

# UNDOONE



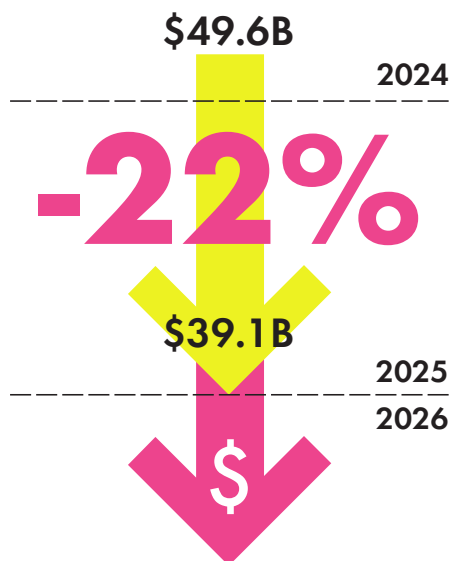
How funding cuts are reversing a generation of progress on HIV and malaria

May 2026

 **aidsfonds**

 Friends of  
the Global Fund  
Europe

# The shape of the crisis



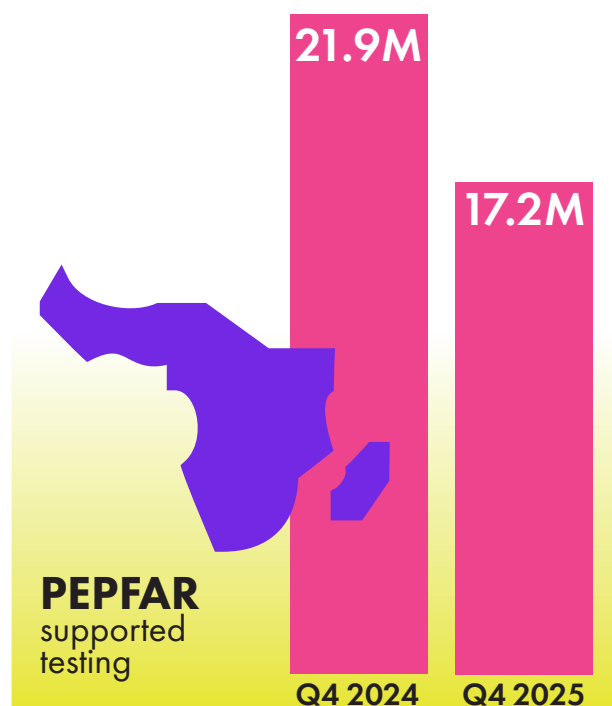
## 1.1 The funding floor has collapsed

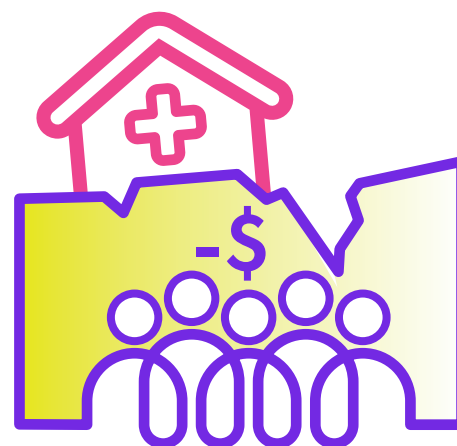
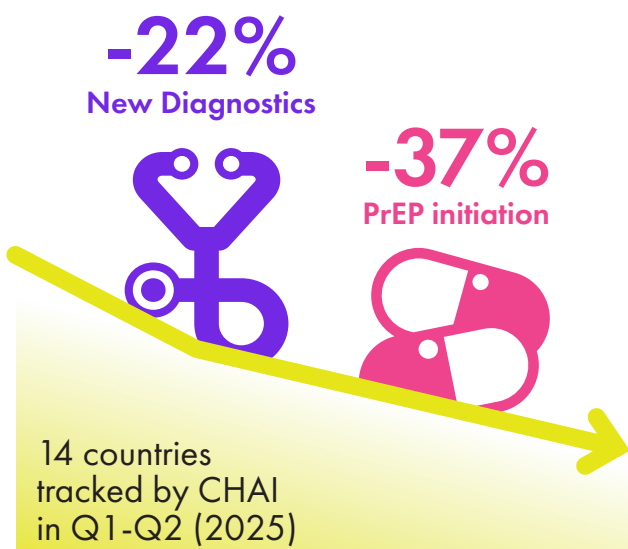
Since January 2025, global health financing has contracted at the fastest rate in a generation. **Development assistance for health fell by 22% between 2024 and 2025, with further reductions projected in 2026.** The United Kingdom, Germany, Belgium, Switzerland, and France have all announced cuts. The scale of the disruption is defined above all by the United States, which, before 2025, accounted for approximately three-quarters of global HIV/AIDS funding and was the largest single contributor to the malaria response, accounting for almost 40% of total financing.” USAID closed formally in July 2025. PEPFAR (President’s Emergency Plan for AIDS Relief) and PMI (President’s Malaria Initiative) have been severely curtailed. Where new bilateral arrangements have been announced under the America First Global Health Strategy, implementation lags behind commitment.

