPs discontinued KP-outreach services, 63% stopped any structural interventions, and 65% stopped gender-based violence services for KPs. Even among IPs who did not lose funding, the most commonly dropped services were for KPs (64%).

Photo: Mayur Kakade

Across countries, the data reveal **deep and uneven damage to HIV services** including destabilized HIV treatment programs, a breakdown of HIV prevention work, and the **collapse of services** for the world's most at risk populations.

- **Prevention, a cornerstone of successful epidemic control, has been sharply reduced.**
  Overall, PEPFAR expenditure data show that prevention spending fell 51% from fiscal year 2024 to fiscal year 2025, with condom and lubricant expenditures down 93%. These cuts are reflected in the survey data, with 43% of partners permanently stopping at least one prevention activity. Among IPs previously providing each service, 42% stopped condom programs and 29% stopped offering PrEP.

- **Locally based partners were hit hardest.**
  For years, PEPFAR has worked to send more of its funding to organizations based in the countries where it implements programs, rather than to U.S.-based organizations. This is also a priority shared by the Trump Administration. Yet it was these locally based partners that suffered the most funding disruptions in 2025. Local partners were significantly more likely than international organizations to have an award terminated (63% vs. 41%) and to close service delivery sites (23% vs. 6%).

- **Funding disruptions destabilized interconnected HIV service systems.**
  Nearly one-third (31%) of partners reported interruptions in access to critical HIV data systems, more than half (55%) reported that a partner they rely on to deliver services lost funding, and almost half (47%) reported additional disruptions to HIV commodity supply chains, including challenges accessing condoms, PrEP (pre-exposure prophylaxis), laboratory commodities, and HIV treatment.

- **Disruptions were not limited to funding losses.**
  Even among organizations that did not lose funding, substantial changes were made to organizations' awards and service delivery. More than three-quarters (77%) of IPs reported being asked to comply with new restrictions on their activities as a condition of keeping PEPFAR support. Among fully funded organizations, over 60% stopped providing at least one service and 44% stopped serving a specific population. These disruptions were commonly to key population and prevention services.

Taken together, these results describe widespread degradation of the infrastructure built to deliver HIV services worldwide, with the deepest damage falling on the populations and partners most essential to controlling the epidemic. The disruption reached well beyond the Administration's stated priorities, and services that were explicitly meant to continue were damaged. The partners most impacted by the funding disruptions were local organizations, which are the keystone of a sustainable, locally owned HIV response.

PEPFAR PULSE BY THE NUMBERS

77.2%
OF IMPLEMENTING PARTNERS
had an award terminated or payment delayed during 2025.

72.6%
OF ORGANIZATIONS
providing key population services permanently stopped providing at least one service.

1,714
CLINICS, DROP-IN CENTERS, MOBILE CLINICS, AND SERVICE DELIVERY SITES
closed due to funding cuts.

43.0%
OF ORGANIZATIONS
providing prevention services permanently stopped at least one service.

21.2%
OF ORGANIZATIONS
providing HIV care and treatment stopped at least one service.

63.3% **OF ORGANIZATIONS**
providing prevention of mother-to-child HIV transmission services reported disruptions, with **22.4% ending services entirely**.

Key population-focused programming faced the deepest cuts. These are also the programs least likely to be integrated into primary healthcare systems, particularly where the populations they serve are criminalized or face structural barriers to care. As U.S. assistance shifts to government-to-government (G2G) funding, community-based and key population services face the biggest risks. Other funders, including philanthropic and multilateral partners, can make a substantial impact by directing funds to sustain community-led and key population service delivery. In addition to maintaining HIV treatment programs, national governments must also make a deliberate effort to sustain prevention services and the services that reach marginalized populations. Without these efforts, the twenty years of momentum built toward ending the HIV epidemic is unlikely to survive the transition.

BACKGROUND/CONTEXT

The President's Emergency Plan for AIDS Relief (PEPFAR) is the United States government's bilateral contribution to the HIV response. Since 2003, PEPFAR has saved over 26 million lives[1] by providing HIV treatment and prevention services, and funding healthcare workers who provide care and help detect other emerging infectious disease threats in over 50 countries. Initially created under the George W. Bush Administration, PEPFAR has historically enjoyed a high level of bipartisan support and is recognized as one of the most effective and transparent global health programs in existence.

On 20 January 2025, the Trump Administration released a series of executive orders targeting American foreign assistance. Among these was an order to pause new obligations and the disbursements of funds for a 90-day period, while the Administration conducted a portfolio-wide review of "programmatic efficiencies and consistency with United States foreign policy."[2] While PEPFAR was granted a limited waiver to allow the continued provision of "life-saving" services during the 90-day review, the approved activities were largely confined to HIV treatment, testing, and the prevention of mother-to-child transmission (PMTCT), including pre-exposure prophylaxis (PrEP) for pregnant and breastfeeding women. Nearly all other prevention programming was excluded from the waiver, including PrEP for the general population, voluntary medical male circumcision (VMMC), and other core programming such as services for orphans and vulnerable children, family planning, and most research and data systems work.[3,4]

In the weeks that followed, the Administration moved from pausing aid to dismantling the structures that implemented it, including dissolving the U.S. Agency for International Development (USAID).[5] USAID has historically been the largest implementer of PEPFAR, managing roughly 60% of the program's funding. After the six-week review conducted with the Department of Government Efficiency (DOGE), Secretary Marco Rubio announced in March 2025 that the government was canceling 83% of USAID's programs, or roughly 5,200 contracts, with the remaining 1,000 or so absorbed into the State Department.[6] Early evidence suggested the rapid and large-scale disruption of PEPFAR impacted implementing partners' (IPs) ability to remain financially solvent and continue delivering allowable services.[7] Many of the cuts fell heavily on programs related to gender, equity, and reproductive health—which are essential components of quality HIV care and critical for a successful HIV response.[8,9,10]

Compounding existing pressures on gender-focused programs, the Administration also reinstated and expanded the Mexico City Policy, sometimes called the Global Gag Rule. This policy has historically barred foreign non-governmental organizations (NGOs) that receive U.S. funds from providing or promoting abortion, even with non-U.S. money. However, in January 2026, the Administration further required that recipients must also agree not to provide gender-affirming care,[11] or "diversity, equity, inclusion"-related programming. These policies were also, for the first time, applied to U.S.-based organizations receiving U.S. global health funding.[12] The extent of the programmatic impacts from these expanded policies is not yet known. However, previous work on the 2017 Mexico City Policy expansion found widespread disruptions to PEPFAR programming, reducing a wide scope of HIV and reproductive health services, with disproportionate harm to pregnant women, youth, and key populations.[13]

Early estimates of the impact of 2025 PEPFAR disruptions relied largely on mathematical modeling, which projected tens of thousands of excess HIV-related deaths over the years from the temporary freeze alone.[14] More recently, empirical data have emerged highlighting the longer-term effects of these changes. A facility-level analysis of data from PEPFAR's Monitoring, Evaluation, and Reporting data release for fiscal year (FY) 2025 documented measurable declines across nearly every service area in 2025, including substantial drops in HIV testing, PrEP initiation, and the frontline workforce, with the steepest losses concentrated among community-based services.[15] Country-level studies have reported similar trends in disrupted services. For example, a facility survey in one South African province found that nearly 40% of clinics, serving about half the province's people living with HIV, reported interruptions to services, operations, or staffing.[16] In Nigeria, the number of people receiving PrEP fell from roughly 43,000 in late 2024 to fewer than 6,000 by April 2025—an almost 85% decline in a matter of months.[17] A broader multi-country effort, including a 32-country survey of 103 clinics by the International Epidemiology Databases Evaluating AIDS (IeDEA) consortium, found nearly half of facilities reported significantly disrupted HIV services.[18]

In addition to facility-level or country-level impacts, it is also important to document the effects of the disruption on PEPFAR implementing partners, who are the backbone of PEPFAR service delivery with implications for program sustainability and quality. The PEPFAR Pulse Study was launched to fill these gaps. By surveying IPs across the entire PEPFAR program, it offers a system-wide view, with the dual aim of measuring the historical impact of U.S. government policies on the HIV response, as well as to generate actionable evidence to guide the future of the PEPFAR program.

METHODS

PEPFAR awards are typically issued to 'prime' IPs to implement specific activities either themselves or through their own network of subpartners. IPs consist of organizations from a variety of sectors including NGOs, government, private contractors, academic institutions, and multilaterals. Lists of prime PEPFAR IPs and awards at the country level are available through publicly accessible PEPFAR budget datasets, housed on the PEPFAR Panorama Spotlight.[19] The network of subpartners for PEPFAR awards is not readily available, but can extend to several thousand partners.

From November 2025 to April 2026, an electronic Qualtrics survey was distributed to all prime IPs budgeted to receive funding in FY2025 Country Operational Plans. Organizations operating in more than one country received a separate survey request for each country, so that responses reflected the awards and services in that specific country. Due to limited capacity to conduct active contact solicitation, this study only surveyed prime IPs and did not gather information about terminations or service disruption from sub-partners themselves.

For each IP, the study team sourced contact information through their professional networks and public sources. The survey targeted individuals employed by IPs in each country of operation who were knowledgeable about the organization's awards and services (e.g., country directors, program managers, etc.). Each participant was contacted up to three times before being coded as non-responsive.

The study received a determination of "exempt research; non-human subjects research" by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board in October 2025.

SURVEY

The survey asked respondents about any changes to their awards, programming, staff, site operations, and service delivery between FY24 and FY25 related to changes in PEPFAR funding or policies. IPs were asked to identify what of their FY24 PEPFAR awards were terminated, and, where possible, the reasons for the terminations. For each service that the IP had previously delivered, respondents were asked if they had "reduced" or "stopped" that service either "temporarily" or "permanently." Disruptions to commodities, data systems, referral networks, and subgranting were also captured. Similar questions were asked of IPs who did not lose any funding but may still be impacted by changes in U.S. policy. The survey was available in English, French, and Portuguese.

