OUT OF FRAME

How PEPFAR's MoUs remove key populations from the HIV response

This is part of a three-part GBGMC policy series that explores PEPFAR MoUs, PEPFAR reporting, and access to long-acting PrEP.

KEY FINDINGS

The first round of PEPFAR MoUs signals a clear shift in the HIV response—and the direction is not neutral.

- Funding is declining sharply. Current projections—confirmed by analysis of 24 signed MoUs as of March 2026—show an overall U.S. funding reduction of roughly 47% over five years, with country-level cuts ranging from 13% to 84%. The sharpest declines are in prevention: family planning and nutrition have been eliminated from the framework; maternal and child health is minimally present.

- Co-financing burdens are often unrealistic. Countries are expected to contribute an average of 33% of MoU program costs—equivalent to roughly 13% of 2023 domestic government health expenditure. In several countries, this exceeds projected government spending increases.

- Funding is front-loaded, creating dangerous cliffs. Kenya's U.S. funding, for example, drops 61% by year five. Annualised figures obscure the steep back-end reductions that threaten service continuity.

- Performance metrics are weak and do not track equity. The MoUs rely on population-level aggregate targets—derived from estimates with wide confidence intervals—that cannot reliably detect whether services are reaching the most at-risk populations.

- Key populations are not visible in the agreements. Across all signed and draft MoUs reviewed—including Rwanda, Liberia, Kenya, Uganda, and Zambia—there is no explicit mention of MSM, sex workers, people who inject drugs, transgender people, or AGYW-specific prevention services in service delivery commitments.

- The removal is structural, not accidental. When funding contracts, measurement weakens, and populations are not explicitly protected, services for key populations become the first to disappear—not through policy, but through systematic invisibility.

EXECUTIVE SUMMARY

A response that cannot see its most affected communities cannot end the epidemic

PEPFAR's new Memoranda of Understanding are being positioned as a transition toward country ownership and long-term sustainability. In practice, they mark a significant shift in how the HIV response is financed, measured, and held accountable—with consequences that fall disproportionately on the populations who have always driven the epidemic.

Recent analyses confirm that the metrics underpinning the MoUs are often difficult to measure, internally inconsistent, and not designed to support meaningful oversight. The transition toward national data systems and reduced transparency limits independent assessment. And the financing structures—declining U.S. contributions, aggressive co-financing demands, front-loaded funding followed by steep cliffs—create conditions in which difficult trade-offs become unavoidable.

What is systematically absent from the agreements is any explicit recognition of key populations: the gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and adolescent girls and young women who bear a disproportionate share of new HIV infections. Across every MoU reviewed, these populations are invisible in service delivery commitments, absent from performance metrics, and unprotected in the transition frameworks that will determine how services are funded and delivered over the next five years.

This is not a marginal oversight. In concentrated and mixed epidemics—which characterize most PEPFAR countries—key populations and their partners account for the majority of new infections. A response that cannot see these communities cannot achieve the epidemic control it has promised.

These changes are occurring as new prevention tools emerge. Lenacapavir (LEN) for PrEP has generated significant attention within the MoU framework and represents a genuine opportunity. But as the PIH and UCSF analysis presented in May 2026 observed: lenacapavir in the absence of functioning delivery systems is a very expensive shot in the dark. Without explicit inclusion of key populations in delivery models, a breakthrough technology risks perpetuating the same inequities it should address.

GBGMC and partners have continued to act in the absence of consistent guidance. Fourteen country-level implementation plans for reaching key populations with prevention and care services have been developed through this work—plans that are operational and grounded in service delivery realities. What is notable is not only that these plans exist, but that they have emerged largely outside formal national planning processes. At a moment when the broader system is still adjusting, much of the concrete planning for how to reach key populations is being carried out by the communities themselves.

PART ONE

A Structural Shift in the HIV Response

The MoUs do not simply change who funds the response. They change what the response is designed to see—and whom it is designed to reach.

