UNDONE

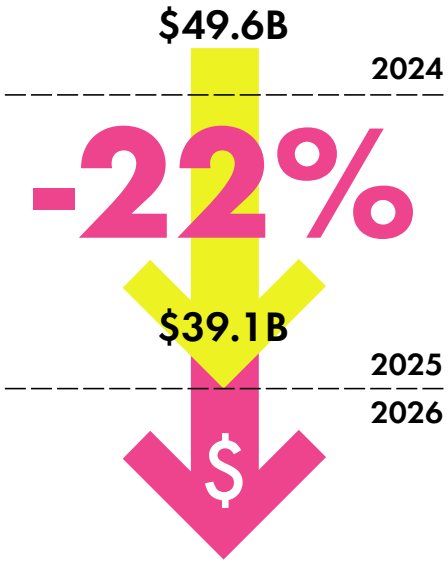
Cuts to HIV and Malaria Funding in Mozambique, Nigeria and Uganda

May 2026

aidsfonds

Friends of the Global Fund Europe

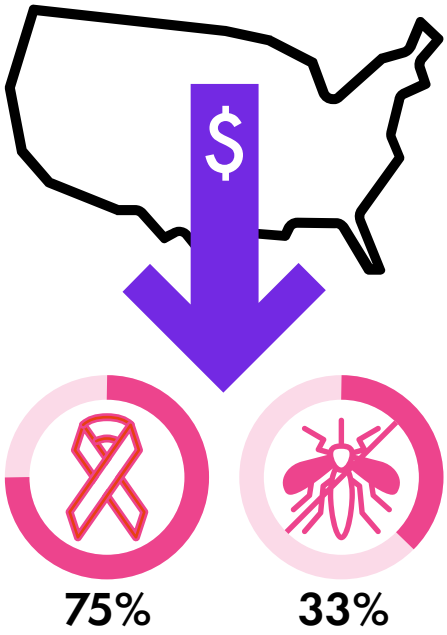
Introduction



Since January 2025, the global health financing landscape has undergone a rapid and significant shift, marking the beginning of what has been described as a period of sustained contraction in development assistance for health (DAH). **A study of global 2025 DAH cuts concluded a decrease by 22% ($11.2 billion) between 2024 and 2025, with additional decrease expected in 2026.**[1]

Central to this shift has been the rapid freezes and cuts of the United States Government DAH in 2025. Until then, the United States Government had been the single largest donor to global health, funding significant portions of the global HIV and malaria responses. This was accompanied by the formal closure of USAID in July 2025 and substantial reductions in funding flows through major bilateral programmes, most notably the President's Emergency Plan for AIDS Relief (PEPFAR),[2] and withdrawal from several key global health and other multilateral institutions, including the World Health Organization (WHO), United Nations Population Fund (UNFPA), UN Women, and other bodies with direct or indirect relevance to health systems, equity, and research.[3] The United Kingdom, Germany, Belgium, Switzerland, and France also announced cuts to their DAH in 2025, which will worsen an already difficult situation and deserve further studies.[4,5] The scope of this report focuses on the United States DAH reductions and their knock-on effects on the largest multilateral funder for HIV and malaria, the Global Fund to Fight HIV, Tuberculosis and Malaria (Global Fund).

The scale and speed of these changes have had immediate implications for global health. Beyond the loss of financial resources, the withdrawals have affected technical capacity, institutional continuity, and the operational infrastructure underpinning disease responses globally. While a new set of bilateral agreements has been announced under the America First Global Health Strategy, their implementation remains unclear. Gaps emerging between commitments and disbursements have already contributed to programme disruption, staffing losses, and the erosion of technical expertise.[6]



These shifts are particularly consequential given the pre-existing structure of global health financing. **Prior to 2025, the United States accounted for approximately three-quarters of global HIV/AIDS funding,[7] and around one-third of global malaria funding.**[8] At the same time, policy changes have further shaped the operating environment. The reintroduction and expansion of the Mexico City Policy has added constraints for organisations receiving US funding, with implications for programme scope, partnerships, and service delivery.[9] In parallel, the announced discontinuation of the U.S. Global Health Supply Chain Program has halted procurement for new commodities and has left distribution systems for essential commodities, including those for HIV and malaria, without a clearly established replacement mechanism.[10,11]

These developments have caused broader pressures on multilateral systems by way of impact on the Global Fund: until 2025, it channelled 26% of HIV programme financing[12] and 59% of malaria programme funds.[13] The United States, previously the largest donor to the Global Fund, also reduced its contribution in 2025. The status of payments of existing pledge commitments remains unclear. France and Japan more than halved their pledges; Sweden cut their pledge by US$200 million; the UK cut by 15%, Germany cut by $200 million; in combination contributing to a shortfall of almost $4 billion in the 2025 Global Fund replenishment, with delayed payments and money set-aside for technical assistance[14] resulting in cuts for ongoing Grant Cycle 7 grants and reprioritisations, i.e., limits on what will be funded, for forthcoming Grant Cycle 8 allocations.[15]

This report examines how these global shifts are translating into country-level impacts in Mozambique, Nigeria, and Uganda, with a focus on HIV and malaria responses. It explores how the scale of funding reductions is reshaping service delivery, community systems, and access to care; what this may mean for the trajectory of these epidemics; and makes recommendations to avoid setbacks while sustaining progress from prior years.

aidsfonds

Friends of the Global Fund Europe

Case Study: Mozambique

1.1 Overview of Situation Prior to Cuts

HIV and Malaria: snapshot prior to DAH cuts

- One of the highest burdens of HIV and malaria globally.
- HIV: Third highest number of people living with HIV worldwide; the second highest number of new infections.[16] 300,000 people living with HIV not on antiretroviral therapy (ART). Adolescent girls and young women account for one third of new infections, highlighting persistent prevention gaps.[17]
- Malaria: Highest malaria prevalence in Eastern and Southern Africa. The entire population is considered at risk.[18] Malaria cases are highly sensitive to extreme climate events, e.g., Cyclone Freddie in 2023.[19]
- Mozambique was ranked among the five poorest countries globally in 2025, with a debt burden nearly equivalent to its gross domestic product.
- Progress against HIV and malaria is underpinned by a high degree of dependence on external funding from Global Fund, PEPFAR, and President's Malaria Initiative (PMI).
- Mozambique's domestic health budget has declined to 8.3%,[20] driven by low domestic revenue and debt burden.[21] The Abuja Declaration target is a 15% budget threshold, while the WHO recommends US$112 per capita. If either target was reached the resulting health budget amount would still be insufficient to cover actual needs, e.g., 5% of GDP for health would have been USD 63-68 per capita in 2023.[22]

1.2 Recent Trends and Nature of Cuts

- 67% of Mozambique's HIV budget had originated from the US Government,[23] much of which had been "paused or terminated" in 2025, meaning that all PEPFAR implementing partners have either halted or scaled back their work with key populations.[24] The 2023 PMI budget for malaria in Mozambique was US$29m.[25]
- The current GC7 grant allocation from the Global Fund was reduced by 12%. Other international health agencies stopped funding work in Mozambique due the US cuts' impact on their fiscal abilities.[26]
- The new Memorandum of Understanding (MOU) commits US$1.8bn in US support over 2026–2030. Combined with projected domestic spending, total health expenditure in Mozambique will still be 17% lower in 2030 than in 2025 - meaning the agreement does not restore pre-cut funding levels. The gap between commitments and actual need remains.[27]

1.3 Impact of the cuts

Despite these adaptive responses, a set of significant and interrelated impacts is emerging across Mozambique's HIV and malaria responses. These reflect both the direct effects of funding reductions and the limits of community and system capacity to absorb and respond to the shock.