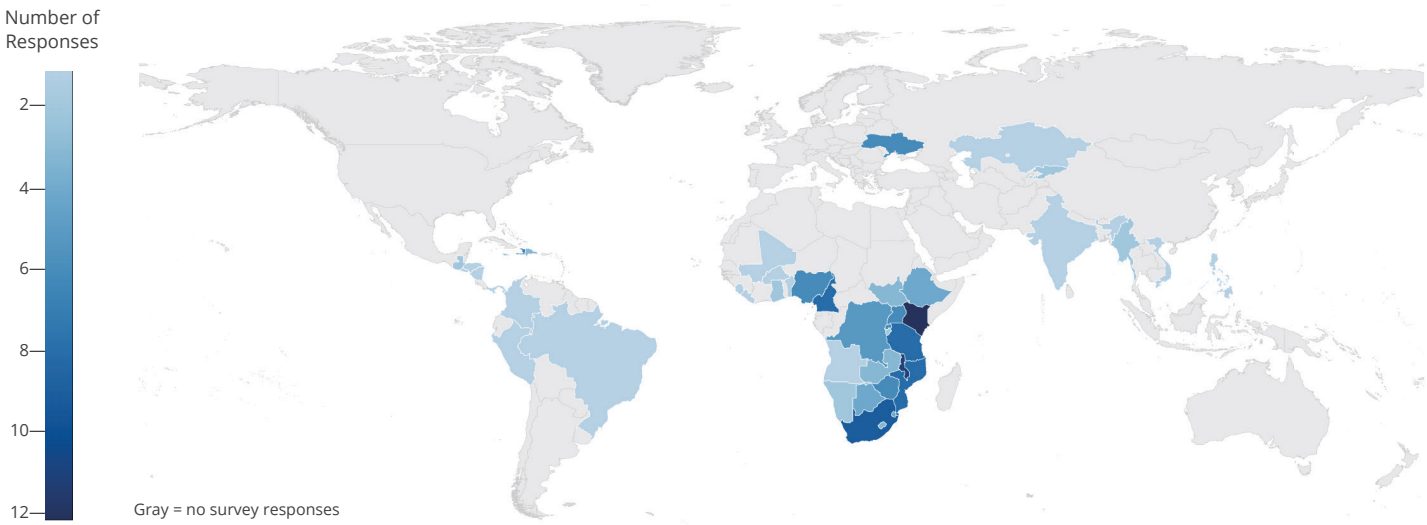
PEPFAR EXPENDITURE DATA

In addition to primary data collection, this report is supplemented by PEPFAR public expenditure data released in April 2026.[19] PEPFAR expenditure data show PEPFAR spending by program and sub-program area for each fiscal year. Expenditure data from FY2025 were assessed against FY2024 to report changes in spending by program category and compared to changes in services delivery identified by the survey.

SAMPLE

Overall, 166 IPs from 46 countries responded to the survey (country mean 3.6 responses; range 1–12), representing 23% of all country-level IPs intended to receive FY2025 PEPFAR funding. Responses came from seven world regions, but were concentrated in Eastern and Southern Africa (Figure 1). Most respondents (39%) came from local NGOs or from international NGOs (28%);

Figure 1: Survey Responses Per Country



other organization types included universities, governments, faith-based organizations, multilaterals, and contractors (Table 1). For the purposes of this analysis, an organization was classified as local if it was headquartered in the same country in which the award was implemented.

Researchers compared the characteristics of the IPs that were included in the sample to the full list of PEPFAR IPs in order to better understand the representativeness of the study sample. IPs in the survey self-reported organization type and location. For all other listed IPs who did not respond to the survey, researchers manually reviewed public records of the organization in the U.S. government website on federal spending[20] to make a determination based on headquarter location and organization categorization. Overall, local NGOs were overrepresented in survey respondents (>5% difference from all PEPFAR IPs) and national government and international private contractors were under-represented (Table 1). By region, responses from Asia and the Pacific were underrepresented (>5% difference from all PEPFAR IPs) and Western and Central Africa were moderately over-represented (>3% difference).

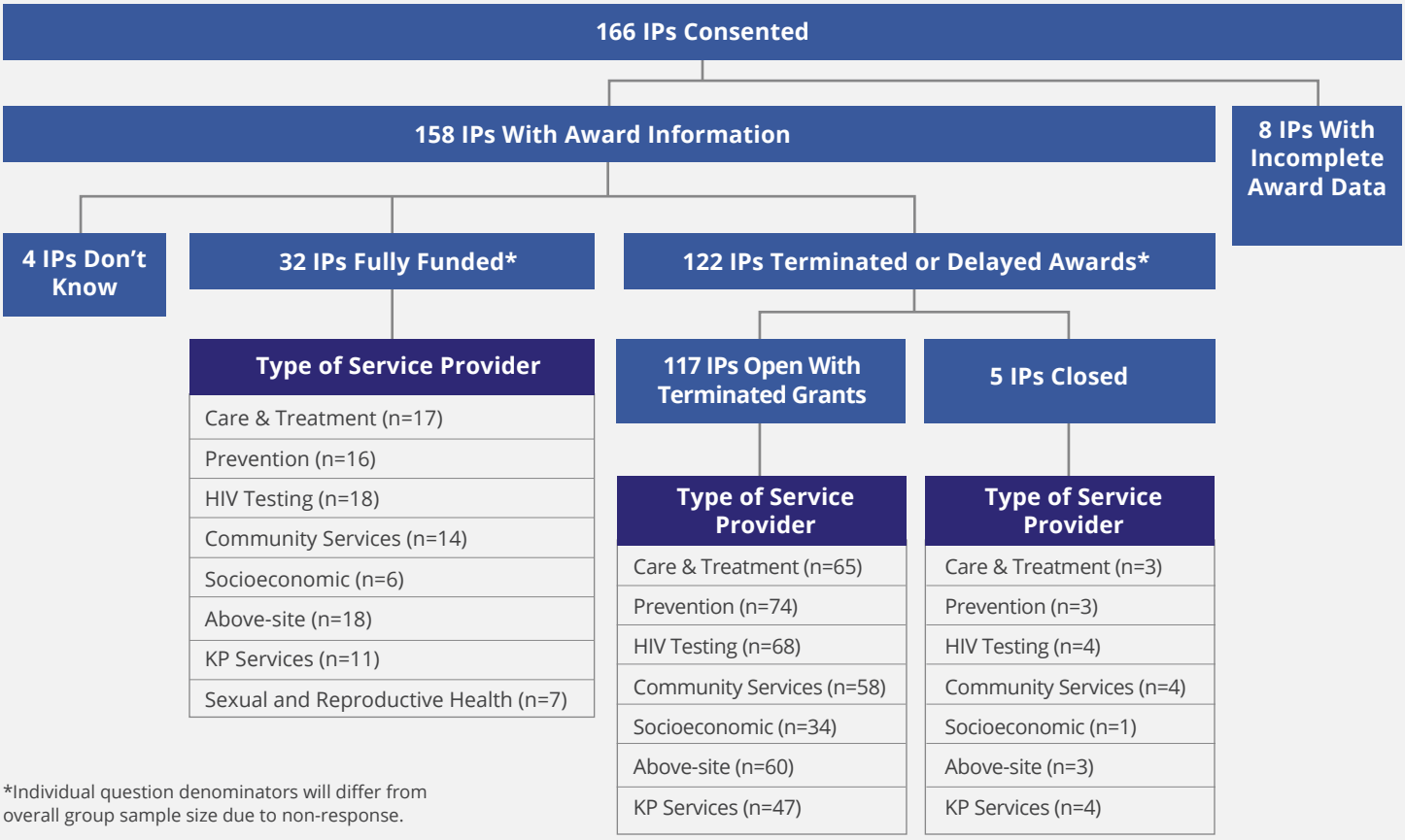
Table 1: PEPFAR Pulse Sample Comparison to All PEPFAR Partners

	ALL PEPFAR IPs (%)	SAMPLE IPs (%)	REPRESENTATIVENESS (% difference)*
IP type			
International NGO	23.3	28.3	5.0
Local NGO	21.3	38.6	17.3
National government	16.6	7.8	-8.8
International private contractor	13.8	3.6	-10.2
Multilateral agency	7.6	3.6	-4.0
International university	7.3	7.2	-0.1
Local university	3.2	1.8	-1.4
Local faith-based organization	2.5	3.0	0.5
Local private contractor	1.8	3.0	1.2
International faith-based organization	1.3	0.6	-0.7
Local KP-led organization	1.1	2.4	1.3
Region			
Asia and the Pacific	8.5	3.0	-5.5
Central Asia	2.3	1.8	-0.5
Eastern and Southern Africa	57.3	55.4	-1.9
Europe	1.4	3.6	2.2
Latin America and the Caribbean	12.4	14.5	2.1
Western and Central Africa	18.1	21.7	3.6

* ≤2.9% = light blue, 3% - 5% =yellow, ≥ 5.1% = orange

Throughout the report, denominators will differ based on which respondents answered the question. For example, loss of prevention services will only be calculated among those IPs which were previously providing prevention services. Not all respondents finished the survey and stopped at various times throughout. Respondents were also given the option to "refuse" or answer "don't know" to any question, which will affect indicator-specific sample sizes. Additionally, some questions which were "select all" will sum to more than 100% as respondents reported multiple categories of disruptions. Figure 2 displays the broad categories of respondents throughout the survey.

Figure 2: Survey Participant Flow Chart



*Individual question denominators will differ from overall group sample size due to non-response.

