FRIENDS OF THE GLOBAL FIGHT | AGAINST AIDS, TUBERCULOSIS AND MALARIA

Sustaining progress against AIDS, tuberculosis and malaria as countries transition to growing self-reliance

The crucial role for Congress in protecting a lifesaving legacy

April 14, 2026

Contents

Introduction

American leadership against the epidemics of AIDS, tuberculosis (TB) and malaria has saved tens of millions of lives, changed the course of the world's deadliest infectious diseases and transformed the prospects for communities around the world – all while advancing U.S. interests and reputation abroad.

The Administration's America First Global Health Strategy (AFGHS), released in September 2025, seeks to transition leadership of the response to the three epidemics to partner countries, gradually reducing U.S. investments as partners invest more. **Significant U.S. funding cuts and ambitious co-financing targets included in bilateral agreements to implement the strategy pose risks for many countries' efforts against AIDS, TB and malaria.**

As the steward of U.S. leadership against AIDS, TB and malaria, Congress has an essential role in ensuring the transition of U.S. assistance is successful. Through the Fiscal Year (FY) 2026 appropriations and accompanying report language, Congress has already taken important steps to exercise oversight of the AFGHS and guide its implementation.

The stakes could not be higher.

- → **Successful transitions** will put governments and communities in the lead and continue progress towards ending the three epidemics as public health threats.
- → **Failed transitions** will result in epidemic resurgence, unnecessary death and suffering, and the squandering of decades of U.S. leadership and investment.

The AFGHS identifies multiple targets to drive down death and infection rates in AIDS, TB and malaria by 2030. **Execution must now focus on delivering against these targets as global health financing transitions**, optimizing investments by the U.S., partner countries and the Global Fund to Fight AIDS, TB and Malaria. The Global Fund is an essential partner in successful transition.

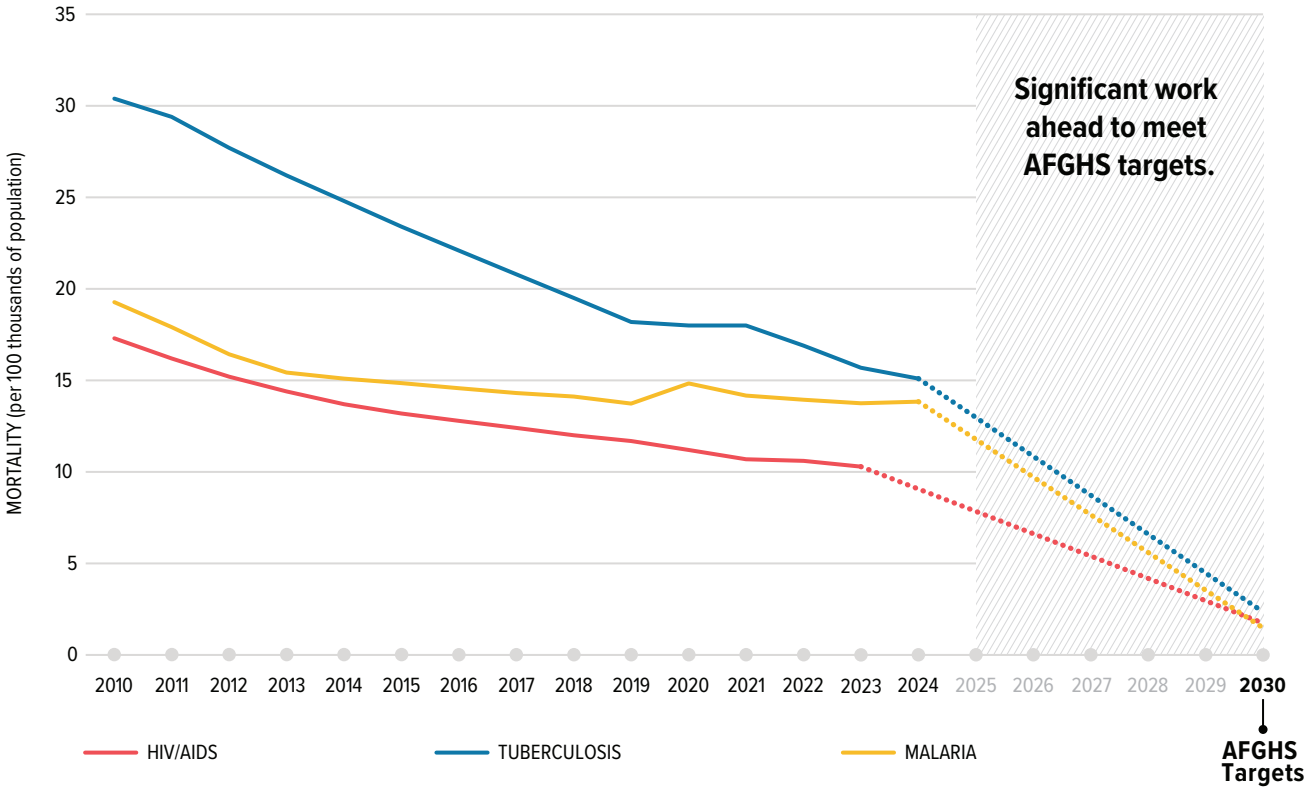
FY26 CONSOLIDATED APPROPRIATIONS REPORT:

"… the Secretary of State shall submit … a comprehensive strategy to guide the structured transition of PEPFAR-supported programs to country-led ownership, while maintaining the integrity, quality and outcomes of the global HIV/AIDS response."[1]

BOX 1. WHAT THIS PAPER OFFERS AS NEW INFORMATION

This brief examines the challenges and opportunities in the rapid shift from donor to national financing in the fight against AIDS, TB and malaria. It looks at plans for aid transition, several policy and implementation issues for Congress to consider, and recommendations for Congressional oversight. (See recommendations on page 17.)

FIGURE 1.
PROGRESS TOWARD THE AMERICA FIRST GLOBAL HEALTH STRATEGY'S AIDS, TB AND MALARIA TARGETS



Notes: The America First Global Health Strategy 2030 targets represent a 90% reduction from baseline mortality rates: HIV (2010: 17.3 deaths per 100,000), TB (2015: 23.4 per 100,000) and malaria (2015: 14.85 per 100,000 population at risk).

Sources: World Health Organization, Our World in Data, America First Global Health Strategy

Overview of the bilateral health agreements negotiated under the AFGHS

The Administration is negotiating a large number of new Memoranda of Understanding (MOUs) with countries across different regions of the world. As of April 2026, a total of 30 have been signed, and many others are being actively negotiated. Several countries do not have MOUs, including (as of this writing) South Africa, with the world's largest number of people living with HIV. These MOUs reflect a number of important policy changes:

Shift to government-to-government (G2G) agreements. The bilateral MOUs signal a shift in U.S. global health engagement toward greater partner country leadership through G2G financing. The emphasis on national ownership is consistent with calls for health sovereignty in the Ghana-led Accra Reset[2] that urges stronger alignment between external financing and national priorities. While HIV funding dominates the agreements, there is a stated desire towards a less siloed, disease-specific approach. *Experience shows that effective programming requires both government and community engagement and leadership.*

Accelerated transition. Most MOUs operate on a five-year timeline from 2026 to 2030, reflecting an accelerated transition toward country financing. Partner governments are expected to steadily increase their domestic health financing as U.S. funding declines, and the transition timelines and co-financing commitments vary widely across MOUs. Of the countries that have signed MOUs, two – Botswana and Panama – are on three-year horizons.

Changing program priorities. The text of the publicly available MOUs suggest that HIV platforms remain the foundation of the bilateral framework, reflecting PEPFAR's extensive infrastructure. HIV programming appears more often than other disease areas, while malaria, TB, maternal and child health, polio and global health security appear in varying combinations. The MOUs do not address several other congressionally appropriated health areas, including family planning, nutrition and broader maternal and child health programming.

Oversight and transparency. A majority of the agreements are not public, raising transparency concerns.[3] Those MOUs that are available remain high-level frameworks, with implementation plans to follow. Mentions of vulnerable populations and community-led services are limited, pointing to the fact that some of the key actions needed for successful transition have not yet been fully addressed.

Non-health related requirements in MOUs. Early reactions from some partner governments, notably Zambia and Zimbabwe, suggest resistance to MOUs that tie U.S. funding to demands for domestic health data, 25 years of pathogen samples or minerals access.[4]

FIGURE 2. MOUs AND GLOBAL FUND SUPPORT BY DISEASE AREA

	USG Global Health MOU			The Global Fund (Eligibility in 2026 for GC8)		
Country	**HIV/AIDS**	**TB**	**Malaria**	**HIV/AIDS**	**TB**	**Malaria**
Angola	Y	N	Y	Y	Y	Y
Botswana	Y	N	N	Y	Y	N
Burkina Faso	Y	N	Y	Y	Y	Y
Burundi	Y	N	Y	Y	Y	Y
Cameroon	Y	N	Y	Y	Y	Y
Cambodia	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	N	N	N	Y	Y	Y
Democratic Republic of the Congo	Y	Y	Y	Y	Y	Y
Dominican Republic	Y	N	N	Y	N	N
El Salvador	Y	N	N	Y	Y	N
Eswatini	Y	N	N	Y	Y	Y
Ethiopia	Y	Y	Y	Y	Y	Y
Guatemala	N	N	N	Y	N	N
Guinea	Y	N	Y	Y	Y	Y
Honduras	Y	N	N	Y	Y	Y
Kenya	Y	Y	Y	Y	Y	Y
Lesotho	Y	N	N	Y	Y	N
Liberia	Y	N	Y	Y	Y	Y
Madagascar	N	N	Y	Y	Y	Y
Malawi	Y	Y	Y	Y	Y	Y
Mozambique	Y	Y	Y	Y	Y	Y
Niger	N	N	Y	Y	Y	Y
Nigeria	Y	Y	Y	Y	Y	Y
Panama	Y	N	N	N	N	N
Rwanda	Y	N	Y	Y	Y	Y
Senegal	Y	N	Y	Y	Y	Y
Sierra Leone	Y	Y	Y	Y	Y	Y
Tajikistan	Y	Y	N	Y	Y	N
Uganda	Y	Y	Y	Y	Y	Y
Total	**25**	**10**	**19**	**28**	**26**	**22**

Notes: Global health program area information based on publicly available information but may not reflect the full scope of areas to be addressed. Global health MOU agreements for Botswana and Panama are for a three-year period. Guatemala's press release does not mention the duration of the agreement. All other agreements span five years.