The Global Fund to Fight HIV, Tuberculosis and Malaria has been simultaneously weakened. Almost \$4 billion in pledges is unavailable for the 2023-2025 funding cycle, either due to payment delays, unclear donor intentions, or being set aside for technical assistance, resulting in reductions in country allocations. For the 2026-2028 cycle, the Global Fund raised \$12.64 billion - France and Japan more than halved their pledges, the UK cut by 15%, Germany cut by \$200 million - well below the \$15.7 billion raised for the previous cycle, which was already considered insufficient to reach elimination goals for HIV and malaria according to modellings.

## 1.2 Prevention and outreach bear the brunt of the cuts

**HIV:** The current wave of funding losses is disrupting supply chains, laboratory services, and health information systems, and has led to clinic closures, staff reductions, and stockouts, with resulting treatment interruption. Prevention has been hit first and hardest, reflecting its heavy reliance on external financing, which accounts for nearly 80% of prevention funding in sub-Saharan Africa. DREAMS – a flagship initiative focused on preventing HIV among adolescent girls and young women – has been reduced, and around 450,000 women in sub-Saharan Africa have lost access to “mother mentors,” weakening linkage to care. Services for key populations, voluntary medical male circumcision, and efforts to address stigma, discrimination, and gender-based violence have also been scaled back or cancelled. **PEPFAR-supported testing fell from 21.9 million in Q4 2024 to 17.2 million in Q4 2025. Across 14 countries tracked by the Clinton Health Access Initiative, PrEP initiations fell by 37% in the first half of 2025, while new diagnoses declined by 22%,** indicating reduced reach of community-based testing and outreach among populations at highest risk.



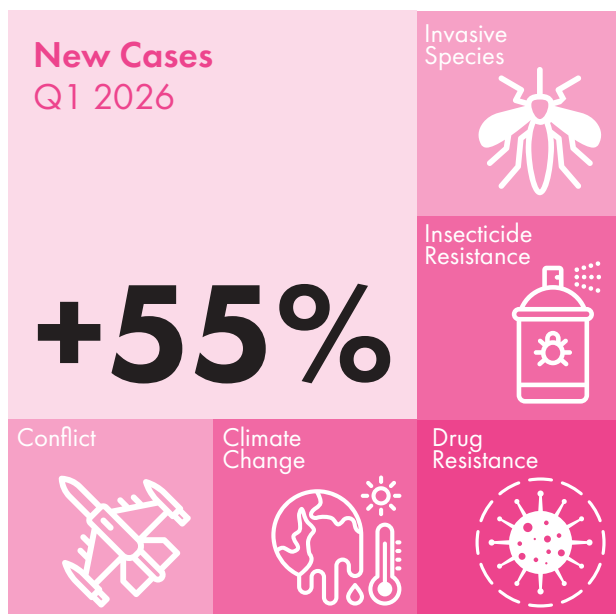


### 1.3 Community-led systems are under particular strain

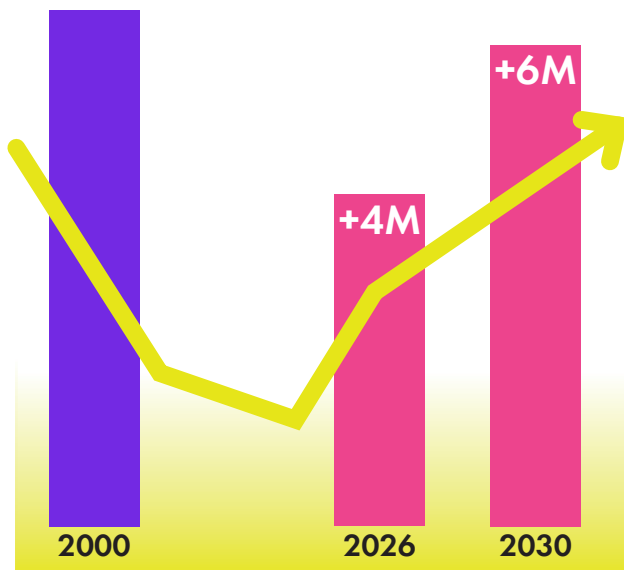
Much of the HIV and malaria response in high-burden countries is delivered through community-led organisations: peer educators, outreach workers, adherence supporters, harm reduction services, and platforms designed for populations that formal health systems do not safely reach. These organisations operate with almost no domestic financing base. In Mozambique, community-led organisations rely on bilateral donors for 89% of their funding and multilateral sources for a further 10.9%, with less than 0.1% coming from domestic sources. When external funding contracts are not renewed, these organisations scale back or close, and the people who depended on them do not simply transfer to public facilities.