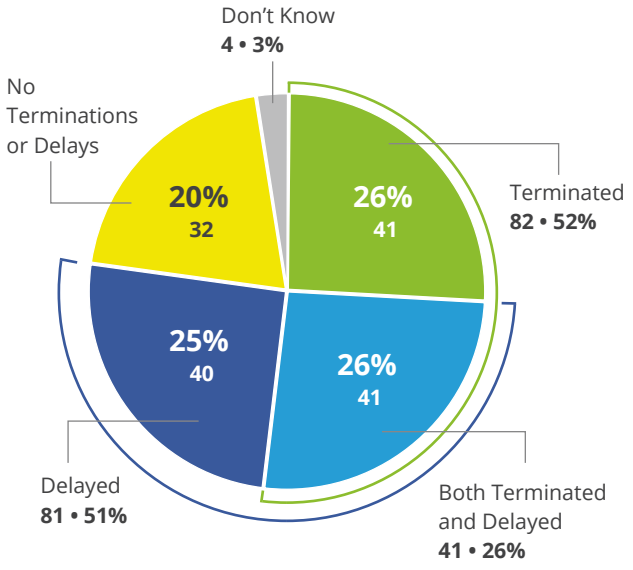
RESULTS

Widespread Funding Disruption and Site Closures

Data show widespread disruptions to IP funding, with the majority of respondents (77.2%, n=122) reporting at least one terminated award or an award for which payment was delayed. About half of respondents, 51.9% (n=82), reported at least one of their PEPFAR awards was terminated early. Similarly, 51.3% (n=81) reported that at least one of their awards was delayed or may not be paid (Figure 3). Terminations were recorded in every region receiving PEPFAR support, with no statistically significant differences by region.

Even termination of a single award can have substantial impacts on organizational operations as many IPs were substantially dependent on PEPFAR funding prior to cuts. The majority of IPs (57.8%, n=93) reported that PEPFAR made up more than half of their FY2024 budget, and 44.7% (n=72) reported PEPFAR funding was between

Figure 3: PEPFAR Award Terminations and Delays, Among All Respondents (n=158)



75% and 100% of their budget. Importantly, the most common source of other funds in IPs' budgets was from other U.S. government funding (34.2%, n=54), followed by the Global Fund (32.3%, n=51). PEPFAR reductions were just one of several simultaneous funding shocks in 2025, including cuts to other non-PEPFAR U.S. government funding streams and a recall of already allocated Global Fund funding for the first time in its history. As a result, many IPs faced compounding financial crises not fully captured by PEPFAR funding reductions. In the PEPFAR Pulse data, **five prime IPs reported fully closing, with three closing as a direct result of losing PEPFAR funding**. However, this is likely a significant undercount, since closed organizations would no longer have active email accounts by which to receive the survey.

PEPFAR IPs operate across both government facilities and stand-alone sites such as population specific drop-in centers (DICs) and mobile clinics. When an IP stops working at a site, the effect can range from a full closure, where loss of funds prompts a site closure, to a partial reduction, where some services are cut but the site stays open. The number of sites reported closing as a result of funding cuts to IPs varied by site type including public health facilities, access points, and DICs (Table 2). Of these closed sites, most were in Western and Central Africa (869) and in Eastern and Southern Africa (799). Mobile clinics and DICs represent a smaller share of total site closures, but are sometimes the only safe access point for key populations, particularly in settings where same-sex relationships or drug use are criminalized. Indeed, most DIC closures were in countries that criminalize more than one key population: 100% (n=126) of closed DICs were located in countries that criminalize drug use, 86.5% (n=109) were in countries that criminalize sex work, and 41.3% (n=52) were in countries that criminalize same-sex relations.

Table 2. Number of Site Closures by Type

Site Type	Number
Public Health Facilities	1,010
Service Delivery or Access Points Within a Larger Clinic	325
Private HIV Specific Facilities	206
Drop-in Centers/One-Stop Shops for Specific Populations	126
Mobile Clinics	47
Total	**1,714**

The **number of sites reported closing** as a result of funding cuts to IPs **varied by site type** including public health facilities, access points, and drop-in centers. Of these closed sites, most were in Western and Central Africa (**869**) and in Eastern and Southern Africa (**799**).

Limited Replacement Funding

Among respondents with at least one terminated or delayed PEPFAR award, nearly half (44.1%, n=49) successfully identified additional funding sources after the loss of U.S. funding. However, the vast majority of these IPs (95.9%, n=47) indicated that these alternative funding streams did not adequately offset the funding loss from PEPFAR terminations. Most commonly, additional funding came from U.S.-based private foundations (47.9%, n=23). Host-country governments increased support among 14.6% (n=7) of IPs, demonstrating that while some governments may have increased financial support for HIV programming, it may not be reaching the same IPs which historically implemented services.

Among respondents with new sources of funding (n=48), funds were most commonly directed to prevention programming (Figure 4) and to adolescent girls and young women (41.7%, n=20) or were not population-specific (37.5%, n=18) (Figure 5). Notably, new funding was rarely directed to key populations who are, to a large extent, the populations most impacted by award terminations and exclusionary U.S. policies, and who account for the majority of new HIV infections globally (55%).[21]

Figure 4: Percent of IPs Receiving New or Increased Financial Support by Program Area (n=48)

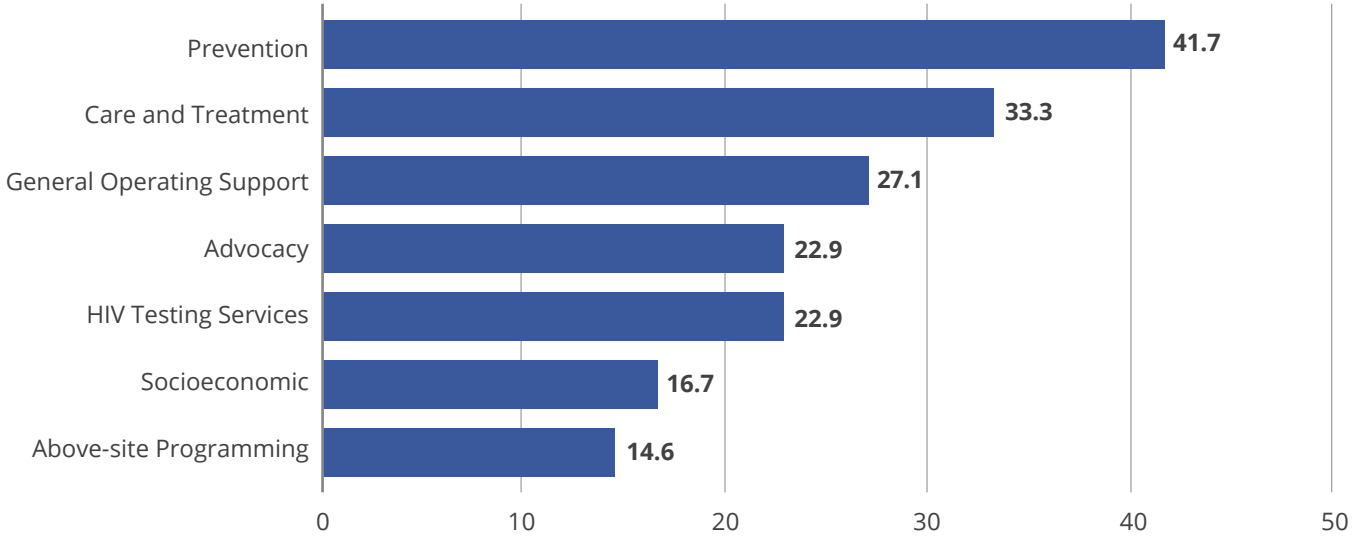
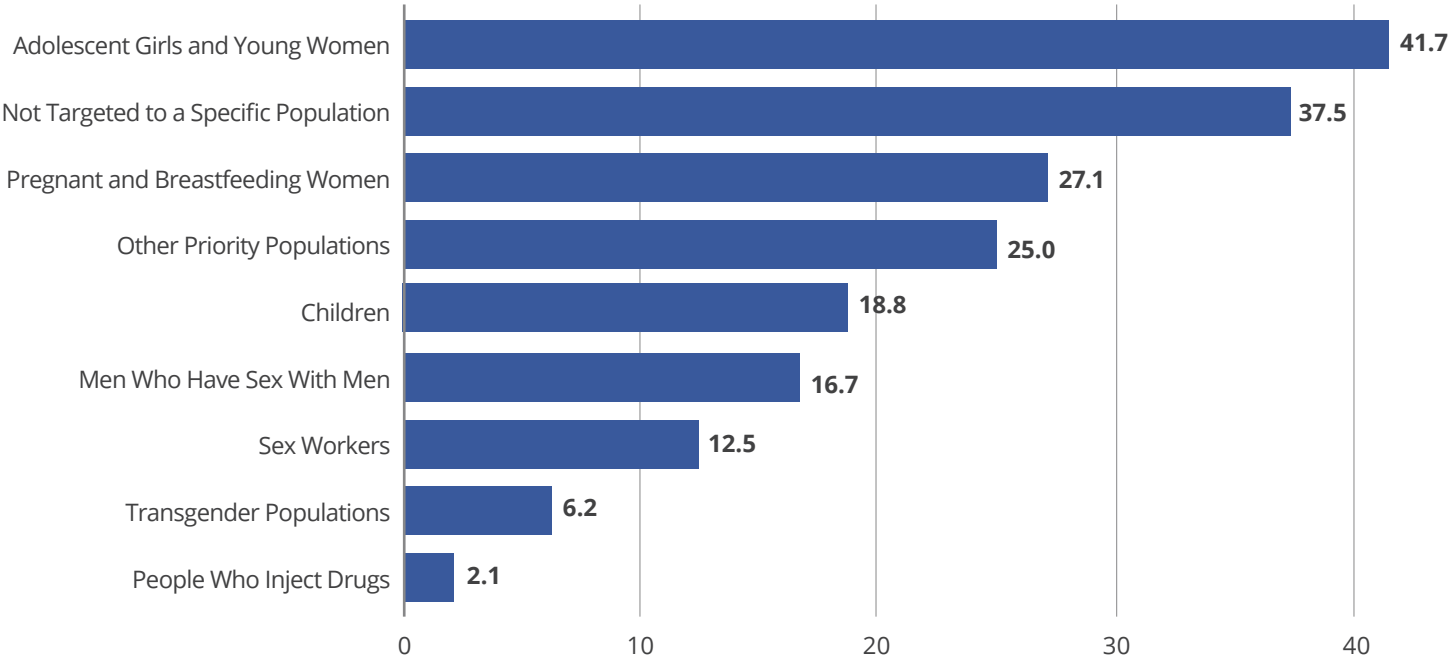


Figure 5: Percent of IPs Receiving New or Increased Financial Support by Population Type (n=48)