Sources: U.S. Department of State; U.S. Embassies; Ministries of Health. Press releases, memoranda of understanding (MOUs) and related documents. Global Fund. "2026 Eligibility List."

Bilateral health agreements: Implementation watch areas

According to the State Department, MOU implementation plans should follow within 60 days of MOU signing, though these deadlines may be slipping. There are several areas to monitor:

1. Services and outcomes

Timely and credible data is essential to protecting progress.
Implementation plans should specify who collects data, how often it is reported, whether it is disaggregated by geography and population, and what independent validation mechanisms are in place. These questions are especially important as U.S. in-country presence and historic data collection efforts decline. Data systems should be strong enough to detect problems early and support countries in course correction.

Implementation should prioritize accountability and results.
Implementation metrics should be sufficient to assess both disease-specific outcomes and the core service-delivery indicators needed to identify prevention and treatment gaps, course-correct programs and protect progress. As implementation shifts to more national and locally based actors, clear accountability structures, data integrity safeguards and mechanisms for meaningful community engagement[5] will be essential to achieve shared goals.

BOX 2. IS TRANSITION WORKING?

Watch for warning signs of backsliding:

- Drop in the number of people tested for HIV or initiated on HIV treatment
- Increase in the number of patients dropping out of HIV treatment
- Spikes in malaria cases or deaths
- Declines in bed net coverage for malaria and delays in seasonal campaigns
- Falling TB detection and notification rates
- Increase in attrition among healthcare workers
- Theft or diversion of drugs and health commodities
- Delays or gaps in the reporting of data
- Reports of insufficient information or resources at the sub-national level.

Sources include: Kates, J et al., Questions for the America First Global Health Strategy, Think Global Health, Nov 6, 2025, https://www.thinkglobalhealth.org/article/questions-for-the-america-first-global-health-strategy

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In developing its transition strategy consider "a phased approach for reducing reliance upon United States bilateral funding in countries deemed ready for transition, informed by clearly defined, transparent economic and programmatic criteria benchmarks…"

The configuration of service delivery is a core oversight issue. Many MOUs anticipate larger roles for faith-based organizations, private-sector entities and local organizations in frontline care, supply chains and workforce support. Plans for delivery of prevention, treatment and community-based services, especially for women, adolescents and vulnerable populations, should be explicit. In most countries, vulnerable groups are most effectively reached by local community-based organizations that have relied heavily on PEPFAR and the Global Fund for support. These organizations will increasingly require national financial support as donors phase down.

U.S. government capacity will be tested because of the dramatic reduction in technical and managerial staff. A minimum number of knowledgeable, well-trained and supervised staff will be needed in Washington and in embassies to expedite and monitor the new global health programs. It is not clear that capacity is being rebuilt.

Congressional action: *Strengthen oversight on early warning indicators of incidence, mortality and service delivery overall and in populations most affected to be ready to course correct through oversight, appropriations and legislative directives.*

2. Funding and fiscal capacity

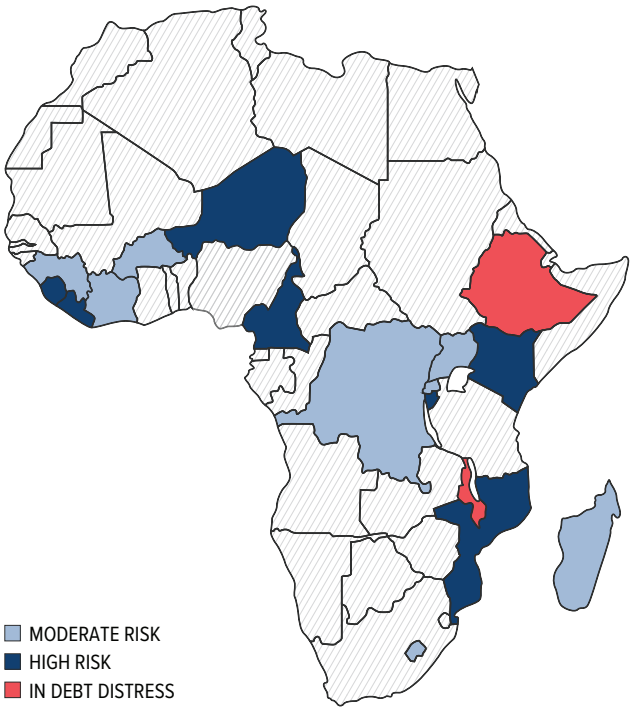
The MOUs detail expected declining investments by the U.S. and increasing domestic commitments over the next three to five years. While increasing domestic financing is essential to sustainability, Congress should consider several factors in monitoring resources for fighting AIDS, TB and malaria:

- **Impact of rapid funding reductions:** Relative to the FY25 congressional budget justification, the bilateral agreements with countries amount to about a one-third decrease in total five-year U.S. funding. At the same time, countries are also facing multiple co-financing requirements across donors and development bank agreements. Multiple countries face a funding "cliff" in year two or three of their agreement.
- **Ambitious targets and penalties:** Many of the agreements set highly ambitious goals for increased domestic resources and threaten to withdraw funds if targets are not met. Yet multiple countries face constrained fiscal space, with many categorized by the World Bank as at high risk of – or already in – debt distress.[6] For example, Mozambique and Ethiopia, among the five countries with the highest malaria burden, have considerable fiscal challenges.[7] Mozambique faces high risk of debt distress and Ethiopia is already in debt distress.

- **Investing new money or shifting funds?:** Given the ambitious domestic resource targets and fiscal constraints, the Administration should ensure that MOU targets are not resulting in funding or service reductions in other critical areas of health and development.
- **Financing assumptions in implementation plans:** A review of domestic financing plans alongside U.S. disease-specific funding, grants from the Global Fund and national health priorities is necessary to identify whether domestic funding goals might be unrealistic or where extra help is needed.
- **Measuring national funding contributions:** Government spending is typically difficult to track and verify. Clear, standardized reporting systems are needed from the start, supported by the World Bank, International Monetary Fund (IMF) and technical partners.
- **Differential funding by disease:** The publicly available MOUs appear to suggest steeper funding reductions for malaria and TB and other health areas than for HIV, despite both diseases' high susceptibility to resurgence.
- **Use of the Transition Assistance Fund & Performance Incentive Fund:** These new funds are to provide extra help to countries struggling with capacity challenges or that have been successful in implementation. They need to be monitored closely.
- **Promote innovative finance:** Countries should be assisted in considering options to generate new resources, including dedicated taxes, health insurance, debt swaps and partnerships with international financing institutions – including the World Bank and IMF – the private sector and others. The Development Finance Corporation (DFC) should actively support fiscal sustainability in MOU countries.
- **Use of Annual Program Statements (APS):** The Administration is also advancing global health priorities through targeted APS across a range of priority areas. Initial addenda have focused on orphans and vulnerable children and global health security, with more expected.[8]

Congressional action: *Congress should require transparency on funding levels across disease areas and ensure progress is monitored and achieved. It should consider whether penalizing countries that fall short of their funding target is warranted given fiscal realities. Congress should direct the State Department to provide details on the newly created funds. It should direct the Development Finance Corporation to actively support fiscal sustainability in MOU countries, aligned with global health transition objectives. Congress should ensure APS investments are strategically aligned, fill critical delivery gaps and leverage scalable innovations.*

FIGURE 3. MOU COUNTRIES AT RISK OF DEBT DISTRESS



Sources: World Bank. "Debt Sustainability Analysis." https://www.worldbank.org/en/programs/debt-toolkit/dsa.

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"The agreement includes funding to support HIV prevention activities, including to scale-up the use of long-acting injectable antiretrovirals, to reduce HIV transmission in vulnerable populations. The Secretary of State shall rapidly roll out this intervention through the Global Fund and bilateral programs and prioritize these technologies in high-burden-countries …"

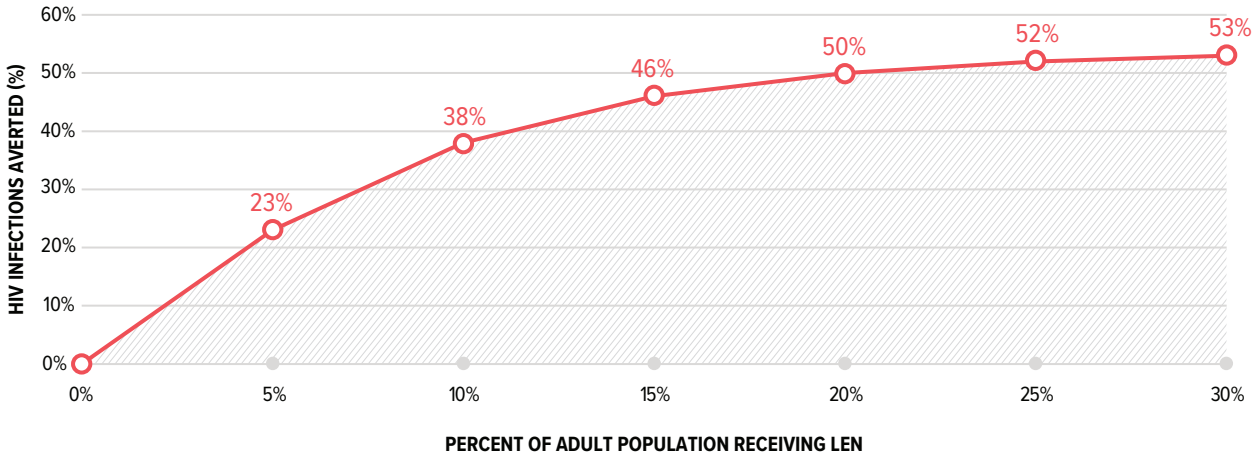
3. Scaling breakthrough technologies that save lives at low cost