Severe service disruption: Reductions in development assistance for health have had immediate and severe impacts on Mozambique's HIV and malaria responses, exposing deep structural dependencies on external financing and significantly disrupting service delivery across multiple levels of the health system.

Sharp decline in HIV treatment: Mozambique's HIV programme is highly dependent on external support, with approximately 91% of people living with HIV receiving treatment through direct or indirect PEPFAR support prior to the cuts, and overall antiretroviral treatment coverage reaching an estimated 95%.[28] Following US stop-work orders, ART coverage fell from an estimated 95% to approximately 55% - not because treatment needs reduced, but because the delivery systems connecting people to it collapsed.

Increased vulnerability and inequity: For key populations, reports from affected communities indicate that the shift to public health facilities has led to increased experiences of stigma and discrimination, particularly for criminalised populations. Individuals have described being judged and humiliated when accessing services, which has eroded trust and discouraged them from returning to care. At the same time, the loss of peer-led support systems, psychosocial services, and community-based outreach has removed critical points of engagement, further weakening continuity of care for populations already facing heightened vulnerability.

Rising malaria burden: The impact of funding disruptions is also evident in Mozambique's malaria response, with emerging data pointing to significant deterioration in outcomes. Reporting from February 2026 indicates a 55% increase in malaria cases in the first six weeks of the year.[29] While reported deaths decreased over this period, the sharp rise in cases signals weakening prevention and control efforts at the time when extreme weather events are multiplying and accelerating malaria transmission. Subnational data reinforce this trend: in Niassa Province, malaria cases increased by 62.3% between January and August 2025 compared to the same period in 2024, coinciding with the period of US Government funding cuts.[30] These trends suggest that disruptions to community-based interventions, commodity distribution, and routine service delivery are already translating into increased transmission at population level.

Breakdown of community-led systems Community-led organisations in Mozambique receive less than 0.1% of their operating support from domestic sources, with 89% coming from bilateral donors and 10.9% from multilateral sources, according to UNAIDS. These shifts are increasing the strain on community actors and raising risks of burnout, with implications for the sustainability and quality of service delivery. Across both HIV and malaria responses, organisations have been forced to scale back operations, reduce staffing, and limit service delivery - leaving significant gaps particularly in areas where community-based programmes were the primary point of access.[31]

In response to reductions and disruptions in external health financing, both community actors and government systems in Mozambique have undertaken a range of adaptive measures to sustain essential HIV and malaria services. These responses demonstrate resilience, but also a shift towards more constrained, uneven, and potentially unsustainable models of service delivery.

At community level, stakeholder reports indicate a shift away from structured, programme-based service delivery towards more informal, relationship-based systems. Where funding for peer educators, outreach workers, and community health activities has been reduced or interrupted, community actors have continued to provide support through existing social networks and voluntary engagement. This includes maintaining contact with clients, supporting treatment adherence, and sharing information through informal channels such as mobile communication platforms. As community-based service delivery points have been reduced or closed, public health facilities are absorbing more demand for both HIV and malaria services.

In this context, community actors are taking on an expanded mediation role, supporting individuals to access and navigate public services. This includes accompanying clients to facilities, facilitating referrals, and helping to manage barriers related to stigma, discrimination, and system complexity. While particularly important for key populations, this role is uneven and largely unsupported, and cannot fully compensate for the loss of decentralised, community-led service delivery models that were previously more accessible and acceptable.

While these approaches have enabled some continuity of care, they represent a shift away from organised, quality-assured delivery towards more informal, relationship-based systems that depend heavily on personal commitment. At the same time, community organisations have been required to prioritise limited resources. Efforts have increasingly focused on maintaining treatment continuity for individuals already on antiretroviral therapy, particularly those at risk of interruption, while prevention and outreach activities have been scaled back in some areas.

Similar patterns are affecting malaria responses, where frontline systems are prioritising diagnosis and treatment over preventive and outreach activities. In practice, this means reduced investment in vector control, including insecticide-treated net distribution and other measures to reduce malaria-transmitting populations. While these decisions are rational in the short term, they risk increasing transmission and delaying case detection.

The reduction or closure of community-based and key population-friendly service delivery points has also led to a shift towards more decentralised and less visible forms of service delivery, including smaller-scale or informal support mechanisms. These spaces have historically played a critical role in providing integrated, stigma-free services and psychosocial support within the HIV response.

Despite funding constraints, community-led monitoring (CLM) and feedback mechanisms continue to function in adapted forms. Communities are still identifying and reporting service disruptions, including treatment interruptions, stockouts, and access barriers, using more informal or reduced-cost approaches. However, participation is declining as financial and logistical support diminishes, raising concerns about the sustainability of community-based accountability and real-time feedback systems.

At government level, adaptation has focused on maintaining core service delivery within a constrained fiscal and operational environment. Mozambique continues to rely heavily on external financing for both HIV and malaria programmes, including support from the Global Fund, and has engaged in reprioritisation processes to protect essential life-saving interventions over prevention.