Beginning in November 2025, the U.S. Department of State signed five-year Memoranda of Understanding with PEPFAR partner countries under the 'America First Global Health Strategy.' By March 2026, 24 countries had signed agreements, and as of June 2026, over 30 countries have concluded deals. Together, these represent approximately $13 billion in U.S. funding commitments over five years—one-third less than those same countries received over the previous five years, according to KFF.

Where earlier phases of the response relied on detailed programmatic oversight, standardised reporting, and publicly available data, the MoUs emphasise bilateral agreements, country-level responsibility, and a narrower framework for measuring progress. The stated goal is sustainability and country ownership. The underlying question is whether the systems that made the response effective—particularly for the most marginalised populations—are being carried forward.

What the MoUs Cover, and What They Don't

Each MoU establishes six core areas of cooperation: Surveillance and Outbreak Response, Laboratory Systems, Commodities, Frontline Healthcare Workers, Data Systems, and Strategic Assistance. HIV, tuberculosis, malaria, and global health security form the disease priorities.

What is not in the framework matters as much as what is. Analysis of signed MoUs confirms the following has been eliminated or sharply reduced:

Program areas eliminated or deprioritized (confirmed across signed MoUs)

→ Family planning / reproductive health: Eliminated from the MoU framework entirely
→ Nutrition: Eliminated from the MoU framework entirely
→ DREAMS (adolescent girls and young women prevention): Not mentioned in any MoU reviewed
→ Key population-specific programming: Not explicitly referenced in any MoU reviewed
→ Maternal and child health: Minimally present; at risk unless actively advocated for
→ Community-based prevention for MSM, sex workers, PWID: No protected status

In Kenya, for example, the shift is quantifiable. In FY2025, HIV represented 78% of the funding envelope. Under the five-year MoU, that share rises to 91%—meaning the absolute reduction in non-HIV areas is even steeper than the headline funding decline suggests. Family planning, previously 4% of the envelope, drops to zero. Nutrition, previously 1%, drops to zero.

Source: December 2025 MoU Analysis; Kenya program area distribution.

The Transactional Context

The MoU framework is explicitly transactional in ways previous PEPFAR was not. Countries must meet co-financing commitments or face dollar-for-dollar reductions in U.S. contributions. In Uganda, non-compliance penalties are steeper still—$2 for every $1 shortfall. Data and specimen sharing requirements are prerequisites for continued funding. In some cases—most visibly with Zambia—the U.S. linked health funding to access to critical minerals, a coupling Zambia's Foreign Minister described as unacceptable.

> *"A further concern... is the coupling of the proposed agreements and frameworks to one another such that the conclusion of the critical minerals agreement is made conditional to the conclusion of the Health MOU. The Zambian Government has been consistent that the agreements must be considered separately on their respective merits."*
> — Zambian Foreign Minister Mulambo Haimbe, May 4, 2026

Zimbabwe rejected its agreement entirely, citing demands for access to sensitive health data for American research and commercial use without guaranteed benefits to Zimbabwe's population. Ghana also withdrew from negotiations over data privacy concerns. Kenya's civil society and local government authorities have filed legal challenges over data sharing terms, putting that agreement on hold.

These tensions matter for key populations. When health data must flow to a government that criminalizes same-sex conduct or drug use, the assurances that data will not be used against service users—assurances that previously existed within implementing partner safeguards—are absent from the MoU framework.

PART TWO

When Metrics Stop Measuring

A performance framework that cannot detect whether key populations are being reached is not a framework for accountability. It is a framework for plausible deniability.

The effectiveness of any performance system depends on whether it can assess progress clearly and consistently. Across the MoUs that have been analysed, that clarity is not present—and the gap falls disproportionately on the communities least able to advocate for their own visibility.