Reducing disease incidence and mortality is central to successful aid transition. Innovations in HIV, TB and malaria – alongside other proven-effective interventions – could have enormous impact but only if there is sufficient investment to deliver these tools widely. Yet support for scaling innovations is not visible in MOUs, nor is it yet clear how the newly established funds – including the new **Innovation Fund** – will be utilized. *Some examples of American-made innovations that need to be scaled for impact:*

HIV incidence reduction: lenacapavir and other HIV prevention tools
Lenacapavir (from U.S.-based Gilead Sciences) is a twice-yearly injectable that provides nearly 100 percent protection against HIV infection. Other current and future long-acting HIV prevention tools include CAB-LA (from ViiV Healthcare) and, currently in clinical testing, MK-8527 (from U.S.-based Merck). These products could be game changers in HIV prevention, significantly reducing incidence (Figure 4).

TB case detection rate increase: AI-based portable x-ray
These systems, like that from U.S.-based MinXray, provide expert-level TB screening directly to remote and underserved communities without needing electricity, a radiologist or a health facility (Figure 5).

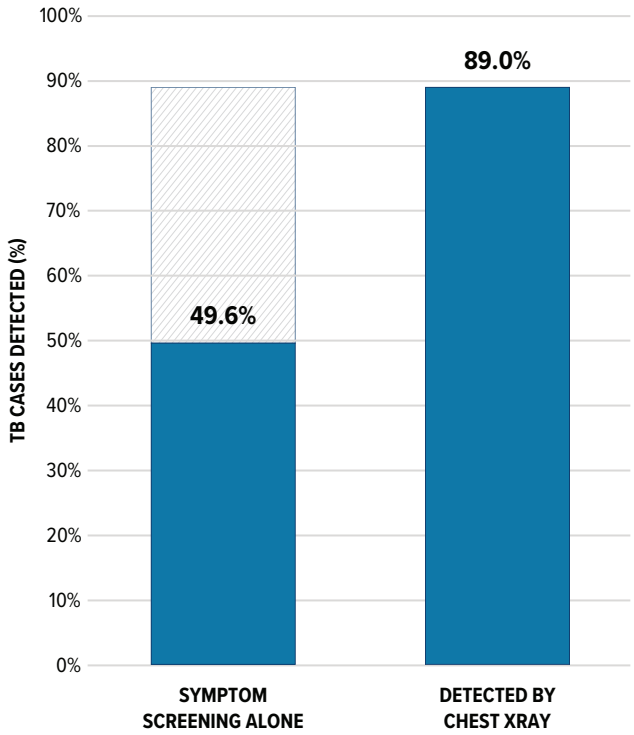
FIGURE 4. EXPECTED HIV INFECTIONS AVERTED WITH INCREASING POPULATION COVERAGE OF LEN IN A GENERALIZED EPIDEMIC



Notes: This figure shows the estimated share of HIV infections averted at different levels of adult population coverage with LEN.

Sources: UNAIDS, Consultation on the Projected Impact and Cost-Effectiveness of Long-Acting Injectable Lenacapavir as Pre-Exposure Prophylaxis, 2025

FIGURE 5. HOW AI-ENABLED X-RAY SCREENING CAN HELP CLOSE THE TB DETECTION GAP



TB screenings that utilize chest X-ray technology have the potential to identify substantially (up to 39%) more cases when compared to symptom-based screenings alone.

Scaling up these products, like that from US-based MinXray, can help expand access to portable, AI-enabled chest X-ray screenings, making it possible to find TB cases that may have otherwise gone undetected.