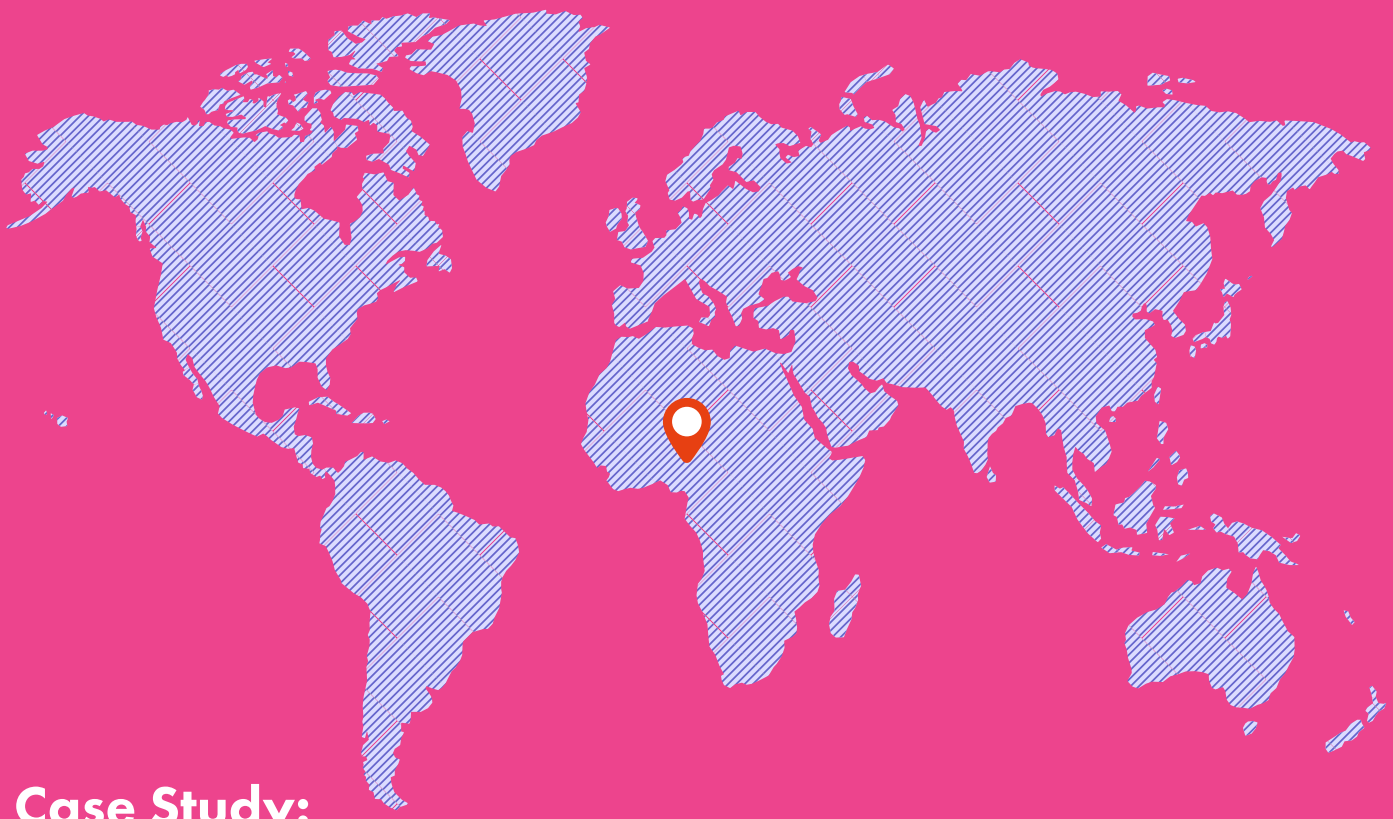
1.4 Critical risks to watch

Current trends point to a set of interrelated risks that could undermine recent progress in Mozambique's HIV and malaria responses. Chief among these is a growing financing gap, which may lead to rapid contraction of essential services, particularly in prevention and community-based delivery. Early signals, including reduced HIV testing and prevention coverage alongside rising malaria cases, suggest a risk of increased transmission and reversal of recent gains. At the same time, the sustainability of treatment programmes may be threatened by service disruptions, raising the risk of treatment interruption and loss of adherence.

The continued erosion of community-led systems, combined with increasing pressure on overstretched public health facilities, risks reducing both access to and quality of care, particularly for key and vulnerable populations. Weakening monitoring and feedback mechanisms further limit the ability to detect and respond to emerging service gaps in a timely manner.

In parallel, the current focus on maintaining life-saving services is constraining investment in longer-term resilience. This limits Mozambique's ability to adopt a One Health approach and prepare for environmental challenges, despite recent extreme weather events that have already disrupted health systems and affected malaria transmission.

Taken together, these dynamics point to a heightened risk of declining coverage, widening inequities, and deteriorating health outcomes in the absence of sustained and predictable support.



Case Study: Nigeria

2.1 Overview of Situation Prior to Cuts

Nigeria: HIV and Malaria - snapshot prior to DAH cuts

- HIV: 90-90-90 targets unmet as of 2025. 87% of the national HIV budget funded by the US Government. Legal barriers compound vulnerability with same-sex relationships and drug use criminalised, driving HIV risk among key populations.
- Malaria: Highest global malaria burden and endemic nationwide. Between 2022 and 2023, cases declined by approximately 2% and deaths by 6.5%. Over half of estimated malaria cases remain undiagnosed. Prevalence significantly higher in rural areas.
- Health system context: Only an estimated 20% of primary healthcare facilities are fully functional. Out-of-pocket expenditure stands at approximately 76%, among the highest globally.
- Nigeria has the strongest economy in Africa, yet poverty has risen from 56% in 2023 to 63% in 2025.[32]
- In 2023, Nigeria spent 4.19% of its GDP on health,[33] though 5% is commonly recommended as minimum for moving towards Universal Health Coverage.[34]
- The response to HIV and malaria has been strongly supported by external financing, particularly through the Global Fund. For the 2023–2025 allocation period, Nigeria received approximately US$933 million from the Global Fund, with 40% allocated to HIV and 45% to malaria. The 2023 US Government contribution for health in Nigeria was US$600 million.[35]
- Legal and structural barriers also persist, including the criminalisation of same-sex relationships and drug use, which has been linked to increased HIV vulnerability among key populations.[36]

2.2 Recent Trends and Nature of Cuts

- In 2025, the US Government cut approximately US$600 million of funding to Nigeria, i.e., over 20% of Nigeria's health budget.[37] Under its first MOU with the United States through the America First Global Health Strategy, Nigeria is set to receive US$2.1 billion over five years for essential preventative and curative services for HIV, tuberculosis, malaria, maternal and child health, and polio.[38]
- The US had been the Global Fund's largest donor. The reduced US pledge and cancelled payments resulted in a 10% reduction of the current grant cycle 7 allocation for Nigeria, causing significant reductions to several ongoing or planned projects.[39]
- Much of Nigeria's HIV budget has been "paused or terminated". The national health budget had not increased and remained at 5.51%. Estimates at that time approximated loss of "tailored HIV prevention services" for over 2 million people, with interventions for young people particularly having been disrupted.[40]

2.3 Adaptations and responses

Nigeria's response to recent funding disruptions has been shaped by both government action and rapid, locally driven adaptation by community and civil society actors. While national coordination and partner reprioritisation have helped stabilise core services, stakeholders described a response in which communities are actively reconfiguring service delivery.

The Government of Nigeria has taken steps to coordinate the response, mobilise domestic resources, and maintain engagement with partners. In February 2025, the government appropriated US$200 million to mitigate the effects of US funding cuts and approved approximately US$3.6 billion in 2025 to fund 150,000 HIV treatment packs.[41] The Global Fund and other partners have played a critical role in sustaining core services through grant reprioritisation, though this has involved trade-offs, including reduced investment in prevention, community systems, and integrated service delivery.

At community level, organisations have adapted service delivery to sustain access under constrained conditions. Outreach has been reorganised into smaller, decentralised networks, while peer educators and community health workers have maintained engagement with clients despite disruptions to formal programmes. Service delivery has shifted from structured models to more flexible, relationship-based approaches, relying on informal follow-up and adherence support. Communities are prioritising limited resources towards maintaining treatment continuity and supporting individuals at risk of disengagement from care.

These adaptations reflect a shift towards more constrained and uneven service delivery models. As community-based service points have been reduced, reliance on public health facilities has increased, with community actors supporting access, facilitating referrals, and helping individuals navigate stigma and system barriers. While critical for key populations, these roles remain uneven and largely unsupported.