The Limits of 95-95-95

The MoUs rely on outcome metrics aligned with global targets—the 95-95-95 framework for HIV diagnosis, treatment, and viral suppression. On paper, this suggests continuity with the global AIDS response. In practice, these metrics carry significant limitations when applied as primary accountability measures.

Outcome metrics are based on estimates of the total number of people living with HIV. Even robust national surveys carry margins of uncertainty that can be wider than the year-on-year changes being tracked. This makes it difficult to determine whether observed progress reflects genuine service delivery improvements, statistical variation, or changed assumptions in the underlying models.

More critically, population-level viral suppression figures tell us nothing about whether key populations are being reached. A national 90% viral suppression figure is consistent with near-complete exclusion of MSM and sex workers if those populations are small relative to the total. The metric passes. The epidemic does not.

Metric gaps that affect key populations (across reviewed MoUs)

→ No MoU contains key population-disaggregated HIV testing, treatment, or viral suppression targets
→ No MoU includes PrEP uptake targets disaggregated by population group—despite lenacapavir emphasis
→ Process metrics for new HIV diagnoses are aggregate (e.g., Zambia: reduce from 119,359 to 101,217 by 2030)—no breakdown by transmission route or population
→ AGYW-specific prevention metrics (DREAMS-aligned) absent from all reviewed MoUs
→ Outbreak response metrics focus on notification timelines, not equity of response

Process Metrics: Activity Without Evidence of Reach

Process metrics were intended to provide more concrete accountability than outcome estimates. But they do not consistently do so for key populations.

In the Zambia draft MoU, the target for new HIV diagnoses among adults and children is to reduce from 119,359 to 101,217 by 2030—a 15% reduction. No mechanism is specified for achieving this. No breakdown is provided by population group. No prevention program targeting key populations is named. The metric is set; the path to reaching it is invisible.

PMTCT performance will be measurable. But Rwanda's HIV epidemic is one where key populations—MSM, sex workers—have historically been documented as driving ongoing transmission among the general population. Those transmission dynamics are not tracked in any MoU metric.

Similarly, the Liberia MoU targets reducing adult and child new diagnoses from 690 to 350—a 49% reduction over five years. No prevention program to achieve this reduction is specified. Community health workers who previously delivered community-based testing and prevention are fully transitioned off U.S. funding by 2030, with no requirement that government-funded successors provide equivalent services to key populations.

The Loss of Visibility

The shift toward national data systems, combined with reductions in independent reporting requirements, limits the ability of external actors to assess performance—and limits the visibility of key populations specifically.

PEPFAR's data systems were historically notable for their transparency. Detailed datasets were publicly available, enabling analysis of program performance disaggregated by population. That level of transparency is no longer assured under the MoU framework. The MoUs emphasise national health data warehouses, G2G reporting, and bilateral data sharing arrangements—none of which carry equivalent public accountability provisions.

> *The old transparency infrastructure—PEPFAR Data Dashboard, public DATIM reporting, disaggregated COP/ROP data—is being replaced by systems where public accountability depends on what governments choose to disclose.*

For key populations specifically, this matters in a direct way. In countries where MSM, sex workers, and PWID are criminalized, government-run data systems have limited incentive to accurately track service delivery to those populations—and may have active incentives to undercount. PEPFAR's parallel data systems provided a check on that dynamic. That check is being removed.

PART THREE

Financing Pressures and Program Trade-offs

The numbers add up to a system under pressure—and under pressure, the least visible populations bear the greatest risk.

~47% projected reduction in U.S. funding over 5 years across signed MoUs	**33%** average country co-financing share of total MoU envelope	**13%** annualized co-financing as % of 2023 domestic health expenditure (average)	**84%** largest country-level U.S. funding reduction across signed MoUs

The Funding Cliff

Funding is not only declining—it is unevenly distributed over time in ways that create structural instability. The MoU framework front-loads U.S. contributions in the early years and reduces them steeply toward year five. This pattern is documented across multiple signed agreements.
In Kenya, U.S. funding declines 61% by year five relative to FY25 levels. In Liberia, the decline is 42%. In Uganda, 69%. These figures are confirmed by analysis from multiple sources including the December 2025 and March 2026 MoU analyses.
Annualized figures obscure the shape of this problem. A reported 'average' annual contribution looks manageable on paper. The year-five reality—when domestic health systems are expected to have absorbed the full program burden—may be very different from what current fiscal space makes possible.