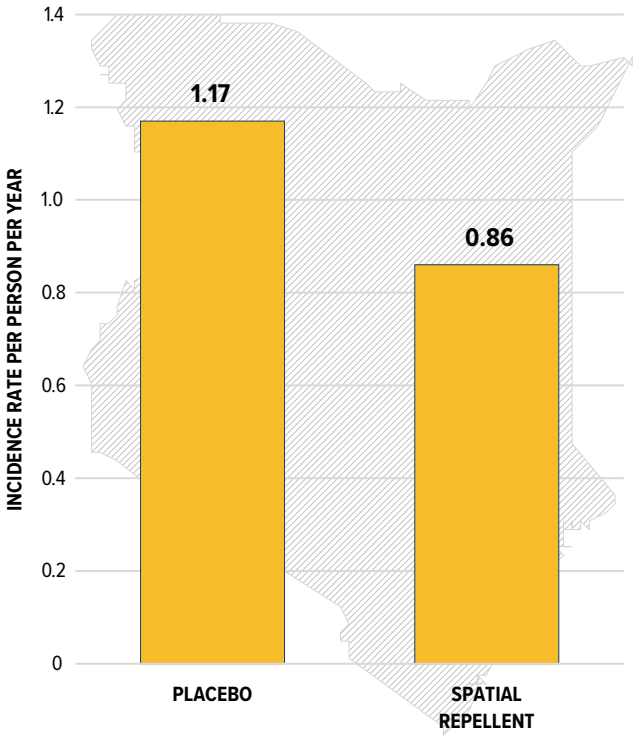
Notes: Figures shown are for a median country in the study sample, not all TB cases globally. The 49.6% baseline reflects the estimated share of TB cases that would be diagnosable through symptom screening alone; chest X-ray screening could identify up to 89.0% of cases.

Sources: Beatrice Frascella et al., "Subclinical Tuberculosis Disease—A Review and Analysis of Prevalence Surveys to Inform Definitions, Burden, Associations, and Screening Methodology," Clinical Infectious Diseases 73, no. 3 (August 1, 2021): e830–e841, https://doi.org/10.1093/cid/ciaa1402

Malaria incidence reduction: spatial repellent

Spatial repellents, like that from U.S.-based SC Johnson, repel mosquitoes from living spaces for up to a year with no electricity, flame or daily action required (Figure 6).

FIGURE 6. IMPACT OF SPATIAL REPELLENT ON MALARIA INCIDENCE IN WESTERN KENYA



Notes: A recent study showed that the use of spatial emanators combined with bed nets reduced the rate of first-time malaria infection by 33% compared with those who used bed nets without spatial emanators.

Sources: Ochomo, E, Effect of a spatial repellent on malaria incidence in an area of western Kenya characterized by high malaria transmission, insecticide resistance and universal coverage of insecticide treated nets (part of the AEGIS Consortium): a cluster-randomized, controlled trial, Lancet, January 2025

4. Faith-based communities, the private sector, civil society and other enablers of success

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The transition strategy should include "a framework to sustain the role of faith-based and community-based service providers … and a plan to engage the private sector …"

Global health transitions toward greater country ownership cannot be achieved by governments alone. Transition will require governments to increasingly finance services delivered by public systems, community-based organizations, private providers and faith-based facilities. Sustainable responses to AIDS, TB and malaria depend on governments working in partnership with non-government actors. These groups extend the reach of health systems, build trust with communities and introduce innovations in service delivery, financing and technology. Yet current bilateral MOUs largely focus on government commitments; implementation plans will need to be clearer on the role of non-governmental stakeholders.

Faith-based actors reach into every community: Faith leaders have historically played a critical role in disease responses. For example, in Mozambique, the U.S.-supported Programa Inter-Religioso Contra a Malaria (PIRCOM) trained more than 27,000 Christian, Muslim and Baha'i leaders to promote malaria prevention, reaching nearly two million congregants. Faith institutions remain among the most trusted networks and can help sustain prevention and treatment programs, and monitor access to them.

Civil society must be engaged: Civil society and community organizations are essential for transparency and access to care, particularly among the most vulnerable.

- In Kenya, groups such as the Lean on Me Foundation work with national networks including HENNET and KELIN to expand treatment access for adolescent girls and young women, monitor drug stockouts and strengthen health budgeting accountability.
- In Mozambique the civil society organization N'weti made detailed recommendations for that country's bilateral agreement and achieved significant improvements.[9] The government's openness to civil society recommendations needs to be replicated in other countries.
- In Cambodia, six large country non-governmental organizations (NGOs), led by the Khmer Health Action Network Association (KHANA), have provided the bulk of HIV and TB prevention services for poor and marginalized families, which has been key to stopping both epidemics in the country. *These and other promising examples can be adopted by other countries.*[10]

Photo: An i-BreakFree youth ambassador talks to students at a rural school in Namibia. Ambassadors lead educational talks and activities, and counsel young people on preventing HIV. *The Global Fund/Karin Schermbrucker*

The private sector offers critical expertise: Private firms increasingly contribute innovation and operational capacity to disease control. The U.S.-Kenya MOU recognizes the private sector's role in health delivery and innovation. It supports public-private partnerships in supply chains, diagnostics and health technology; promotes market-access pathways for U.S. investment; and explores local manufacturing partnerships with Kenyan firms.

