Abandoning Data and Science:

PEPFAR's systematic dismantling of Key Population Programs and what PEPFAR's New Direction Means for Key Populations

GLOBAL BLACK GAY MEN CONNECT

Timeline of changes to USG - supported HIV Programming for Key Populations 2025

- Executive Order pauses foreign assistance, Jan 2025
- Stop-work orders issued, Jan 2025
- Community KP programs begin closing, Jan - Feb 2025
- Review and redesign of U.S. global health assistance, including development of a new bilateral government-to-government approach, Jan - Sept 2025
- USAID programs are terminated or transferred, USAID dismantled, Feb -July 2025
- Prevention programs collapse, UNAIDS estimates that up to 3.5 million people from key populations are no longer covered by biomedical HIV prevention, May 2025
- KP data collection stops, IBBS suspended, KP indicators disappear, Mid 2025
- America First Global Health Strategy, Sept 2025
- Bilateral MOUs introduced, Dec 2025 onward
- No explicit KP programming in the MOUs, Dec 2025 onward
- Domestic financing requirements increase, 2026
- Community-led implementation reduced, 2026
- PEPFAR releases FY2025 program data, April 2026
- Chemonics-led GHSC-PSM procurement system terminated, 2026
- End of CDC-supported implementation, Sept 2026
- Future: Greater reliance on governments despite uncertain financing for KP services

Figure 1. Timeline of changes to USG- supported HIV Programming for Key Populations 2025

The New PEPFAR Memoranda Of Understanding (MOU)

There is no mention of key populations in any of the memoranda of understanding between PEPFAR and countries raising important questions about how HIV prevention and treatment services for populations at greatest risk will be prioritized and financed over the next five years.

On January 20, 2025, President Trump signed an Executive Order pausing U.S. foreign assistance programs for 90 days pending a comprehensive review. Following this review, the United States Government introduced a new Government-to-Government (G2G) grant model, formalized through bilateral Memoranda of Understanding (MOUs) between the U.S. Government and partner governments. Although these MOUs establish shared priorities and funding commitments, they are not legally binding treaties or contracts and remain subject to future congressional appropriations and may be affected by changes in U.S. foreign policy priorities and executive branch decisions.

The MOUs represent a fundamental shift from previous PEPFAR partnership and planning frameworks and provide the clearest indication to date of how the America First Global Health Strategy will be implemented[8]. Unlike previous Country Operational Plans (COPs), which included detailed annual budgets, program targets, implementing partners, and specific investments for key populations, the MOUs establish only broad five-year funding commitments and strategic priorities. The agreements are organized around six areas of cooperation: surveillance and outbreak response, laboratory systems, health commodities, frontline health workers, data systems, and strategic investments.

The new agreements also introduce significant changes in the financing and governance of U.S.-supported health programs[9]. They reduce overall U.S. funding while requiring partner governments to substantially increase domestic health financing, despite longstanding evidence that many countries have struggled to meet previous co-financing commitments[10]. Several MOUs, including those with Kenya, Uganda, and Liberia, explicitly allow the United States to reduce or terminate funding if governments fail to meet agreed domestic investment targets[11].

In addition, the MOUs prioritize direct government-to-government assistance while significantly reducing the role of communities and civil society in program design, implementation and oversight. They also remove several longstanding data and reporting requirements and introduce new pathogen-sharing provisions. Although the largest share of funding is expected to support commodities and frontline health workers, the agreements indicate considerable reductions in investments for tuberculosis, malaria, and community systems that play a critical role in reaching populations most at risk and supporting treatment adherence, and maintaining retention in care.

To date, 32 MOUs have been signed[12], while negotiations for the remaining countries have either been delayed or have not been publicly reported. Each agreement establishes a five-year U.S. non-binding (for both the United States and the partner governments) funding commitment alongside expectations for increased domestic investment in health.