Civil society organisations continue to play a central role in coordination, accountability, and system feedback. They remain engaged in national technical working groups, contribute to data validation processes, and participate in platforms such as the National Civil Society Accountability Forum. Community-led monitoring (CLM) continues to identify service disruptions, including treatment interruptions, stockouts, and access barriers, but participation is declining as financial and logistical support diminishes.

A central constraint remains the absence of institutionalised mechanisms to finance and sustain community-led responses. Nigeria does not yet have functional social contracting systems to enable direct government funding of civil society organisations, leaving community actors to take on expanded roles without a clear pathway for integration into the formal health system.

Alongside these immediate adaptations, Nigeria is pursuing longer-term reforms to strengthen integrated, people-centred health services. This includes efforts to expand integration across HIV, sexual and reproductive health, mental health, and primary care, as well as pilot training of healthcare workers in selected states. Nigeria

has also taken steps to strengthen the policy environment for communities and adolescents, including commitments under the West and Central African Commitment on health and education and revisions to the Family Life and HIV Education curriculum. However, implementation remains contested and uneven, with resistance to comprehensive sexuality education and restrictive age-of-consent laws continuing to limit access for young people.

2.4 Impact of the cuts

Severe service disruption: Funding disruptions have had rapid and far-reaching effects on Nigeria's HIV and malaria responses, exposing deep structural dependence on external financing and weakening both service delivery and prevention outcomes across multiple levels of the health system. The disruption of service delivery platforms has compounded these trends.

Several targeted programmes have been interrupted, including Operation Triple Zero, which provided prevention and treatment support for adolescents and young people living with HIV, and iCARE, another youth-focused initiative.[42] Funding cuts have also reduced access to pre-exposure prophylaxis (PrEP) and other prevention services for these groups, as well as HIV treatment, education, and basic healthcare for children affected by AIDS.

Vulnerability of HIV treatment programmes: Nigeria's treatment programme remains highly dependent on external support, with approximately 80% of people living with HIV receiving treatment through direct or indirect PEPFAR support.[43] As a result, funding uncertainty has immediate implications for continuity of care. While the Government of Nigeria has allocated an additional US$3.2 million to support treatment, stakeholders report persistent access challenges, including delays, reduced service availability, and increased pressure on already constrained facilities. Reductions in the community health workforce have further disrupted HIV testing and counselling services, limiting outreach, follow-up, and adherence support.

Decline of HIV prevention services: Prevention services have been more severely affected. Oral PrEP use has declined sharply, with an estimated 85% reduction in users, and the number of people receiving HIV preventive drugs fell from approximately 43,000 in November 2024 to fewer than 6,000 by April 2025.[44] This reflects both the suspension of community-based delivery models and disruption to implementing partner operations. UNAIDS also reported a significant decrease in the availability of HIV testing services and community health workers in March 2025, further constraining access to prevention and early diagnosis. Broader prevention efforts, including condom distribution, harm reduction, and behavioural change programmes, have been scaled back. These disruptions increase the risk of rising HIV and hepatitis C transmission among people who use drugs and threaten to undo years of progress in harm reduction.

Constraints on innovation and future prevention tools: The roll-out of new prevention technologies has also been disrupted. The introduction of long-acting cabotegravir (CAB-LA), a key innovation in HIV prevention, is continuing only at sites supported by the Global Fund, highlighting the increasing concentration of innovation within externally financed programmes and raising concerns about equitable access and long-term sustainability.

Increased vulnerability and inequity: More than 80 one-stop shops providing integrated, stigma-sensitive services have been affected, limiting access to comprehensive care for vulnerable populations. Although national guidance for stigma-free services exists, stakeholders report inconsistent implementation in public health facilities, particularly for key and vulnerable populations. The loss of tailored, community-based services has reduced access to safe and acceptable care for key populations.

Emerging risks in malaria control: The impact of funding disruptions is also evident in Nigeria's malaria response, particularly in the delivery of prevention campaigns and essential commodities. Malaria control remains heavily dependent on external financing, including support from the Global Fund and US-backed programmes. Stakeholders report emerging risks to the continuity of seasonal malaria chemoprevention (SMC), insecticide-treated net (ITN) distribution campaigns, and community-level case management. Disruptions to implementing partners and community health worker networks have reduced the reach and timeliness of these interventions,

particularly in high-burden northern states. For malaria, initiating treatment within days is essential to avoid death in children under five, any disruption of services constitutes a reduction in chances of survival.

Supply chain instability and system fragility: Uncertainty in funding flows is affecting procurement planning and supply chain stability, increasing the risk of stockouts of rapid diagnostic tests (RDTs), antimalarial medicines, and preventive commodities. As with HIV services, reductions in community-based delivery capacity are constraining outreach, early diagnosis, and treatment at household level. While large-scale disruptions have so far been partially mitigated, stakeholders emphasise that the system is increasingly fragile, with further funding gaps likely to translate rapidly into increased transmission and preventable mortality. Unclear continuation plans for the U.S. Global Health Supply Chain Program will exacerbate the fragility unless addressed.