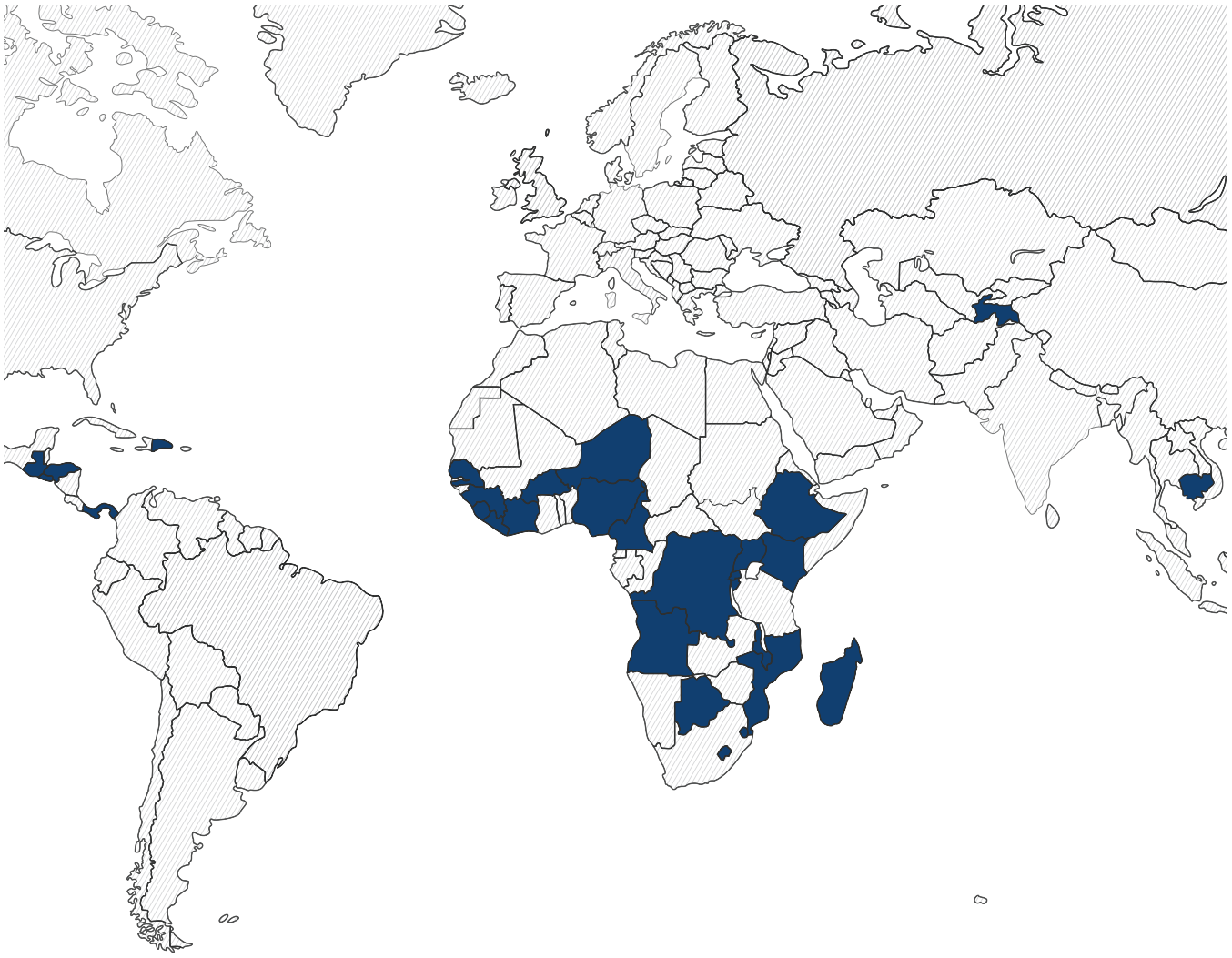
In most countries, donors have for the past two decades paid for the majority of the HIV, TB and malaria services delivered by faith organizations, local community service organizations and the private sector. Given the importance of these services, it is essential that global health transition agreements with the U.S. government describe how partner governments will take over the funding of these "social contracts" as donor money declines.

Congressional action: *Ensure transition arrangements include participation and input from faith-based organizations, civil society and the private sector, and that partner governments (or donors) continue funding for service delivery by these groups. Maintain clear coordination mechanisms to ensure integration is not fragmented or uneven across programs. Ensure community-led monitoring supplements more formal data reporting on services access and quality.*

The Global Fund: Driver of successful aid transition

The Global Fund has long operated in close partnership with U.S. bilateral assistance and is an indispensable actor in aid transition. Since it was founded in 2002, the partnership has saved over 70 million lives[11] while helping countries increase investment and leadership in health. In 2025, the Trump Administration made a generous pledge of $4.6 billion to the Global Fund's 8th Replenishment. Congress has long supported the Global Fund on a bipartisan basis. The Global Fund itself is facing funding cuts and, while essential to progress towards AFGHS targets, cannot make up for funding reductions elsewhere.

FIGURE 7. GLOBAL FUND PARTNERS WITH MOUs



FY26 CONSOLIDATED APPROPRIATIONS REPORT:

"Sufficient unobligated balances exist … to fulfill the United States' pledge for the seventh replenishment, for which the Secretary of State is directed to contribute such funds to the Global Fund in a timely manner and which are in addition to funds provided in the Act for the eighth replenishment."