[8] https://www.state.gov/america-first-global-health-strategy
[9] hhttps://www.science.org/content/article/trump-administration-cuts-cdc-s-key-role-global-program-stop-hiv
[10] https://archive.theglobalfund.org/media/15304/archive_bm52-07a-oig-operational-progress_report_en.pd
[11] https://www.cgdev.org/blog/what-we-know-and-dont-know-about-trump-administrations-global-health-agreements
[12] https://www.kff.org/global-health-policy/kff-tracker-america-first-mou-bilateral-global-health-agreements/

The New PEPFAR Memoranda Of Understanding (MOU)

However, unlike previous PEPFAR planning processes, none of the signed MOUs explicitly commits to maintaining investments in key population programming, community-led services, human rights interventions, stigma reduction, or community-led monitoring. The absence of these commitments creates significant uncertainty about the future sustainability of HIV prevention and treatment services for the populations most affected by the epidemic and weakens accountability for ensuring that they remain central to national HIV responses.

The six areas of cooperation[13]:

1. **Surveillance and Outbreak Response:** Early detection of outbreaks, integrated disease surveillance, emergency preparedness, response coordination, pathogen detection.
2. **Laboratory Systems:** National laboratory networks, molecular diagnostics, genomic sequencing, laboratory quality assurance, point-of-care diagnostics for HIV, TB and emerging diseases.
3. **Health Commodities:** Procurement and supply chains for HIV medicines, TB medicines, malaria commodities, diagnostics, vaccines, warehousing, distribution and inventory management. The procurement of commodities will be transitioned from the U.S. government to partner governments gradually over the established period of the agreement.
4. **Frontline Health Workers:** Transition of U.S.-supported health workers to government payrolls. Frontline health workers currently funded by the U.S. government will be mapped to the cadres of health workers that can be employed by partner governments, and those cadres of health workers will be transitioned to the partner government payroll over a multi-year period as jointly agreed to.
5. **Data Systems:** Integrated national health information systems, disease surveillance data, supply-chain information systems, monitoring program performance across HIV, TB, malaria and polio.
6. **Strategic investments:** Government capacity strengthening, technical assistance, innovation, health systems management, partnerships with governments, faith-based organizations and the private sector.

[13] https://www.state.gov/america-first-global-health-strategy

TABLE 1: The PEPFAR Country Operational Plans (COP) vs The PEPFAR Memorandum of Understanding (MOU)

PEPFAR COP	PEPFAR MOU	Why does this matter?	Recommendation
These were 1-2 year agreements.	These are five year agreements.	The agreements provide less explicit program accountability and fewer opportunities for regular performance-based adjustment than the previous COP process. The 5 year agreements are also not a guarantee of 5 years of funding making it difficult to plan sustainably.	Countries must make sure that these agreements cover all their needs. In the past communities had midpoints to change the implementation which do not exist in the new agreements.
These were binding agreements.	These are not binding.	The MOUs are not legally binding, neither the United States nor partner governments can legally enforce the commitments against one another, limiting accountability to political and financial mechanisms.	Advocates should consider this as open points for future negotiation.
These documents were public.	These documents are mostly hidden.	Public documents allow for scrutiny and recommendations which was a key success of the old PEPFAR engagement system.	Advocates need to push to ensure that all MOUs are public and that agreements between countries and the US are evaluated.
Implemented by publicly identified agencies and implementing partners.	Implementation arrangements are unclear. Faith-based implementers are the only community-based implementers mentioned.	Implementation arrangements are critical as they share clearly who will implement supported programs to ensure success.	Advocates should push for information on who implements what to be sure that the right implementers are trusted with the task. They should also push for IPs with technical expertise and ability to capacitate local partners.
Community and stakeholder engagement was critical to the process	Only government engagement is fully prioritised.	Engagement of multiple stakeholders is critical to ensuring that agreements are sound and have the best interest of those in need of services. The current engagement has lacked standardization	Advocates should not tire of pushing for inclusion at all the stages

TABLE 1: The PEPFAR Country Operational Plans (COP) vs The PEPFAR Memorandum of Understanding (MOU)