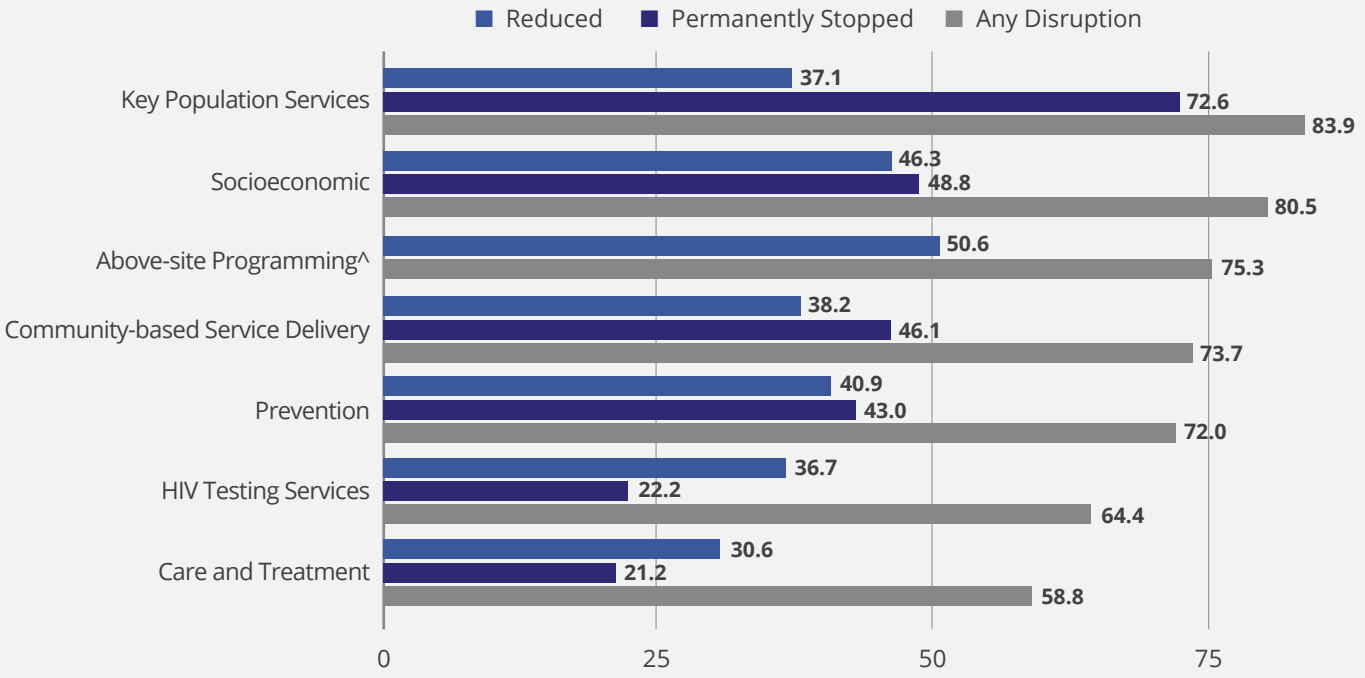
Service Disruptions Across the Cascade

Service disruptions were widespread across the HIV care cascade. For each service, disruptions were measured only among organizations who previously provided that service. Therefore the analysis will show the level of disruption for each service, rather than how common the service was across the whole sample.

Across all program areas, KP programming was the hardest hit (Figure 6). Among IPs that previously provided KP services, 83.9% (n=52) reported service disruptions with 72.6%, (n=45) permanently stopping at least one KP-specific service. Other highly impacted program areas included socioeconomic support services, above-site programming,[22] community-based service delivery, and prevention services.

Even among partners delivering HIV care and treatment, typically the most protected programming, 58.8% reported a disruption to service delivery, with 21.2% reporting having permanently stopped at least one care and treatment activity.

Figure 6: IPs Stopping or Reducing at Least One Activity by Program Category, Among IPs Previously Implementing These Services*

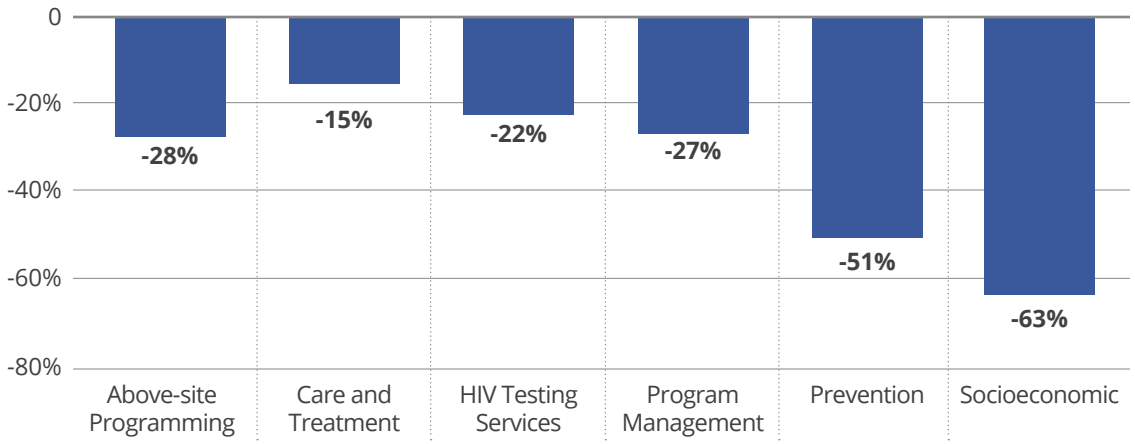


*Percentages are among IPs previously implementing these services by category.

^Due to an error in coding the response option "permanently stopped" was not visible to some respondents and is missing from reporting.

PEPFAR expenditure data, which track actual spending by program area, provide independent corroboration of these self-reported reductions. Between FY24 and FY25, spending on socioeconomic and prevention programming fell by 63% and 51% respectively, the steepest declines of any area. Spending on HIV care and treatment, which was intended to be protected by the waiver, fell 15% (Figure 7).

Figure 7: Percentage Change in PEPFAR Program Expenditure by Area, FY24 to FY25



Prevention

Within prevention programming, violence prevention and response programming and PrEP services were most likely to be disrupted, with 92.3% and 87.3% of IPs reporting that they reduced or stopped programming, respectively. Permanent service stoppages were most common for condoms and lubricants (42.2%, n=19) and non-biomedical HIV prevention (38.0%, n=19) (Table 3).

Despite PMTCT services ostensibly being protected from funding cuts under waivers from the U.S. government, nearly two thirds of IPs (63.3%) who previously offered PMTCT reported reducing or stopping the service. These reductions or stoppages may have occurred due to disruptions in other award-funded activities, confusion about implementing the waiver, loss of staff supporting these services, and broader supply chain or partner organization breakdowns that affected program delivery.

PrEP programming was not explicitly included as a "lifesaving intervention" under the U.S. government waiver, except for delivery to pregnant and breastfeeding women. Reflecting these limited protections for PrEP services, many IPs reported high levels of disruptions. Despite the guidance that PrEP should continue to be delivered to pregnant and breastfeeding women, 29.4% (n=10) of organizations permanently stopped serving these populations. PrEP for key and vulnerable populations was extremely impacted with over 40% of PrEP-providing organizations permanently stopping PrEP for MSM, adolescent girls and young women (AGYW), transgender populations, sex workers (SW), and PWID (Table 4).

Despite PMTCT services ostensibly being **protected from funding cuts** under waivers from the U.S. government, **nearly two thirds of IPs (63.3%)** who previously offered PMTCT reported reducing or stopping the service.

Table 3: HIV Prevention Services Reduced or Stopped by IPs as a Result of PEPFAR Disruptions, Among Partners That Previously Offered Each Service, %(n)

Prevention: Among IPs Previously Offering Service (n)	Reduced	Stopped Temporarily	Stopped Permanently	Any Disruption
Violence prevention and response (52)	44.2% (23)	13.5% (7)	34.6% (18)	92.3% (48)
PrEP (55)	41.8% (23)	16.4% (9)	29.1% (16)	87.3% (48)
Non-biomedical HIV prevention (50)	32.0% (16)	16.0% (8)	38.0% (19)	86.0% (43)
Condom & lubricant programming (45)	33.3% (15)	8.9% (4)	42.2% (19)	84.4% (38)
Medication assisted treatment (30)	26.7% (8)	16.7% (5)	26.7% (8)	70.0% (21)
PMTCT (49)	24.5% (12)	16.3% (8)	22.4% (11)	63.3% (31)
VMMC (24)	20.8% (5)	4.2% (1)	37.5% (9)	62.5% (15)

Note: Data include all IPs with terminated or delayed awards, excludes fully funded IPs.