Country funding trajectories (U.S. funding reduction, FY25 baseline to Year 5)
→ Uganda: −69% by Year 5 | Co-financing penalty: $2:$1 for shortfalls
→ Liberia: −42% by Year 5 | All 1,851 USG-funded healthcare workers phased out by 2030
→ Rwanda: −13% by Year 5 (lowest reduction, reflecting smaller program) | All 2,734 USG-funded healthcare workers transitioned by 2028
→ Kenya: −61% by Year 5 | Civil society has sued over data sharing terms; agreement on hold
→ Zambia: Negotiations stalled; deal linked to minerals access and data sharing dispute
→ Source: March 2026 MoU Analysis; country-level MoU documents

Co-financing: Ambition Disconnected from Fiscal Reality

Countries are expected to absorb an average of 33% of total MoU program costs through domestic co-financing—a commitment that averages 13% of 2023 government health expenditure annually, with wide variation. In several countries, this exceeds realistic fiscal space.
The March 2026 MoU analysis found that annualized co-financing commitments represent between 5% and 27% of domestic government health expenditure, depending on the country. In some settings, this is equivalent to the projected increase in total government health spending—meaning the MoU commitments would consume virtually all new health investment, leaving no fiscal room for additional priorities.

The consequences for key population services are direct. When co-financing commitments are tight, governments will prioritize the services that are explicitly tracked in performance agreements. Services for populations not mentioned in those agreements—including MSM, sex workers, PWID, and transgender people—face de facto deprioritization not through explicit policy decisions, but through resource allocation under constraint.

The G2G Transition Without Safeguards

The transition from implementing-partner-led delivery to government-to-government (G2G) funding is the central structural change in the MoU framework. Where implementing partners operated under contractual non-discrimination requirements and accountability mechanisms that PEPFAR had developed over two decades, G2G funding flows directly to ministries of health—without equivalent protections.
This creates an acute risk in countries with punitive legal environments. PEPFAR currently operates across multiple countries with active criminalisation of same-sex conduct, sex work, or drug use:

- Uganda enacted the Anti-Homosexuality Act in 2023, with potential life imprisonment for 'aggravated homosexuality.' The Uganda MoU is signed and active.
- Tanzania has active enforcement of colonial-era penal code provisions against same-sex conduct. Its MoU is signed.
- Zambia's Penal Code sections 155–157 criminalise same-sex conduct. Negotiations are ongoing amid mineral and data-sharing disputes.
- Kenya, Ethiopia, Burundi, Niger: Various criminalisation provisions across the portfolio.

When funds flow directly to governments with active criminalisation of key populations, without non-discrimination requirements in the MoU text, there is no mechanism to ensure national health systems serve those populations. This is not a theoretical risk. Uganda's government has already moved to restrict civil society organisations serving LGBTQ populations. The tools PEPFAR previously used to navigate that environment—implementing partner requirements, civil society delivery, parallel data systems—are being removed.

PART FOUR

How Key Populations Are Removed: Country Evidence

Key populations are not removed through a single decision. They are removed through the accumulation of silences—in metrics, in financing structures, in governance arrangements that exclude the communities most affected. The following section reviews evidence from the three MoUs for which full text is available: Rwanda (signed December 5, 2025), Liberia (signed December 9, 2025), and the Zambia draft circulated in March 2026. Together with comparative analysis from Kenya and Uganda, they reveal a consistent pattern.