- **Driving country investment:** The Global Fund requires partner countries show steadily increasing domestic investment in health. The Global Fund estimates financing by countries will increase by 23% between the current and forthcoming grant round.[12]
- **Investing in systems:** The Global Fund invests in strengthening multiple components of health systems – surveillance, data, human resources, procurement, supply chain and medical oxygen.
- **Efficiency:** At six percent, the Global Fund's administrative overhead is among the lowest of any major multilateral institution.[13] By pooling purchasing, the organization dramatically drives down the cost of commodities.
- **Complementary to U.S. government agreements:** The Global Fund's Country Coordinating Mechanism structure brings together multiple stakeholders in shared decision-making. The organization reaches the most vulnerable people – including those marginalized by poverty, stigma or geography – a prerequisite to ending epidemics.
- **Partner to U.S. government:** In September 2025, the Trump Administration announced a partnership with Gilead Sciences and the Global Fund to accelerate the introduction of injectable lenacapavir.[14] *This partnership can serve as a model for additional public-private collaboration.*
- **Accelerating transitions:** The Global Fund is implementing three strategic shifts aligned with aid transition: a sharper focus on low-income, high-burden countries; defined and predictable transition timelines; and optimized use of resources. As bilateral transitions accelerate, the Global Fund will be critical to maintaining continuity, aligning financing and mitigating transition risks.

Congressional action: *Appropriate $1.533 billion for the Global Fund in FY27, one-third of the U.S. commitment to the Global Fund's 8th replenishment. Congress should also press for release of* ***more than $3 billion in previously appropriated but withheld funds*** *to the organization. Further, Congress should review alignment between country MOU transition policies and Global Fund commitments in the 2027–2029 grant cycle, and request regular reporting from the State Department and the Global Fund on their coordination in partner countries.*

Recommendations for Congress

1. **Ensure all current and past appropriated support for AIDS, TB and malaria are obligated, spent and utilized for global health as Congress has specified**, both through bilateral programs and the Global Fund. This includes PEPFAR-related funding for the Centers for Disease Control (CDC) that, as of this writing, has not yet gone to the agency,[15] and over $3 billion in past appropriations to the Global Fund.
2. **Track new funds closely.** Require transparency on how bilateral resources and the newly created **Innovation, Transition Assistance and Performance Incentive Funds**, as well as APS funding, are utilized for maximum impact.
3. **Stay the course by maintaining appropriations.** Appropriation levels should reflect the evolving need to sustain progress toward ending these diseases, not pre-set levels in MOUs. In addition, appropriations should be sufficient to seize strategic opportunities and scale innovations to accelerate the pace and feasibility of transition. The FY27 White House Budget request proposes deep cuts to global health funding that would undermine progress toward AFGHS targets.
4. **Require a formal midpoint review of the implementation of the AFGHS in 2027** to assess progress and recalibrate funding and policy, including an honest assessment of co-financing requirements. Track early warning markers of program and outcome success or backtracking, as well as data quality and timeliness. Require regular reporting on service levels, budget, expenditure and performance.[16]
5. **Protect community services and vulnerable populations.** Require implementation plans to specify how services for vulnerable populations, women, adolescents, maternal and child health, and community-based programs are protected. Ensure funding continues for key prevention and treatment services delivered by faith-based organizations, communities and the private sector to preserve these vital services.
6. **Ensure health services are not conditioned on unrelated non-health policy issues.** Epidemic control and life-saving health services, a U.S. national security interest in its own right, should not become bargaining tools in unrelated foreign policy interests such as mineral rights.
7. **Ensure multistakeholder engagement:** Ensure partner governments consult with and fully engage communities, faith-based groups and the private sector in implementation.

FY26 CONSOLIDATED APPROPRIATIONS REPORT:

"not later than 90 days after the date of enactment of the Act, the Secretary of State shall submit … a comprehensive strategy to guide the structured transition of PEPFAR-supported … [and in addition] submit a report … outlining the details of the global health compacts and bilateral agreements … for all programs and activities funded under Global Health Programs."

8. **Include detailed oversight language for malaria and TB programs** in FY27 appropriations legislation, like that for HIV in the FY26 Consolidated Appropriations bill.
9. **Require transparency and verified data systems.** Require MOUs and transition plans be public and preserve data-driven programming. Ensure quality data systems are in place.
10. **Protect procurement and supply chain management:** As the State Department implements changes in its procurement and supply chain contracting, ensure there is sufficient planning to maintain service delivery and avoid people losing access to life-saving health products.

Acknowledgements

This brief was prepared by Friends of the Global Fight with the research and writing assistance of Dr. Jirair Ratevosian. Thank you to the many people who reviewed a draft of this brief.

Friends wishes to thank Coefficient Giving for their support of this work.

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4 Health Policy Watch; https://healthpolicy-watch.news/zambia-and-zimbabwe-back-away-from-prescriptive-us-health-deals/; Feb 26, 2026

5 Meaningful community engagement should include a role in decision-making (beyond just consultation), access to disaggregated data, independent community monitoring, and direct, predictable and sustainable funding channels to community organizations.

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