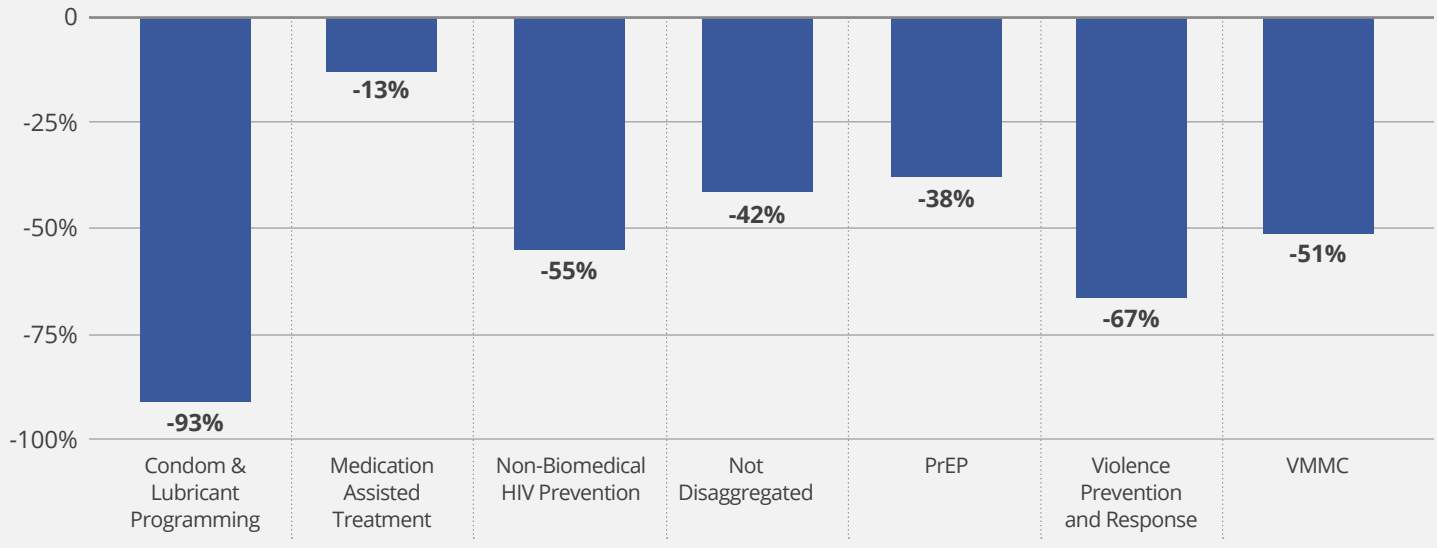
Table 4: Changes in PrEP Service Provision by IPs as a Result of PEPFAR Disruptions, by Priority Population Previously Served, %(n)

Population: Among IPs Previously Offering Service (n)	Reduced	Stopped Temporarily	Stopped Permanently	Any Disruption
Sex workers (33)	36.4% (12)	15.2% (5)	42.4% (14)	93.9% (31)
MSM (32)	34.4% (11)	9.4% (3)	46.9% (15)	90.6% (29)
AGYW (36)	25.0% (9)	19.4% (7)	44.4% (16)	88.9% (32)
Transgender (29)	27.6% (8)	13.8% (4)	44.8% (13)	86.2% (25)
Non-targeted (28)	25.0% (7)	14.3% (4)	35.7% (10)	75.0% (21)
PWID (25)	12.0% (3)	16.0% (4)	44.0% (11)	72.0% (18)
Prisoners (19)	10.5% (2)	10.5% (2)	47.4% (9)	68.4% (13)
Pregnant women (34)	17.6% (6)	8.8% (3)	29.4% (10)	55.9% (19)

Note: Data include all IPs with terminated or delayed awards, excludes fully funded IPs.

Changes in PEPFAR prevention expenditures between FY2024 and FY2025 mirror changes indicated by IPs, with overall prevention expenditures decreasing by 51% or $270 million USD. The largest percent drop in expenditures by prevention sub-category was to condom and lubricant programming which saw a 93% drop (Figure 8).

Figure 8: Percentage Change in PEPFAR Prevention Expenditures, FY24 to FY25



Testing

Overall, community testing was most likely to be disrupted, with 82.0% (n=50) of IPs reporting reducing or stopping the service. Community-based testing and self-testing were most likely to be permanently stopped, each with about 24% of IPs reporting (Table 5). The same trends followed in PEPFAR expenditure data where overall reductions in expenditures for HIV testing between FY24 and FY25 were 22%, but community testing expenditures decreased by 30% compared to a 16% reduction in facility-based testing.

Table 5: HIV Testing Services Reduced or Stopped by IPs as a Result of PEPFAR Disruptions, Among Partners That Previously Offered Each Service, % (n).

Testing: Among IPs Previously Offering Service (n)	Reduced	Stopped Temporarily	Stopped Permanently	Any Disruption
Community-based Testing (61)	42.6% (26)	14.8% (9)	24.6% (15)	82% (50)
Self Testing (50)	32.0% (16)	10.0% (5)	24.0% (12)	66.0% (33)
Facility-based Testing (54)	25.9% (14)	14.8% (8)	18.5% (10)	59.3% (32)

Note: Data include all IPs with terminated or delayed awards, excludes fully funded IPs.

Care and Treatment

Within HIV care and treatment services, HIV clinical services were the most likely to be disrupted, with 67.3% (n=37) of IPs reporting reducing or stopping services (Table 6). This is particularly notable given that HIV treatment was supposed to be maintained in its entirety under PEPFAR's continuation of services, yet roughly a third of partners still reported reducing core treatment-related services (30.9% for clinical services; 33.3% for drug procurement; and 27.3% for laboratory services). This suggests that the directive to maintain treatment alone was not sufficient to preserve service delivery, likely due to disruptions in other parts of organizational awards, staff reductions, supply chain issues, or partner organization breakdowns. Of note, tuberculosis (TB) programming was also frequently disrupted with 21.6% (n=11) of organizations permanently stopping TB service delivery. While TB is categorized under HIV care and treatment in PEPFAR's framework, it sits at the intersection of two disease programs and may have been more vulnerable to disruption given the prioritization of HIV treatment continuity.

Table 6: HIV Care and Treatment Services Reduced or Stopped by IPs as a Result of PEPFAR Disruptions, Among Partners That Previously Offered Each Service, % (n).

Care and Treatment: Among IPs Previously Offering Service (n)	Reduced	Stopped Temporarily	Stopped Permanently	Any Disruption
HIV clinical services (55)	30.9% (17)	16.4% (9)	20% (11)	67.3% (37)
HIV laboratory services (44)	27.3% (12)	18.2% (8)	18.2% (8)	63.6% (28)
HIV drug procurement (42)	33.3% (14)	14.3% (6)	14.3% (6)	61.9% (26)
TB services (51)	21.6% (11)	13.7% (7)	21.6% (11)	56.9% (29)

Note: Data include all IPs with terminated or delayed awards, excludes fully funded IPs.

Within **HIV care and treatment services**, HIV clinical services were the most likely to be disrupted, with **67.3% of IPs reporting** reducing or stopping services.

Collapse of Community, Key Population, and Wrap-Around Services

Much of PEPFAR's success in reducing HIV transmission and improving treatment outcomes has been attributed to the program's investment in reaching and retaining the hardest-to-reach populations, including KPs. These populations are most often reached through community-based service delivery and supported by socioeconomic, or "wrap-around," services that address the structural barriers to HIV care. Within the PEPFAR Pulse Study, the most heavily disrupted service categories following PEPFAR funding changes were to KP services, community-based services, and socioeconomic support services.

Key Population Services

KP services were highly disrupted, with nearly all IPs reporting disruptions to their KP outreach, prevention, and peer education services. KP-specific outreach services were the most likely to be stopped permanently (66.7%, n=26), followed by KP-focused gender-based violence services (64.7%, n=22) and KP-focused structural interventions such as legal strategies, stigma and discrimination mitigation, mental health services, and economic empowerment (63.3%, n=19) (Table 7).

Within the PEPFAR Pulse Study, **the most heavily disrupted service categories** following PEPFAR funding changes were to KP services, community-based services, and socioeconomic support services.

Table 7: KP Services Reduced or Stopped by IPs as a Result of PEPFAR Disruptions, Among Partners That Previously Offered Each Service, % (n).

Key Population Services: Among IPs Previously Offering Service (n)	Reduced	Stopped Temporarily	Stopped Permanently	Any Disruption
KP peer educators (42)	33.3% (14)	4.8% (2)	59.5% (25)	97.6% (41)
KP prevention services (42)	33.3% (14)	11.9% (5)	52.4% (22)	97.6% (41)
KP outreach services (39)	23.1% (9)	7.7% (3)	66.7% (26)	97.4% (38)
KP gender-based violence services (34)	20.6% (7)	8.8% (3)	64.7% (22)	94.1% (32)
KP-focused structural interventions (30)	23.3% (7)	6.7% (2)	63.3% (19)	93.3% (28)
KP–specific service sites (32)	21.9% (7)	6.2% (2)	56.2% (18)	84.4% (27)
Medication assisted treatment (27)	14.8% (4)	11.1% (3)	55.6% (15)	81.5% (22)

Note: Data include all IPs with terminated or delayed awards, excludes fully funded IPs.

Community-Based Services

Community-based services were highly disrupted, with over 80% of IPs reporting disruptions in every service category (Table 8). Of all community-based services, community-led monitoring was the most likely to be stopped permanently (62.2%, n=23), followed by support for peer-led community educators (41.7%, n=20) and community adherence clubs (41.5%, n=17). Notably, the loss of community-led monitoring is compounded by simultaneous disruptions to PEPFAR's data and reporting systems, meaning that both the community-based and centralized mechanisms for tracking service delivery were diminished during the same time. Direct service delivery mechanisms within communities were also frequently stopped permanently, including community-based outreach (37.3%, n=19), community-based return-to-care services such as home visits (35.4%, n=17), and community ARV pick-up (35.7%, n=15). These community-based services both connect vulnerable groups to HIV care and keep people engaged in treatment. Cutting these services is expected to erode treatment continuity broadly while widening access inequities for young people, rural populations, and key populations.

Photo: Victor Balaban

Community-based services were highly disrupted, with **over 80% of IPs reporting disruptions** in every service category.

Table 8: Community-based Services Reduced or Stopped by IPs as a Result of PEPFAR Disruptions, Among Partners That Previously Offered Each Service, % (n).

Community-based Services: Among IPs Previously Offering Service (n)	Reduced	Stopped Temporarily	Stopped Permanently	Any Disruption
Community-based outreach (51)	35.3% (18)	19.6% (10)	37.3% (19)	92.2% (47)
Peer-led educators (48)	33.3% (16)	16.7% (8)	41.7% (20)	91.7% (44)
Community-led monitoring (37)	21.6% (8)	5.4% (2)	62.2% (23)	89.2% (33)
Community adherence clubs (41)	24.4% (10)	22.0% (9)	41.5% (17)	87.8% (36)
Community-based return to care services (48)	35.4% (17)	14.6% (7)	35.4% (17)	85.4% (41)
Community ARV pick-up (42)	35.7% (15)	11.9% (5)	35.7% (15)	83.3% (35)

Note: Data include all IPs with terminated or delayed awards, excludes fully funded IPs.