Key population visibility in signed and draft MoUs	
Rwanda Signed Dec 2025	No mention of MSM, sex workers, PWID, or transgender people. HIV prevention addressed solely via PMTCT and lenacapavir. Community peer educators and linkage facilitators—cadres that served key populations—fully transitioned off U.S. funding by 2028, absorbed to government payroll with no non-discrimination requirement. Data sharing runs 25 years.
Liberia Signed Dec 2025	No mention of key populations. New diagnosis reduction target of 49% by 2030 with no specified prevention program. 1,521 community health workers phased off U.S. funding by 2030. Liberia's legal environment criminalizes same-sex conduct; no safeguards in MoU text against this affecting service delivery.
Zambia Draft / Stalled	No mention of key populations. PrEP de-medicalization plan (lenacapavir via CHWs and pharmacies) does not specify reach to MSM, PWID, or sex workers. DREAMS absent. Negotiations linked to minerals access; Zimbabwe-like data sharing dispute ongoing. Civil society in briefing role only.
Kenya Signed / Stalled	No mention of key populations. Family planning eliminated (was 4% of envelope). DREAMS not referenced. Civil society has filed legal challenges over data sharing terms. 28,668 USG-funded healthcare workers transition to government by Year 3; no key population continuity requirement.
Uganda Signed	No mention of key populations. Faith-based actors prominent. Anti-Homosexuality Act (2023) in force; MoU contains no non-discrimination provisions. Steepest co-financing penalty ($2:$1); 69% USG funding decline by Year 5.

Sources: Rwanda MoU (Dec. 5, 2025); Liberia MoU (Dec. 9, 2025); Zambia draft MoU (HealthGAP, March 16, 2026); March 2026 MoU Analysis; December 2025 MoU Analysis; HRH Analysis, March 11, 2026.

The Pattern of Removal

Across these five countries, representing a combined U.S. funding envelope of over $7 billion, the pattern is consistent. Key populations are absent from:

1. Service delivery commitments: No country has explicit targets or plans for reaching MSM, sex workers, PWID, or transgender people.
2. Performance metrics: No country has key population-disaggregated viral suppression, testing, or PrEP uptake targets.
3. Healthcare worker transition plans: The absorption of PEPFAR-funded community health workers into government payrolls includes no requirement to maintain services for criminalised populations.
4. Governance structures: Steering Committees are bilateral government arrangements; civil society has no formal governance role in any reviewed MoU.
5. Data visibility: No MoU mandates disaggregated public reporting on key population service delivery outcomes.

When removal operates across all five dimensions simultaneously, the effect is cumulative and durable. A population that is not tracked in metrics, not referenced in service commitments, not protected in transition plans, not visible in public data, and not represented in governance structures has no formal leverage to restore its visibility once it is lost.

> *This is how removal happens in practice—not as policy, but as a structural outcome. When funding contracts, measurement weakens, and populations are not explicitly protected, services become less visible, less protected, and more vulnerable to reduction over time.*

A Note on Lenacapavir and the Limits of Biomedical Progress

The MoU framework gives significant attention to lenacapavir as a next-generation HIV prevention tool. The Zambia draft includes de-medicalised PrEP delivery. Rwanda's strategic assistance section envisions performance incentives supporting HIV next-generation treatment adoption. Kenya's MoU specifically allocates funding for lenacapavir.

This attention is welcome—lenacapavir's 96% efficacy in prevention trials is genuinely transformative. But as analysis from PIH and UCSF presented in May 2026 noted, the current framework creates a critical tension: who gets the LEN. The choice between key populations and pregnant and breastfeeding women is a real allocation challenge under constrained budgets—and it is not being addressed transparently in any MoU.

More fundamentally, delivery of an injectable prevention tool to MSM, sex workers, and PWID requires precisely the community-based infrastructure—trusted providers, non-judgmental services, linkage facilitators—that is being defunded under the G2G transition. The opportunity that lenacapavir represents cannot be realised without explicit inclusion of key populations in delivery models, and without the organizational ecosystem that reaches them.