2.5 Critical risks to watch

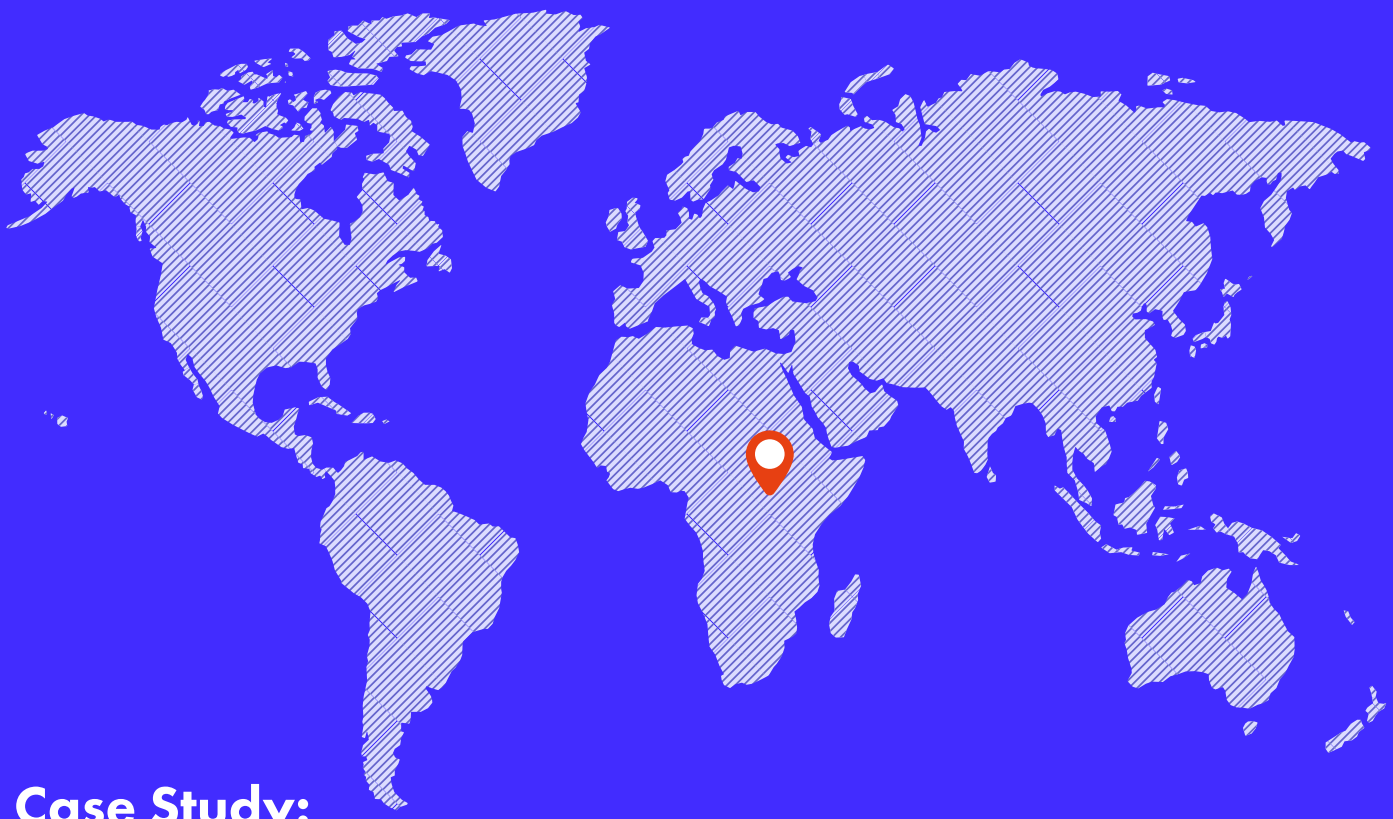
Current trends point to a set of interrelated risks that could undermine recent progress in Nigeria's HIV and malaria responses. Chief among these is a growing financing gap, as core programmes remain heavily dependent on external support. While treatment has been partially protected, prevention, community systems, and campaign-based interventions are already being eroded, increasing the risk of rising HIV infections and malaria transmission. In malaria, reliance on large-scale delivery platforms such as seasonal malaria chemoprevention and insecticide-treated net campaigns means that funding disruptions are likely to translate rapidly into reduced coverage and increased morbidity.

The sustainability of treatment programmes and community-led responses also remains uncertain. The erosion of community systems, combined with increasing pressure on overstretched public health facilities, risks reducing both access to and quality of care, particularly for key and vulnerable populations. Weakening monitoring and feedback mechanisms further limit the ability to detect and respond to service disruptions in a timely manner.

In parallel, legal and policy constraints may further limit the reach and inclusivity of the response. Restrictive laws, combined with emerging donor conditions, risk narrowing programme scope and reducing access for key populations, potentially exacerbating inequities and weakening prevention outcomes. At the same time, gaps in financing for integrated services under universal health coverage and the current focus on maintaining core services constrain investment in longer-term resilience, including preparedness for climate and environmental pressures such as changing rainfall patterns, deforestation, and the spread of new malaria vector species.

The anticipated end of PEPFAR support is expected to exacerbate these trends and expose Nigeria's fragile health system to significant risks, including reduced access to ART, stockouts of essential drugs and diagnostics, loss of implementation capacity and technical expertise, and erosion of gains in prevention of mother-to-child transmission (PMTCT) and viral suppression.

Taken together, these dynamics point to a heightened risk of declining coverage, widening inequities, and deteriorating health outcomes in the absence of sustained and predictable support.



Case Study: Uganda

3.1 Overview of Situation Prior to Cuts

HIV and Malaria: snapshot prior to DAH cuts

- One of the highest burdens of HIV and malaria globally: approximately 1.5 million people living with HIV, of whom around 1.3 million are receiving antiretroviral therapy (ART).[45]
- Among the highest malaria burden countries globally, accounting for approximately 4.8% of cases in the WHO African Region. The entire population is at risk, with malaria responsible for 30–40% of outpatient visits and around 20% of hospital admissions.[46]
- Uganda faces significant fiscal constraints, with a high debt burden and limited domestic resource mobilisation capacity, constraining public spending on health. Domestic health expenditure remains below the Abuja target of 15%, at approximately 8.1% of government expenditure.[47]
- The HIV response in Uganda is heavily dependent on external financing. Approximately 70% of the HIV budget is funded by the United States, and nearly all people on treatment rely on PEPFAR-supported systems.[48]
- Uganda received an allocation of approximately US$587 million from the Global Fund for 2023–2025, with 49% directed to HIV and 45.5% to malaria, reflecting continued prioritisation of these diseases.[49]
- Malaria control is also highly donor-dependent, with the Global Fund as the largest contributor, complemented by US Government support through the PMI. These investments finance core interventions including insecticide-treated net distribution, indoor residual spraying, and access to diagnostics and treatment.[50] 2023 PMI budget for Uganda was US$34m.[51]
- The legal and policy environment remains a significant constraint for key populations. The introduction of the Anti-Homosexuality Act in 2023 has reinforced the criminalisation of same-sex relations, while sex work and drug use remain criminalised under Ugandan law, and transgender people face criminalisation in practice. These legal frameworks create substantial barriers to accessing HIV prevention and treatment services, reinforcing stigma, fear, and reduced engagement with care.[52]

3.2 Recent Trends and Nature of Cuts

- Uganda experienced cuts by USAID, US Centers for Disease Control and Prevention (USCDC), PEPFAR and PMI, as well as secondary cuts when the US Government reduced funding to the Global Fund in 2025. Sources estimate that USAID cut approximately US$307 million from Uganda's allocation (66%).[53]
- 67% of civil society organisations stated that the reduction in USCDC funding affected their operations; USAID withdrawal affected 33% (of PEPFAR-supported organisations).[54] 43% of community organisations stated that 75% of their organizational budget was funded by US Government sources.[55]
- The above-mentioned funding for community-based work was largely rescinded and is unlikely to be covered by the national government, given the Anti-Homosexuality Act.[56]
- Uganda and the US Government signed a MOU that promises US$1.7bn DAH i.e., an annual average of US$340m, with a $577m co-investment from Uganda over the course of five years. This represents a gradual year-on-year increase in Uganda's health spending and an almost two-third annual reduction in US funding (USAID DAH to Uganda in 2024 was reportedly $950 million).[57]

3.3 Adaptations and responses

In response to the funding shock, Uganda's adaptation has been rapid but constrained, with actions across government, partners, and communities focused on maintaining essential services. While these measures demonstrate resilience, they are primarily mitigating immediate impacts rather than addressing underlying structural gaps.

At government level, efforts have prioritised continuity of essential services and accelerated integration into primary healthcare. Domestic health allocation has increased from 5.6% in 2024/25[58] to approximately 8.1% of the national budget signalling political commitment but remains well below the Abuja target and insufficient to replace external funding.[59] Task-shifting and workforce optimisation have been expanded to sustain service delivery under constrained conditions. At the same time, integration is being accelerated under pressure; while aligned with long-term goals, stakeholders caution that, without adequate resources, it risks reducing access to differentiated, community-led services, particularly for key populations.