Socioeconomic Support Services

Of previously supported socioeconomic support services, education assistance (57.7%, n=15) and economic strengthening (57.1%, n=16) were the most likely to be stopped permanently (Table 9). Psychosocial support and case management were more often reduced than stopped permanently, with 51.9% (n=14) of partners reporting reductions in psychosocial support and 53.8% (n=14) reporting reductions in case management. These survey findings align with PEPFAR expenditure data, which show large reductions in spending on socioeconomic support services between FY24 and FY25 (Figure 9).

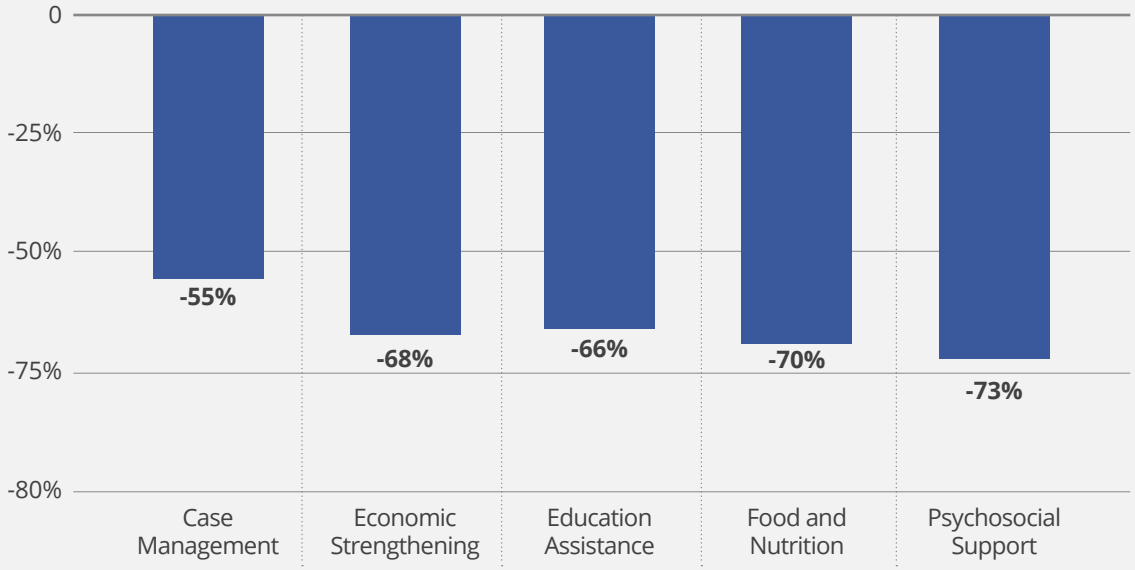
Of previously supported socioeconomic support services, **education assistance** (**57.7%**) and **economic strengthening** (**57.1%**) were the most likely to be stopped permanently.

Table 9: Socioeconomic Support Services Reduced or Stopped by IPs as a Result of PEPFAR Disruptions, Among Partners That Previously Offered Each Service, % (n).

Socioeconomic Support: Among IPs Previously Offering Service (n)	Reduced	Stopped Temporarily	Stopped Permanently	Any Disruption
Economic strengthening (28)	32.1% (9)	7.1% (2)	57.1% (16)	96.4% (27)
Psychosocial support (27)	51.9% (14)	7.4% (2)	33.3% (9)	92.6% (25)
Education assistance (26)	30.8% (8)	3.8% (1)	57.7% (15)	92.3% (24)
Food and nutrition (22)	40.9% (9)	4.5% (1)	45.5% (10)	90.9% (20)
Case management (26)	53.8% (14)	3.8% (1)	30.8% (8)	88.5% (23)

Note: Data include all IPs with terminated or delayed awards, excludes fully funded IPs.

Figure 9: Percentage Change Socioeconomic Programming Expenditures, FY24 to FY25



Disproportionate Impact on Local Organizations

Over the past decade, PEPFAR explicitly worked to shift funding from U.S.-based international organizations to local implementing partners, with the goal of building sustainable, locally led HIV responses. This theme is echoed in the America First Global Health Strategy, which articulates some of the reasoning behind recent U.S. foreign aid policy changes.[23] However, findings from the PEPFAR Pulse Study show the changes to the PEPFAR program in 2025 prompted the opposite effect, with locally based organizations reporting significantly higher rates of award terminations and site closures compared to international partners (Table 10).

Local partners were significantly more likely to experience award terminations (62.9% vs. 40.6%, p=0.008) and site closures (23.3% vs. 5.9%, p=0.004), while international partners were more likely to report award delays (65.6% vs. 47.7%, p=0.043). Local and international IPs were similarly likely to be asked to comply with additional U.S. policy restrictions (77.9% vs. 85.9%, p=0.290) (Table 10).[24] Additionally, local organizations reported a higher median number of locally based full-time equivalent (FTE) positions eliminated (median=12) compared to international organizations (median=2).

These patterns suggest that local implementing partners bore the brunt of the funding cuts, while international partners more often experienced award modifications that allowed continued operation. This may reflect differences in organizational size, financial reserves, or contracting structures, but it may also reflect the types of services local partners tend to deliver, since community-based and key population services were among the categories most likely to be reduced or dropped from programming altogether.

Local partners were significantly more likely to **experience award terminations and site closures**, while international partners were more likely to report **award delays**.

Table 10: Organizational Disruptions Reported by IPs Due to PEPFAR Disruptions, By IP Type

Outcome	Local Organizations[a]	International Organizations	P-value[b]
≥1 terminated award	62.9% (n=56/89)	40.6% (n=26/64)	0.008*
≥1 award delayed/may not be paid	47.7% (n=41/86)	65.6% (n=40/61)	0.043*
Any site closures	23.3% (n=21/90)	5.9% (n=4/68)	0.004*
Asked to comply with additional U.S. policies	77.9% (n=67/86)	85.9% (n=55/64)	0.290

a. Local partners defined as those headquartered in the same country as the award implementation.

b. p-values calculated using Fisher's exact test.

* $p < 0.05$.

Health System Impacts

Staff Reductions

PEPFAR disruptions resulted in widespread staff reductions across IPs, with severance costs largely absorbed by U.S. awards. Among open IPs with terminated or delayed awards, 87.2% (n=95/109) reported staffing reductions as a result of PEPFAR disruptions. Across the 95 organizations reporting eliminated positions, a reported 16,452 FTE positions were lost (14,173 FTE across 90 open organizations and 2,279 FTE across 5 closed organizations). These FTE figures reflect locally based staff only, meaning staff based in the country of award implementation. Of organizations that reduced staff, 73.7% (n=73/99) were required to pay severance or termination-related costs. Among those that paid severance, 70.8% (n=51/72) were able to charge those costs to their U.S. awards.

Across the **95 organizations** reporting eliminated positions, a reported **16,452 FTE positions were lost**.

Photo: Joseph Sohm/Shutterstock.com

Sub-granting

Sub-granting is a common feature of PEPFAR implementation, with prime recipients of U.S. funding passing portions of their awards to other organizations. These sub-grantees are often smaller local partners that deliver services on the ground and have strong relationships with the community. This layer of the system was widely disrupted. Among organizations who report sub-granting in 2025, 80.0% (n=56/70) reported changing their sub-granting practices as a result of PEPFAR policy or funding changes. Most often, prime partners report having to cut off an award to a sub-grantee entirely (64.3%, n=36/56) or reduce funding to a sub-grantee (41.1%, n=23/56). These cuts fell overwhelmingly on local organizations, with 80.6% of IPs reporting they canceled an award to a locally based sub-grantee, vs. 8.3% to an internationally based sub-grantee.

The consequences of award termination to sub-grantees was severe, with 20% (n=14/70) of IPs who had sub-granted in 2025 reporting that at least one of their sub-grantees had closed as a result of PEPFAR funding loss. Since the survey reached prime IPs rather than sub-grantees directly, and primes tend to be larger organizations better able to absorb funding shocks than the smaller sub-grantees they fund, these figures offer only a partial view of closures across the wider sub-grantee network.

Data Systems

PEPFAR has historically played a critical role in both supporting its own data system but also strengthening data quality, use, and systems within partner countries. In 2025, disruptions to data systems were common with 30.5% (n=40) of IPs who remained open reporting interruptions in access to necessary data systems. Among respondents reporting interruptions to data access, the most common reasons for disruptions were loss of staff responsible for data entry or management (42.5%, n=17), loss of access to reporting tools (22.5%, n=9) and loss of access to historical data bases or data (12.5%, n=5).

Referral Networks

PEPFAR awards are not end-to-end, meaning a single award does not cover the full chain from procurement to service delivery. Instead, the program relies on a complex network of partners working together, where one partner might handle medicine procurement, another distribution, and another clinic-level service delivery. This interdependence means that funding disruptions to one partner can ripple through the network and affect the work of partners whose own funding remains otherwise intact or less impacted. More than half (55%, n=60) of

open IPs which were direct service providers reported that a partner they rely on to deliver services lost funding. Among the 49 IPs describing how this affected their work, the most common impacts were disrupted referral networks for clients (63.3%, n=31), advocacy work (46.9%, n=23), and data support (44.9%, n=22) (Figure 10). Even for IPs without any terminated or delayed awards, 39% (n=9/23) reported that a partner they relied on to deliver services lost funding, and of those, 78% (n=7/9) had to reduce or stop at least one service.

Commodities

Almost half (46.8%, n=51/109) of IPs which were direct service providers reported additional challenges accessing commodities due to PEPFAR funding disruptions. IPs most frequently reported issues accessing condoms (22.9%, n=25), lab commodities (22.9%, n=25), PrEP (22.0%, n=24), and HIV treatment (20.2%, n=22) (Table 11). This could be due to cuts to commodity awards themselves, or indirect disruptions to the supply chain due to diminished funding and staff power across implementing organizations.