PART FIVE

Why This Matters Now

The decisions being made in the next 90 days—in implementation plans, in award reviews, in Steering Committee structures—will determine the shape of the HIV response for the next five years.

The HIV response is at a critical juncture. Progress over the past two decades has depended not only on the scale of investment, but on the ability to direct that investment precisely—toward populations most at risk, through mechanisms that can actually reach them. That precision relied on clear data, strong accountability, civil society engagement, and programmatic structures explicitly designed for hard-to-reach communities.

The MoUs change each of these elements. And the window to influence how they change is narrowing.

Within 90 days of each MoU signing, governments and PEPFAR country teams are required to develop detailed implementation plans. These plans determine which implementing partner awards are continued, modified, or terminated; which new awards are created; and which activities are funded within the envelope. They are the primary near-term mechanism through which the architecture of service delivery—including services for key populations—is set.

In many countries, this process is already underway or complete. Award reviews have led to terminations of community-based programs. Health workers who served key populations have been phased out. Civil society organisations that depended on PEPFAR subgrants are operating under bridge funding or have ceased operations. The urgency is not hypothetical.

> *In the absence of consistent guidance and coordinated planning since early 2025, GBGMC and partners have supported the development of 14 country-level plans for reaching key populations with prevention and care services. These are not aspirational documents. They are operational plans, grounded in service delivery realities, developed by communities largely outside formal national planning processes.*

What is notable is that this planning has happened at all—that communities and their advocates have continued to build implementation-ready approaches in an environment of sustained uncertainty. The question now is whether the formal systems being constructed under the MoU framework will integrate this work, or whether it will remain parallel and fragile.

PART SIX

What Must Change

The following recommendations are addressed to advocates, partner governments, PEPFAR country teams, and the U.S. Department of State. They reflect both the immediate urgency of implementation-plan decisions and the longer-term need for structural reform.

1

Mandate key population visibility in implementation plans

Every MoU implementation plan must include an explicit assessment of service continuity for MSM, PWID, sex workers, transgender people, and AGYW. Where the transition to G2G funding would interrupt services to these populations, a documented continuity plan must be required before award terminations are finalized. PEPFAR country teams should be instructed that key population program continuity is a precondition for implementation plan approval.

2

Insert non-discrimination requirements in all active and pending MoUs

For countries with criminalization of key populations (Uganda, Tanzania, Kenya, Zambia, and others), MoU text and implementing agreements must contain explicit non-discrimination requirements applicable to all G2G-funded health services. These requirements should mirror the safeguards previously embedded in implementing partner contracts—non-discrimination in service delivery regardless of sexual orientation, gender identity, or drug use status.

3

Add key population-disaggregated metrics to performance frameworks

Outcome and process metrics must include targets disaggregated by key population group—viral suppression among MSM, PrEP uptake by sex workers, new diagnoses by transmission route. These targets should be included in the 90-day implementation plans and reviewed at each quarterly Steering Committee meeting. Where baseline data are unavailable, surveys to establish baselines should be funded as a priority.

4

Protect and expand DREAMS and community-based prevention

DREAMS must be explicitly named and protected in implementation plans for all countries where it operates. AGYW-specific prevention programming must be carried forward as a protected line item within strategic assistance budgets. Community-based prevention organizations serving MSM, sex workers, and PWID must be categorically protected from award termination without documented transition to equivalent services.

5

Establish formal civil society roles in MoU governance

Steering Committees, Technical Working Groups, and annual review processes must include formal representation from civil society—including key population-led organizations. Observer status is insufficient. Civil society representatives must have the ability to review implementation plan progress, flag performance concerns, and formally recommend course corrections. This is not a consultation mechanism; it is a governance requirement.

6

Require public transparency on program-area allocations

MoU funding allocations must be publicly disclosed at the program-area level—disaggregated at minimum by HIV treatment, HIV prevention, MCH, malaria, TB, and global health security. Within HIV, prevention versus treatment allocations must be separately reported. Annual performance reports must include disclosure of whether key population service delivery targets are being met, comparable to previous PEPFAR public reporting standards.