The Global Fund has initiated reprioritisation processes to safeguard core treatment and high-impact interventions within existing grants. While it remains a critical stabilising actor, Grant Cycle 7 reprioritisation resulted in an estimated 11% reduction across grants in Uganda. In practice, this has meant prioritising treatment continuity, often at the expense of prevention, community systems, and enabling environment interventions, reinforcing a shift away from community-based delivery models.

At community level, organisations have played a central role in sustaining the response, acting as a primary buffer against service disruption. Community-led organisations have conducted rapid assessments, documented service gaps, and engaged in advocacy at national and global levels, while continuing to deliver services through volunteer networks, informal systems, and internal reallocation of limited resources. Peer supporters, expert clients, and community leaders have continued to follow up clients, provide counselling, and support treatment adherence, often without pay and at personal cost.

Adaptation has increasingly shifted from structured service delivery to more informal, relationship-based approaches. Communities are maintaining contact with clients through peer networks, strengthening referral pathways between organisations, and adopting low-cost and digital approaches to counselling and follow-up. In some cases, individuals are travelling longer distances or pooling resources to access services that were previously available locally. Coordination has also been maintained through regular information-sharing mechanisms, including frequent meetings to track service gaps and mobilise support.

For key populations, community organisations have adapted by keeping some drop-in centres partially operational through volunteer labour and in-kind support, while shifting towards peer-to-peer follow-up, digital counselling, and strengthened referral networks. These

approaches have enabled a minimum level of continuity but represent emergency coping mechanisms rather than sustainable service delivery models.

In malaria responses, community actors continue to support awareness, informal distribution of prevention tools, and local surveillance, even as formal systems weaken and preventive activities are deprioritised.

These adaptations demonstrate significant resilience. However, they are increasingly constrained and uneven. Community organisations report rising strain, reduced coverage, and growing uncertainty about their ability to continue operating, with smaller grassroots organisations particularly at risk. Without predictable financing, community-led systems that are currently sustaining service delivery are likely to contract further.

3.4 Impact of the cuts

Severe service disruption: Reductions in development assistance for health have had immediate and systemic impacts on Uganda's HIV and malaria responses, most acutely at community level where prevention, outreach, and last-mile service delivery are concentrated. While treatment commodities remain relatively available in the short term, the systems required to deliver them equitably are being eroded.[60] By early 2025, national authorities reported disruptions to HIV commodity distribution linked to reliance on externally funded implementers, alongside the suspension of programmes addressing stigma and discrimination, with no replacement funding identified.[61]

Erosion of community-led delivery systems: Uganda's HIV response relies heavily on externally funded implementing partners and community-led organisations to deliver services beyond health facilities.[62] As these actors scale back or halt operations, access is declining even where medicines remain available. Community stakeholders describe this as the erosion of the "invisible infrastructure" of the response, including peer networks, outreach teams, and trusted community platforms that sustain engagement in care.

Erosion of HIV prevention services: The most immediate impacts are in HIV prevention. HIV testing, PrEP, condom distribution, and peer-led outreach have been widely disrupted, particularly for key populations. UNAIDS reported that 31% of people lost access to PrEP and that HIV testing declined by 17% in the first half of 2025, with no evidence of recovery during this period.[63] Access to new prevention technologies has also been affected, including the suspension of studies on injectable Cabotegravir and the Dapivirine vaginal ring.

Loss of access for key populations: For key populations, service disruption does not result in substitution but in loss of access altogether. In Uganda's restrictive legal environment, many rely on community-led services as their primary entry point to care. As these services contract, individuals are unwilling or unable to access facility-based services due to stigma, discrimination, and criminalisation, increasing the risk of new HIV infections.

A rapid assessment found that 97% of key population-led organisations reported being affected by funding disruptions, with many indicating reduced capacity to deliver essential services.[64] As community-led platforms scale down, access points that are safe and acceptable for key populations are being lost, contributing to reduced service uptake, increased anxiety, and heightened exposure to stigma and discrimination.

Disruptions to HIV treatment support systems: Although ART commodities remain available in the short term, delivery systems have been disrupted. Close to all ART provision in Uganda has been supported through PEPFAR-linked systems, and early 2025 disruptions affected continuity of treatment delivery. Reductions in mentor mothers, expert clients, and peer navigators are weakening adherence support, prevention of vertical transmission, and early infant diagnosis, increasing risks of treatment interruption, particularly for vulnerable groups.

Breakdown of community systems: Community-based treatment support systems in HIV have also been significantly affected. Reductions in mentor mothers, expert clients, and peer navigators are weakening adherence support, prevention of vertical transmission, and early infant diagnosis,[65] increasing risks of treatment interruption, particularly for vulnerable groups.

Emerging risks in malaria response: Uganda's malaria response is similarly affected, with strong dependence

on community-based delivery systems, particularly in hard-to-reach localities. Funding disruptions are reducing outreach, delaying campaigns, and straining community health workers, with more than 12,000 potentially affected.[66] This directly limits access in high-burden areas, where even short disruptions are likely to increase cases and deaths, particularly among children as delays in diagnostics and treatment in children under 5 affect drastically chances of survival within days.

Widening inequities: Across both HIV and malaria, services closest to communities are the first to be disrupted, while facility-based care remains relatively protected. This risks widening inequities, as populations least able to access formal systems are the first to lose care.

3.5 Critical risks to watch

Current trends point to a set of interrelated risks that could undermine recent progress in Uganda's HIV and malaria responses. Chief among these is a growing financing gap, as prevention, community systems, and outreach services continue to contract. Disruptions to HIV prevention and community engagement are already reducing uptake of services, particularly among key populations, while reduced malaria prevention coverage increases the likelihood of localised transmission and reversal of recent gains.

The sustainability of community-led systems and continuity of care are increasingly at risk. As funding constraints persist, community-led organisations are reducing coverage, with smaller organisations at particular risk of closure. The loss of peer-led support, treatment literacy, and psychosocial services is weakening adherence and retention, while service disruptions, including stockouts of antiretrovirals, PrEP, and harm reduction commodities, are further limiting access. These pressures are especially serious because community resilience is increasingly being sustained through unpaid labour, informal coping mechanisms, and shrinking organisational capacity.

The risks are particularly acute for key populations. As community-led and differentiated services contract, individuals facing stigma, discrimination, and criminalisation are increasingly left without safe access points to care. Integration into general health services, while necessary for sustainability, may further reduce access if not accompanied by strong safeguards, as many individuals are unwilling or unable to seek care in settings where confidentiality and non-discrimination are not assured. In this context, funding cuts risk reinforcing existing legal and structural barriers, effectively excluding key populations from prevention and treatment services at a critical moment in the response.

In parallel, structural and policy constraints continue to limit the effectiveness and inclusivity of the response. While integration into primary healthcare is being accelerated, limited resources and uneven implementation risk reducing access to tailored services, particularly in rural and lower-level facilities. Restrictive legal frameworks, age-of-consent barriers, and a tightening civic space further constrain access, increase the cost and complexity of operating for civil society organisations, and limit their ability to mobilise resources, deliver services, and engage in advocacy. In the context of declining external funding, this creates a compounding risk: community systems are not only underfunded but face growing structural barriers to operating effectively.