Figure 10: Percent of IPs Reporting Each Type of Work Disruption After a Partner Lost Funding (n=49)

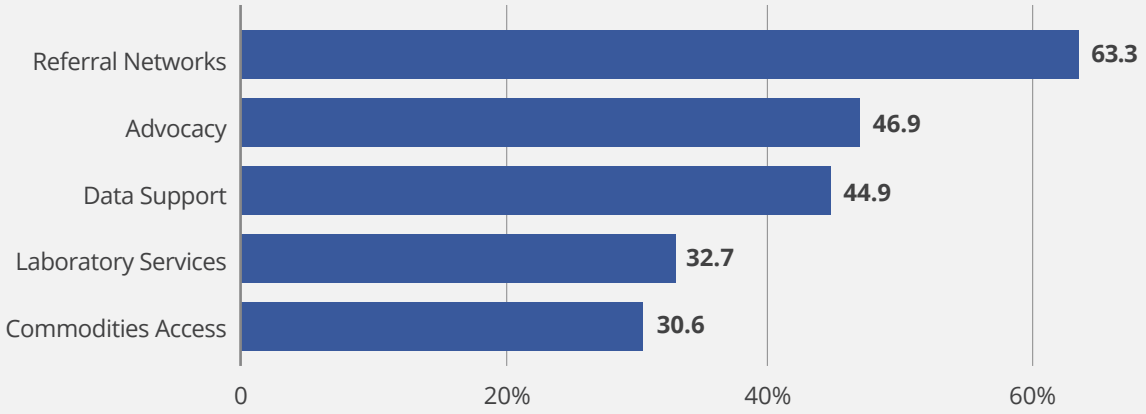


Table 11: Additional Commodity Challenges Reported by IPs Since PEPFAR Disruptions

Commodity	Open Direct Service IPs (n=109)	Percentage
Condoms	25	22.9
Lab commodities	25	22.9
Pre-exposure prophylaxis (PrEP)	24	22.0
HIV treatment (ARVs)	22	20.2
Post-exposure prophylaxis (PEP)	13	11.9
Emergency contraception	12	11.0
Hormonal contraception (pill, shot, etc.)	11	10.1
TB treatment & prevention	11	10.1

Policy Compliance Effects

In addition to funding cuts, IPs reported multiple impacts to their work from new U.S. policies that restricted award language, activities, or allowable partnerships. These restrictions likely stemmed from Executive Order 14151, 'Ending Radical and Wasteful Government DEI Programs and Preferencing' and the Promoting Human Flourishing in Foreign Assistance policy (the expanded 'Mexico City Policy').[25,26] Overall, 77.2% of IPs (n=122) reported that they were asked to comply with an additional U.S. policy restricting their organization's activities if they continued to receive PEPFAR funding. Commonly reported restrictions were related to LGBT services, reproductive health, gender-affirming care, gender-based violence, and services perceived to be related to "diversity, equity, or inclusion" (Table 12). These data represent how IPs themselves are interpreting the restrictions and may or may not reflect what is written in new award agreements or guidance from the U.S. government. Nevertheless, the ways in which IPs are interpreting U.S. policies have real implications on service delivery.

The addition of restrictive policies has meant that services have been dropped or altered even among organizations that did not have cuts to their PEPFAR funding.

Table 12: IPs Interpretations of U.S. Policy Restrictions on PEPFAR-Funded Activities

Quote	Theme	Region
No assistance to key populations, only so-called life-saving activities allowed. OVC (orphans and vulnerable children) activities were also closed.	Loss of KP and OVC programs	East & Central Africa
DEI was not allowed and we had to take out gender-based violence from our proposal and any mention of KPs.	Loss of GBV and KP programs	Southern Africa
We were asked to comply with new policy on DEI and be careful with the language used in project documentation, it was always a risk of being rejected for funding if the "wrong" language appears… But more importantly, recently issued statement terminated funding for medication assisted therapy for people who inject drugs, even referral to state funding programs is impossible.	Censorship of language and loss of PWID programs	Eastern Europe & Central Asia
Discontinuation of certain activities such as case-based surveillance, recency testing and index testing, support to KP activities, and avoidance of certain terminologies including the word "gender" and "gender-based violence."	Loss of GBV and KP programs	East & Central Africa
Not allowed to offer services on family planning. Prevention services are restricted to pregnant and lactating mothers.	Sexual and reproductive health	Southern Africa
Outreach to LGBTQI individuals and collaboration with LGBTQI organizations not allowed.	LGBT services & partnerships	Latin America & Caribbean
Restrictions from supporting programming for key populations (female sex workers, MSM, PWID, transgender). Restrictions on use of many terminologies. Increased emphasis on abortion restriction which was already in existence.	Censorship & loss of KP programs	East & Central Africa
Cessation of HIV prevention activities for all groups except pregnant and breastfeeding women; cessation of program evaluation activities… multiple vocabulary restrictions related to connotations of equity and disparity.	Loss of prevention & evaluation activities	East & Central Africa

Among responding IPs without terminated awards, 78.3% (n=18) reported altering the way their organization worked to comply with these policies. Of those, 61.1% (n=11/18) censored or changed the wording used to describe their services, and the same share stopped providing one or more types of services entirely (Figure 11). Conditioning continued funding on policy compliance is not new, for example, the Mexico City Policy has long restricted activities and advocacy for specific services. What sets these changes apart is their breadth. Rather than restricting a single category of activity, partners reported altering which populations they served, which services they delivered, and how they sub-granted, reshaping the core of what awards were designed to do. In these data, the most commonly dropped services as a result of policy restrictions were to key population services, prevention services, and reproductive health services (Figure 12). Among IPs who stopped serving a specific population, the most common population to be excluded from services was transgender populations (87.5%, n=7/8), followed by MSM (75.0%, n=6/8), and sex workers (75.0%, n=6/8). These findings underscore that U.S. policy changes have impacted HIV service delivery for those most at risk, regardless of whether funding was maintained.

Figure 11: Percent of IPs Without a Terminated or Delayed Award Altering Practices or Services to Comply With U.S. Policies (n=18)

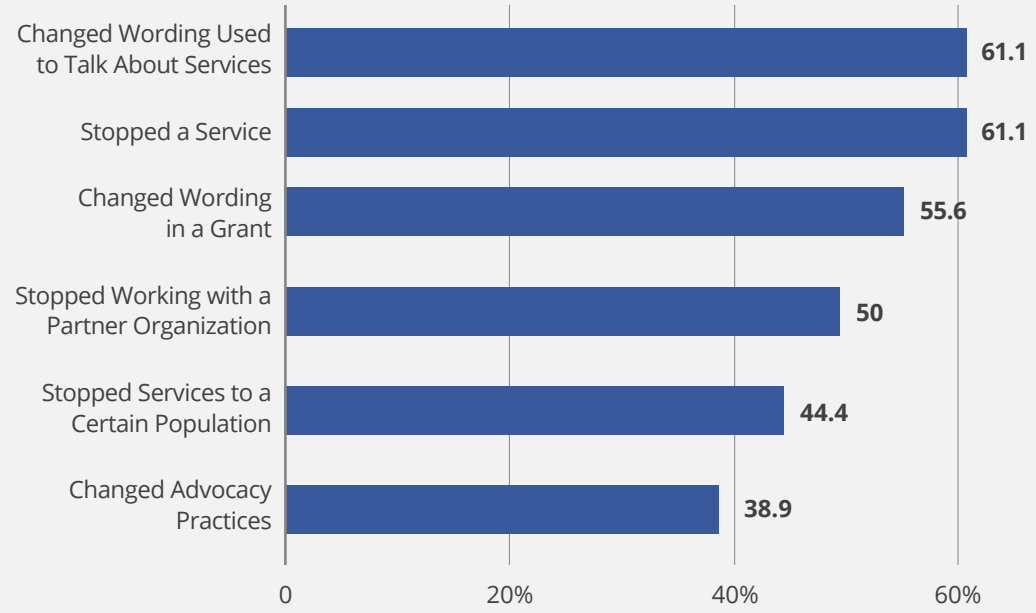
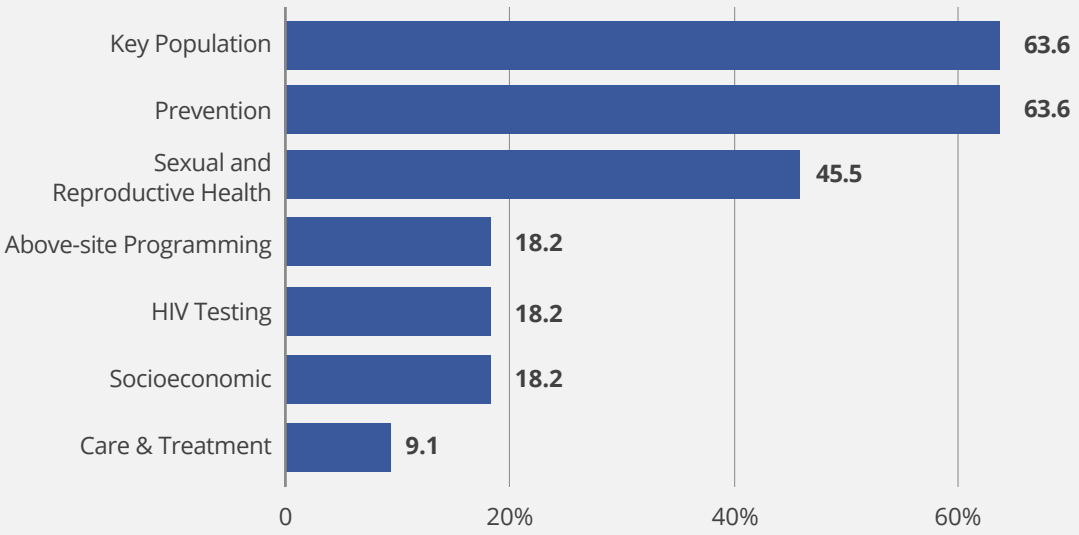


Figure 12: Percent of IPs Without a Terminated or Delayed Award That Stopped or Reduced Services by Category (n=11)



DISCUSSION AND IMPLICATIONS

PEPFAR Pulse data describe significant and widespread disruption due to the 2025 funding and policy changes. The financial effect of these terminations has been severe and devastating, with only a minority of IPs being able to fill the funding gap. In response, IPs report having to close hundreds of clinics and service delivery sites. Also alarming is the disproportionate injury to locally based IPs, which are central both to the sustainability and localization of the HIV response and to reaching marginalized, remote, r disenfranchised populations.