7

Ensure lenacapavir delivery reaches key populations by design

All lenacapavir and long-acting PrEP scale-up plans within MoU strategic assistance frameworks must explicitly include MSM, sex workers, PWID, and transgender people as target delivery populations. Delivery models must be assessed for their ability to reach criminalized populations—and community-based organizations with demonstrated reach to those populations must be included in delivery infrastructure, not phased out.

8

Address data sharing risks for criminalized populations

Data sharing arrangements must include explicit privacy protections for individual patient data related to sexual orientation, gender identity, and drug use. Arrangements must specify that data will not be used for law enforcement purposes. In countries where criminalization creates direct surveillance risk, data sharing annexes should require community consent processes and independent ethics review.

CONCLUSION

If they are not visible, they are not served

PEPFAR's success was built on a principle that proved harder to implement than to state: that ending the epidemic required reaching everyone—especially those the health system had failed to reach before. That principle was not always perfectly implemented. But it was embedded in the architecture—in the data systems, the reporting requirements, the implementing partner obligations, the community-based organisations, and the civil society accountability structures that together constituted the program.

The MoUs, as currently structured, are removing that architecture faster than replacement infrastructure is being built. The shift to country ownership is conceptually defensible—sustainable health systems require domestic ownership and financing. But ownership without accountability is not sustainability. It is the transfer of risk onto the populations least positioned to carry it.

Key populations are not a footnote to the HIV epidemic. In concentrated and mixed epidemics, they are the epidemic. A response designed to achieve 95-95-95 without tracking whether those numbers include or exclude gay men, sex workers, transgender people, and people who inject drugs is not a precision response. It is an aggregate one—and aggregates have always obscured the communities that PEPFAR was most needed to reach.

The window for action is open—but it is not open indefinitely.
Implementation plans are being finalized. Award reviews are underway. The governance structures that will operate for five years are being constituted now. Every week that key populations remain invisible in these processes is a week of ground that will be very difficult to recover.
GBGMC and partners are ready to support governments, country teams, and advocates to develop and advocate for the implementation approaches that can preserve that visibility. Fourteen country-level plans already exist. The question is whether the formal system will use them.

"Our collective work is to channel our power to counter the dangers and change reality so that it is better for us all."
— Micheal Ighodaro, Executive Director, GBGMC

SOURCES AND METHODOLOGY

This paper draws on primary MoU documents and comparative analyses produced between December 2025 and June 2026. All funding figures are drawn from publicly released MoU documents or confirmed analysis by KFF, the Centre for Global Development, or GBGMC partner organisations.

•Rwanda MoU (signed December 5, 2025); Liberia MoU (signed December 9, 2025); Zambia draft MoU (HealthGAP circulation, March 16, 2026)
•U.S. Government MoU Negotiation Analysis: December 2025, January 2026, March 13 2026 (consulting analysis)
•U.S. Government MoU Negotiation Analysis: March 24 2026 (consulting analysis)
•Health Workforce Analysis of USG MoUs, March 11, 2026
•KFF: PEPFAR MoU Tracking Analysis, April 23, 2026 (31 country dataset)
•CGD: PEPFAR's Next Chapter—Tough Times, Tough Choices, December 2025
•PIH / UCSF: PEPFAR, Innovation and the Future of Global Health (presentation, May 6, 2026)
•Reuters: 'Zambia says US health deal must be uncoupled from minerals access,' May 4, 2026
•Wall Street Journal: 'Trump Wants Minerals, Health Data for Aid. African Nations Are Pushing Back,' June 1, 2026
•America First Global Health Strategy Report, U.S. Department of State, December 2025
•PEPFAR Watch: Process Overview—MoU Implementation; PEPFAR Document Tracking 2026

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