Taken together, these dynamics point to a heightened risk of declining coverage, widening inequities, and deteriorating health outcomes in the absence of sustained and predictable support.

Conclusion

The cases of Mozambique, Nigeria, and Uganda demonstrate that recent reductions in development assistance for health are not resulting in a managed transition towards sustainability. Instead, they are generating a systemic shock across HIV and malaria responses in settings that remain structurally dependent on external financing. While treatment continuity has in some cases been partially preserved through e.g., cutting back on other essential services and/or corrective processes such as grant reprioritisation, this has often been achieved by reducing investment in prevention, community systems, outreach, and differentiated service delivery — functions that are essential to the effectiveness, equity, and long-term sustainability of national responses.

Across all three countries, a consistent pattern is evident. First, the reductions are eroding the community-level architecture that enables access to care, particularly for populations facing stigma, discrimination, or legal barriers. Second, they are shifting additional demand onto already constrained public health systems without commensurate increases in financing, workforce capacity, or system readiness. Third, they are increasing the risk of epidemiological reversal, particularly where prevention coverage, early diagnosis, and local accountability mechanisms are weakening. While current adaptations have mitigated immediate collapse, they are largely compensatory and are unlikely to be sustained over time.

Taken together, these trends point to broader systems risk. Health services may remain formally available but are becoming less accessible in practice as the delivery platforms that connect individuals to care are weakened. The result is a gradual loss of coverage, continuity, and trust, dynamics that are not always immediately visible in aggregate data, but which have significant implications for future disease trajectories and response costs.

aidsfonds

Friends of the Global Fund Europe

Endnotes

1 Apeagyei AE, Bisignano C, Elliott H, Hay SI, Lidral-Porter B, Nam S, Shyong C, Tsakalos G, Zlavog BS, Baris E, Murray CJL, Dieleman JL. (2025) Tracking development assistance for health, 1990-2030: historical trends, recent cuts, and outlook. Lancet. Jul 26;406(10501):337-348. doi: 10.1016/S0140-6736(25)01240-1 Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12439094/

2 HIV.gov. PEPFAR. Available at: https://www.hiv.gov/federal-response/pepfar-global-aids/pepfa

3 US Department of Health and Human Services (2026). Fact Sheet: U.S. Withdrawal from the World Health Organization. Available at: https://www.hhs.gov/press-room/fact-sheet-us-withdrawal-from-the-world-health-organization.html

4 Ibid.

5 Chatham House (2025). Africa after USAID. Who Will Foot the Bill? Available at: https://www.chathamhouse.org/2025/10/africa-after-usaid-who-will-pay-health-bill

6 United States of America (2025). America First Global Health Strategy. Available at: https://www.state.gov/wp-content/uploads/2025/09/America-First-Global-Health-Strategy-Report.pdf

7 UNAIDS (2025). Overcoming Disruption. Transforming the AIDS Response. Available at: https://www.unaids.org/sites/default/files/2025-11/2025-WAD-report_en.pdf

8 WHO (2024). World Malaria report 2024. Available at: https://www.who.int/publications/i/item/9789240104440

9 KFF (2026). The Mexico City Policy: An Explainer. Available at: https://www.kff.org/global-health-policy/the-mexico-city-policy-an-explainer/#cfa66cf9-befc-490d-93fc-b3d-26d2cd175

10 Reuters (2026). Exclusive: US upends global supply program for malaria and HIV amid warnings of gaps. Available at: https://www.reuters.com/business/healthcare-pharmaceuticals/us-upends-global-supply-program-malaria-hiv-amid-warnings-gaps-2026-04-03/

11 Health GAP (2026). Open Letter to Secretary of State Marco Rubio. Available at: https://healthgap.org/wp-content/uploads/2026/04/Open-Letter_Secretary-of-State-1-1.pdf

12 Global Fund (2026). HIV and AIDS. Available at: https://www.theglobalfund.org/en/hivaids

13 Global Fund (2026). Malaria. Available at: https://www.theglobalfund.org/en/malaria

14 Human Rights Watch (2026). Donor Nation Cuts to Global Health Financing Affect Millions. Available at https://www.hrw.org/news/2026/01/22/donor-nation-cuts-to-global-health-financing-affect-millions

15 The Global Fund (2025). Strategic Shifts and Adaptations for GC8. Available at: https://resources.theglobalfund.org/en/strategic-shifts-gc8/

16 UNAIDS (2025). HIV Epidemic in Mozambique and US Government Contribution (PEPFAR). Available at: https://www.unaids.org/sites/default/files/20250218_PEPFAR-Mozambique_en.pdf

17 George W Bush Presidential Center (2026). Beyond 2030: Special cases for longer-term U.S. HIV investment. Available at: https://www.bushcenter.org/publications/beyond-2030-special-cases-for-longer-term-u-s-hiv-investment

18 Severe Malaria. Mozambique Malaria Facts. Available at: https://www.severemalaria.org/countries/mozambique

19 WHO (2025). World Malaria Report 2025. Available at: https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2025

20 Frontline AIDS (2025). At a Crossroads. Responding to a New AIDS Emergency in Mozambique. Available at: https://frontlineaids.org/wp-content/uploads/2025/11/MOZAMBIQUE-Accountability-report-2025_FINAL_DIGITAL.pdf

21 N'weti and Wemos (2024). The Future of Health in Mozambique. Collaborative Efforts for Sustainable Financing. Available at: https://www.wemos.org/wp-content/uploads/2024/10/Policy-brief_Wemos-Nweti_The-future-of-health-in-Mozambique.pdf

22 Ibid.

23 Frontline AIDS (2025). At a Crossroads. Responding to a New AIDS Emergency in Mozambique. Available at: https://frontlineaids.org/wp-content/uploads/2025/11/MOZAMBIQUE-Accountability-report-2025_FINAL_DIGITAL.pdf

24 Ibid.

25 Reliefweb (2024). President's Malaria Initiative: Mozambique Fact Sheet (Updated February 2024). Available at: https://reliefweb.int/report/mozambique/presidents-malaria-initiative-mozambique-fact-sheet-updated-february-2024

26 Frontline AIDS (2025). At a Crossroads. Responding to a New AIDS Emergency in Mozambique. Available at: https://frontlineaids.org/resources/at-a-crossroads-responding-to-a-new-aids-emergency/#

27 Think Global Health (2026). Tracking The America First Bilateral Health Agreements. Available at: https://www.thinkglobalhealth.org/article/tracking-the-america-first-bilateral-health-agreements

28 Frontline AIDS (2025). At a Crossroads. Responding to a New AIDS Emergency in Mozambique. Available at: https://frontlineaids.org/resources/at-a-crossroads-responding-to-a-new-aids-emergency/#

29 Beacon (2026). Malaria cases in Mozambique surge 55% in early 2026 amid peak rainy season and floods. Available at: https://beaconbio.org/en/report/?reportid=36de7db7-93ac-40f3-a308-bda3f7500604&eventid=7f1b9f32-0aa5-4495-9e76-a53ffb8f90ee

30 Ibid.

31 UNAIDS (2025). Overcoming Disruption. Transforming the AIDS Response. Available at: https://www.unaids.org/sites/default/files/2025-11/2025-WAD-report_en.pdf

32 Business Day (2026). Nigeria's Poverty Crisis Deepens as 140 million Struggle despite Easing Inflation. Available at: https://businessday.ng/news/article/nigerias-poverty-crisis-deepens-as-140-million-struggle-despite-easing-inflation/

33 World Bank Open Data. Available at: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?end=2023&locations=NG&start=2000

34 Mcintyre D, Meheus F, R ttingen JA. (2017) What level of domestic government health expenditure should we aspire to for universal health coverage? Health Econ Policy Law. 2017 Apr;12(2):125-137. doi: 10.1017/S1744133116000414. PMID: 28332456.