While funding cuts were extremely harmful, these data also reveal an equally significant outcome of the administration's contractual overhaul of the PEPFAR program: an ideological shift of resources away from the populations at highest risk of acquiring HIV. The deepest cuts were concentrated in services for KPs, HIV prevention, and socioeconomic support. The contrast is stark. Prevention and socioeconomic spending was cut by 51% and 63%, respectively, compared to a 15% cut to treatment spending. These funding cuts were compounded by new policies that restricted IP service delivery for LGBT people, reproductive health, gender-based violence, and any services construed as DEI.

Publicly, the administration has described this overhaul as a success. On 17 April 2026, PEPFAR released a tranche of programmatic data[27]—the first such release in 16 months. In this release, PEPFAR reported that 20.6 million people living with HIV are still receiving treatment, pointing to this as evidence the program continues to deliver life-saving care. Yet the same data show that uptake of HIV prevention services and new enrollments in HIV treatment have fallen significantly since 2024.[28] Data from PEPFAR Pulse mirror this finding, with respondents describing high rates of

HIV PREVENTION SPENDING WAS CUT BY

51%

SOCIOECONOMIC SUPPORT WAS CUT BY

63%

TREATMENT SPENDING WAS CUT BY **15%**

The state of PEPFAR **continues to change rapidly**, even in the time since the collection of these data. … These results represent a **snapshot of a still-unfolding disruption**, and conditions may already have deteriorated beyond what they capture.

discontinuation or reduction of community-based HIV testing, condoms and lubricants, PrEP, and violence prevention and response services.

While key population services were most impacted, all parts of the PEPFAR program suffered cuts, and even "waiver-protected" services like HIV treatment and PMTCT services were impacted. The waiver rested on the incorrect assumption that a core HIV testing and treatment program could be insulated while the rest of the program was broadly dismantled. However, the separate components of the PEPFAR program rely on each other to work. HIV treatment programs depend on the same health workforce, supply chains, laboratories, data systems, and outreach as other components of PEPFAR that were defunded. As a result, high proportions of IPs reduced or stopped HIV clinical services, even though permitted under the waiver.

PEPFAR Pulse data also show that community-based services were among the most disrupted. While facility-based services are essential, controlling the epidemic has always depended on reaching the people least likely to reach care on their own. As a result, the PEPFAR program has historically supported strategies to engage harder-to-reach clients in acceptable and accessible care, including delivering community-based interventions and providing wrap-around socioeconomic support. Defunding these wrap-around activities that help people stay on treatment will affect treatment retention, especially among youth and KPs. Inability to retain people in treatment programs ultimately leads to worse medical outcomes, increased mortality, and sustained transmission of HIV. Since key and vulnerable populations are dynamic and interconnected with the general population, the medical neglect of these groups means a failure to achieve epidemic control for all.

These consequences are unlikely to be temporary or self-correcting. As U.S. support shifts from IPs to direct G2G funding, the services cut most deeply, those for KPs and community-based services, are also those least likely to be sustained. This is particularly apparent where these populations are criminalized or politically marginalized and where governments have been unwilling or unable to fund services for them. The programs lost are therefore the ones least likely to reappear as funding changes hands, leaving the populations most central to epidemic control without a clear source of care. Amid continuing uncertainty about PEPFAR's future as a bilateral program, the more urgent question is how much of what it built can be preserved before it is lost for good.

Limitations

There are a number of limitations to these findings. First, the survey did not reach the entire sampling frame of PEPFAR IPs, and the organizations most severely disrupted, or those that closed entirely, may have been the least likely to respond. The disruptions documented here therefore may be an underestimate. However, the opposite could also be true if respondents still receiving U.S. funding may have been more reluctant to participate. Second, the study captured impacts at the prime IP level, but many of the smallest and most locally rooted organizations are sub-partners operating on narrow budgets, and may have been more likely to close when even part of their funding disappeared. The loss of sub-partners is not visible in these data.

Finally, the state of PEPFAR continues to change rapidly, even in the time since the collection of these data. Bridge funding that has sustained services is set to expire, the transition to G2G agreements remains behind schedule, and the future of commodity procurement and supply-chain contracts is unresolved. These results represent a snapshot of a still-unfolding disruption, and conditions may already have deteriorated beyond what they capture. Despite these limitations, the survey aligns with analysis of PEPFAR's own facility-level program data, which documented comparable declines in HIV testing, prevention, and health workforce.[15] The convergence of these analyses lends confidence that the trends identified in the PEPFAR Pulse Study are consistent with broader shifts across the PEPFAR system.

RECOMMENDATIONS

FOR U.S. GOVERNMENT AND PEPFAR LEADERSHIP

1) **Maintain and protect public data reporting systems.** PEPFAR's quarterly data have long been a cornerstone of accountability. HIV services funded through the new G2G approach should be subject to the same routine, public reporting PEPFAR has historically provided. This should be paired with a one-time accounting of the terminations including sub-grantees, who remain invisible in current reporting.

2) **Reinstate support for the full continuum of HIV services, not treatment alone.** PEPFAR should abandon any treatment-only model. The evidence is clear that maintaining budgets for treatment without investment in treatment delivery programs, prevention, workforce, community-based services, and key population programming is not a viable path to epidemic control.

3) **Ground G2G funding models in the scientific evidence on epidemic control.** This means reaching KPs, and other vulnerable groups, through the community-based and differentiated service models proven to work. Without explicit requirements built into the agreements, governments are unlikely to sustain these approaches in many contexts.

4) **Prioritize local organizations in recovery and recontracting.** Local implementing partners were hit hardest by award terminations and site closures—reversing years of progress on localization. Any PEPFAR recovery strategy must actively redress this imbalance.

5) **Ensure that any transition to new funding models is orderly and adequately resourced rather than abrupt.** The disruptions documented here were driven dually by the speed and disorder of the changes as by the cuts themselves. Funding transitions may be necessary, but their pace should be driven by health system capacity to absorb them and transition impact assessments with funded mitigation plans in place are needed before changes proceed.

FOR PHILANTHROPIC AND OTHER BILATERAL DONORS

1) **Preserve community-led and KP infrastructure through flexible funding, particularly in criminalized settings where other funders are unlikely to step in.** Crucially, this support should be directed to local implementing organizations. Philanthropic support should be distributed as core funding to keep the organizations themselves solvent, since many operate on narrow margins and cannot survive on project-restricted funding alone.

2) **Invest in independent community-led monitoring and data systems.** Disruptions to PEPFAR's monitoring and reporting infrastructure, compounded by loss of staff, reporting tools, and community-led monitoring, have created a significant visibility gap. Donor support for community advocates to collect data and then hold their governments to account is urgently needed and unlikely to be supported by national governments.

3) **Call for a pooled HIV Continuity Fund.** Philanthropic, bilateral, and multilateral donors should establish a pooled HIV Continuity Fund to provide emergency bridge financing for community-led and KP-led organizations, workforce retention, commodity distribution, drop-in centers, mobile clinics, and other essential service platforms threatened by U.S. funding withdrawal.

4) **Coordinate to avoid duplication and ensure coverage of the most neglected areas.** The data show that new funding came primarily from U.S.-based private foundations, and was rarely targeted to key populations. A coordinated donor mapping exercise is urgently needed to identify both geographical and service coverage gaps that are unlikely to be filled by national governments.

5) **Leverage donor-to-donor outreach to new or disengaged HIV donors.** Philanthropic funding for HIV has declined in recent years as perceptions of risk shift and new health crises emerge. Donors can reach out to their networks providing education on the current gaps and pitching opportunities to make HIV investments with a big impact.

FOR NATIONAL GOVERNMENTS

1) **Increase domestic investment in HIV services, with explicit commitments to fund community-based and KP programming.** Facility-based care alone cannot reach everyone who needs it, as it is inaccessible or unsafe for many young, rural, and criminalized populations. The closure of drop-in centers and mobile clinics, previously supported by PEPFAR, is an urgent issue which has left many people without care. Governments should explicitly work to sustain drop-in centers, mobile clinics, and other community-based access points and invest in ensuring services friendly to all are available in general service clinics.

2) **Contract with NGOs and KP-led organizations to deliver community-based services.** The infrastructure, trust, and expertise needed to reach marginalized populations lives in civil society. Sustaining the epidemic gains of the past two decades requires formal recognition that community and KP-led organizations are a core part of HIV service delivery.

3) **Protect and absorb the local implementing partner workforce.** Many organizations have shed thousands of trained HIV workers as a direct result of PEPFAR disruptions. Governments should explore mechanisms, through the national health systems, transition funding, or secondment arrangements, to retain this workforce before it disperses permanently, taking with it decades of hard-won expertise.

4) **Strengthen and formalize civil society and community participation in planning the HIV response.** Meaningful community involvement in HIV planning is well established: it was a hallmark of PEPFAR's process and is already part of some national systems. As ownership grows, that engagement should be elevated and embedded in the bodies that plan and oversee the response.

FOR CIVIL SOCIETY AND COMMUNITY ORGANIZATIONS

1) **Document disruptions and the gaps left behind.** As PEPFAR's data infrastructure is phased out faster than national systems can absorb it, community organizations are often the only ones able to track who has lost access, and whether policy commitments are reaching people on the ground. This evidence holds funders and governments accountable and shows remaining funders where their resources are most needed.

2) **Defend accessible, rights-based services and the funding that facilitates them.** Community organizations are best placed to be able to offer safe and accessible services to populations facing structural barriers to care, and to advocate for the human rights protections and legal reforms, including decriminalization, that make those services possible. This includes advocating for ring-fenced public funding for key population and community-led services, not left to discretionary, residual, or facility-based funding streams.

3) **Press funders and the U.S. government for transparency and accountability.** Civil society advocacy and litigation have already forced the release of data and the payment of funds. Sustained pressure, through Congress, the courts, and public reporting, remains a key lever to compel transparency about what is being cut and what comes next.

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amfAR

The Andelson Office of Public Policy
1100 Vermont Avenue, NW
Suite 600
Washington, D.C. 20005
Phone: +1 202.331.8600
Email: info@amfar.org

www.amfar.org

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