For many, particularly those facing stigma, discrimination, or criminalisation, community-led services are the only viable access point to care. This is especially acute where legal environments compound the funding shock. In Uganda, the Anti-Homosexuality Act of 2023 criminalised same-sex relations, made the promotion of LGBTQ+ rights illegal, and required forced reporting of LGBTQ+ individuals. 97% of key population-led organisations in Uganda reported being affected by funding disruptions. In Nigeria, more than 80 one-stop shops providing integrated, stigma-sensitive services have been affected. When these platforms close, affected populations do not seek care elsewhere - they disengage entirely. In both HIV and malaria responses, community health workers represent the last-mile delivery infrastructure connecting high-burden, hard-to-reach populations to services. In Uganda alone, more than 12,000 community health workers are at risk. Their reduction is not a secondary consequence of the funding cuts; it is where a large share of the loss of access is occurring.

**Malaria:** A similar pattern is emerging, with treatment and case management prioritised over prevention and vector control activities. Insecticide-treated net distribution, indoor residual spraying, and seasonal malaria chemoprevention programmes are among the first to be scaled back. This is happening at a time when a perfect storm of drug and insecticide resistance, coupled with extreme climate events, conflicts and invasive species, are already jeopardising decades of progress. **In Mozambique, the sharp rise in cases (+55% in the first quarter of 2026) signals weakening prevention and control efforts at a time when extreme weather events are multiplying and accelerating malaria transmission.**



# The risks ahead



Looking ahead, if current funding patterns continue, three main risks become more likely:

## 2.1 Rising infections and deaths

As prevention weakens and case finding slows, both HIV and malaria begin to expand again. For HIV, reduced testing, prevention, and outreach mean infections rise before they are detected or treated. UNAIDS modelling shows that **if programmes previously supported by PEPFAR are halted, this could result in more than 4 million additional AIDS-related deaths and more than 6 million additional new HIV infections by 2030, potentially returning global HIV levels to those seen in the early 2000s.**

The same dynamic applies to malaria. If net campaigns are delayed, spraying reduced, or seasonal chemoprevention interrupted, transmission rises before mortality data fully capture the shift. Malaria is highly sensitive to operational disruption: short gaps in prevention can rapidly become large increases in cases, especially in fragile or climate-stressed settings. The most vulnerable populations - children under five and pregnant women - are first affected, with increased mortality linked to barriers in accessing treatment, particularly in rural areas. Case numbers may surge quickly, though deaths may lag as health systems initially absorb the shock, until prevention collapses and mortality inevitably rises.

## 2.2 Widening inequality

As community-led systems contract, those most likely to lose access are not the easiest to reach through formal facilities, but those already facing stigma, criminalisation, poverty, distance, or weak health infrastructure. For HIV, this means LGBTQ+ communities, sex workers, migrants, and people who use drugs; for malaria, children under five, pregnant women, and rural populations, who are affected first and most severely.

## 2.3 Loss of frontline capacity

A third risk is irreversible loss of frontline systems. Community networks, outreach teams, and frontline workers - critical for HIV prevention and malaria case detection - are not easily rebuilt once defunded. Years of trust, local knowledge, and delivery capacity can be lost faster than they can be restored.

These risks combine to produce higher long-term costs and weaker early warning. Delayed diagnosis, treatment interruption, and larger outbreaks become more expensive to manage over time. At the same time, weakened surveillance and reporting systems make it harder to detect problems early, meaning deterioration is identified later, when responses are already more difficult and costly.

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# What the EU must do

The cases of Mozambique, Nigeria, and Uganda reveal a troubling reality: reductions in development assistance for health are triggering systemic shocks across HIV and malaria responses in countries still heavily reliant on external funding. The EU must act decisively to reverse this trend, which is jeopardising its impactful investments in global health over the last few decades and the future of its partnership with African countries:

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Secure and protect global health financing by maintaining the Global Europe Instrument at €200 billion, while adding the Consensus on Development 20% target for ODA to human development, and two gender targets: at least 85% of ODA contributing to gender equality as a significant objective, and 20% of ODA targeting gender equality as a principal objective.

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Champion sustained investment in human rights, democracy, and civil society to address shrinking civic space, discrimination, and criminalisation as structural barriers to health.

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Provide direct, multi-year funding to community-led organisations, which reach populations that formal health systems do not safely serve.

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Deliver Global Fund contributions in full and on time. The current shortfall of over \$5 billion is already causing programme cuts and reduced investment in community systems. Without sustained European support, the risk of epidemiological reversal will grow.

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Beyond financing, the EU must adopt a policy approach that strengthens country-led health systems through inclusive integration and realistic transition planning. This means leveraging existing initiatives to help countries maintain treatment continuity without sacrificing prevention, outreach, or differentiated service delivery - especially for marginalised groups.

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By addressing structural barriers and investing in resilient supply systems, including regional manufacturing, the EU can ensure that health services remain accessible and effective, even as external funding evolves.

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**Policy Briefing**  
**May 2026**

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