35 Associated Press (2025). Nigerian lawmakers approve $200 million to offset shortfall from US health aid cuts. Available at: https://apnews.com/article/nigeria-us-aid-budget-health-c6945ecc3864c39a40f1e6b1cb3b5216

36 Eluwa GIE, Adebajo SB, Eluwa T, Ogbanufe O, Ilesanmi O, Nzelu C. Rising HIV prevalence among men who have sex with men in Nigeria: a trend analysis. BMC Public Health. 2019 Sep 2;19(1):1201. doi: 10.1186/s12889-019-7540-4 Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC6721282/

37 Chatham House (2025). Africa after USAID. Who will foot the bill? Available at: https://www.chathamhouse.org/2025/10/africa-after-usaid-who-will-pay-health-bill

38 U.S. Department of State (20205). Expanding Faith-Based Healthcare in Nigeria Through the America First Global Health Strategy. Available at: https://www.state.gov/releases/office-of-the-spokesperson/2025/12/expanding-faith-based-healthcare-in-nigeria-through-the-america-first-global-health-strategy/

39 Ibid.

40 Ibid.

41 The Borgen Project (2026). Fighting HIV/AIDS in Nigeria. Available at: https://borgenproject.org/hiv-aids-in-nigeria-2/

42 Frontline AIDS (2025). At a Crossroads. Responding to a New AIDS Emergency in Nigeria. Available at: https://frontlineaids.org/wp-content/uploads/2025/11/Nigeria-Accountability-report-2025_FINAL_DIGITAL.pdf

43 Ibid.

44 Ibid.

45 UNAIDS (2024) Uganda country factsheet. Available at: https://www.unaids.org/en/regionscountries/countries/uganda

46 World Health Organization (2024) World Malaria Report 2024. Available at: https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-202447

48 Frontline AIDS (2025) At a crossroads: Responding to a new AIDS emergency in Uganda. Available at: https://frontlineaids.org/wp-content/uploads/2025/11/UGANDA-Accountability-report-2025_FINAL_DIGITAL.pdf

49 The Global Fund (2023) Uganda allocation data 2023–2025. Available at: https://data.theglobalfund.org

50 U.S. President's Malaria Initiative (2023) Uganda Malaria Operational Plan. Available at: https://www.pmi.gov

51 Reliefweb (2024). President's Malaria Initiative Uganda Country Fact Sheet. Available at: https://reliefweb.int/report/uganda/presidents-malaria-initiative-uganda-country-fact-sheet-updated-february-2024

52 Uganda Key Populations Consortium (2025). No Time to Wait: Mobilizing Resources to Safeguard the Health and Human Rights of Key Populations in Uganda. Available at: https://pepfarwatch.org/wp-content/uploads/2025/02/UKPC-no-time-to-wait.pdf

53 The Borgen Project (2025). NGO Partnerships following Foreign Aid Cuts in Uganda. Available at: https://borgenproject.org/foreign-aid-cuts-in-uganda/#

54 Uganda Key Populations Consortium (2025). No Time to Wait: Mobilizing Resources to Safeguard the Health and Human Rights of Key Populations in Uganda. Available at: https://pepfarwatch.org/wp-content/uploads/2025/02/UKPC-no-time-to-wait.pdf

55 Ibid.

56 Ibid.

57 SciDev Net (2025). US aid freeze deals blow to Uganda's health, research. Available at: https://www.scidev.net/global/news/us-aid-freeze-deals-blow-to-ugandas-health-research/

58 UNICEF (2025). Health Sector Financing. Analysis and Strategic Recommendations (FY2025/26). Available at: https://www.unicef.org/uganda/media/20426/file/2025-2026%20Health%20Sector%20Budget%20Brief.pdf

59 Frontline AIDS (2026) At a Crossroads: Responding to a new AIDS Emergency in Uganda. Available at: https://frontlineaids.org/wp-content/uploads/2025/11/UGANDA-Accountability-report-2025_FINAL_DIGITAL.pdf

60 Physicians for Human Rights (PHR). (2025) On the Brink of Catastrophe: U.S. Foreign Aid Disruption to HIV Services in Tanzania and Uganda. Available at: https://phr.org/our-work/resources/on-the-brink-of-catastrophe-u-s-foreign-aid-disruption-to-hiv-services-in-tanzania-and-uganda/

61 UNAIDS (2025). Impact of Funding Cuts on Global AIDS Response. Country Update Uganda. Available at: https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250319_Uganda_fs

62 Physicians for Human Rights (PHR) (2025) On the Brink of Catastrophe: U.S. Foreign Aid Disruption to HIV Services in Tanzania and Uganda. Available at: https://phr.org/our-work/resources/on-the-brink-of-catastrophe-u-s-foreign-aid-disruption-to-hiv-services-in-tanzania-and-uganda/

63 UNAIDS (2025). Overcoming Disruption. Transforming the AIDS Response. Available at: https://www.unaids.org/sites/default/files/2025-11/2025-WAD-report_en.pdf

64 Uganda Key Populations Consortium (2025). No Time to Wait: Mobilizing Resources to Safeguard the Health and Human Rights of Key Populations in Uganda. Available at: https://pepfarwatch.org/wp-content/uploads/2025/02/UKPC-no-time-to-wait.pdf

65 Physicians for Human Rights (PHR) (2025) On the Brink of Catastrophe: U.S. Foreign Aid Disruption to HIV Services in Tanzania and Uganda. Available at: https://phr.org/our-work/resources/on-the-brink-of-catastrophe-u-s-foreign-aid-disruption-to-hiv-services-in-tanzania-and-uganda/

66 Physicians for Human Rights (PHR) (2025) On the Brink of Catastrophe: U.S. Foreign Aid Disruption to HIV Services in Tanzania and Uganda. Available at: https://phr.org/our-work/resources/on-the-brink-of-catastrophe-u-s-foreign-aid-disruption-to-hiv-services-in-tanzania-and-uganda/

Development Assistance for Health

Cuts to HIV and Malaria Funding in
Mozambique, Nigeria and Uganda

Report
May 2026

This research was led by Lesley Odendal for
Aidsfonds and Friends of the Global Fund Europe.

Contact:
Kasia Lemanska
klemanska@aidsfonds.nl

Delphine Thizy
delphinethizy@friendseurope.org

Photo Credit (Cover):
The Global Fund / Tommy Trenchard / Rooftop

Graphic Design:
nakk.studio
info@nakk.studio