PEPFAR COP	PEPFAR MOU	Why does this matter?	Recommendation
These had a mid point review and quarterly data review.	There are no mid-point and quarterly review check-ins added currently.	These check-ins offered an opportunity to change course when the direction was not yielding the desired result.	Advocates should push for implementation review points to ensure that there are opportunities to course correct failing programs.
Visible planning, implementation and tracking of key population funding and targets.	Key population funding, tracking, community-led monitoring and implementation is not explicitly visible/ missing.	There are no key population commitments. Without this transparency, it will be difficult to assess whether key population investments are being protected during the transition.	Government, civil society and community advocates need to ensure that targets, funding and implementation of key population programs continue. Governments must increase domestic spending on key population programs, or risk reversing the gains of HIV programs.
Focused more on aid.	Represents a fundamental shift to co-investment.	Countries are expected to fill funding gaps previously covered by U.S. assistance. Sustainability planning is a central issue, particularly for HIV programs heavily dependent on PEPFAR.	Civil society and community advocates need to engage much more aggressively in domestic resource mobilization and national budget advocacy alongside the US assistance advocacy.
Focused on broader multilateral approaches.	Focused on bilateral agreements.	• Funding decisions are more country-specific and politically negotiated. • There are greater variations in priorities and funding levels between countries. • Community organizations have fewer opportunities to influence funding through regional or multilateral mechanisms.	Advocates need to ensure there is meaningful representation during the MOUs negotiation and that the needs of key populations are shared in the discussions.
Domestic co-financing was encouraged and tracked but not strictly enforced.	Domestic co-financing requirements are some of the most important features of the agreements. Countries are required to increase their own health spending over time.	For countries already facing: • Debt pressures • Fiscal constraints • IMF-related spending limitations there may be substantial challenges in maintaining HIV, TB, malaria, and key population services once external financing declines.	Advocates must track countries' co-financing agreements and ensure gaps are highlighted where countries are committing to co-financing agreements they are unable to honour.

TABLE 2. List of known countries with a finalised PEPFAR MOU and funding support[14]

COUNTRY	US FUNDING (US$ MILLIONS)	CO-FINANCING REQUIREMENT	REDUCTION AGAINST HISTORICAL AGREEMENT
Angola	$71.0M	$50.0M	-67%
Bolivia	$10.0M	$2.0M	-80%
Botswana	$106.0M	$381.0M	-30%
Burkina Faso	$147.0M	$107.0M	-53%
Burundi	$129.0M	$26.0M	-50%
Cambodia	$30.8M	$5.3M	-78%
Cameroon	$399.3M	$450.0M	-28%
Côte d'Ivoire	$487.0M	$450.0M	-33%
Democratic Republic of Congo	$900.0M	$300.0M	-27%
Dominican Republic	$46.7M	$14.1M	-61%
El Salvador	$31.9M	$19.7M	-33%
Eswatini	$205.0M	$37.0M	-36%
Ethiopia	$1.0B	$450.0M	-12%
Guatemala	$60.0M	$1.6M	-61%
Guinea	$91.0M	$51.0M	-53%
Honduras	$29.6M	$16.9M	-38%
Kenya	$1.6B	$850.0M	-21%
Lesotho	$232.0M	$132.0M	-28%
Liberia	$124.4M	$50.7M	-45%
Madagascar	$134.0M	$41.0M	-60%
Malawi	$792.0M	$143.8M	-34%
Mozambique	$1.8B	$70.6M	-24%
Niger	$107.4M	$71.9M	-58%
Nigeria	$2.1B	$3.0B	-58%
Panama	$22.5M	$11.0M	-51%
Papua New Guinea	$15.0M	$3.0M	-26%
Rwanda	$157.8M	$70.6M	-71%
Senegal	$63.1M	$27.3M	-83%
Sierra Leone	$129.0M	$44.0M	-40%
Tajikistan	$38.0M	$40.0M	-27%
Uganda	$1.7B	$577.0M	-52%

[14] https://www.kff.org/global-health-policy/kff-tracker-america-first-mou-bilateral-global-health-agreements/

The importance of PEPFAR to key population programming before the 2025 funding cuts[15]

Before the 2025 U.S. funding reductions, PEPFAR was the single most important bilateral donor supporting HIV services for key populations. In many high HIV burden countries, domestic health systems have historically invested little in key population programming because same-sex relationships, sex work, and drug use are criminalized, governments have deprioritized these populations, and stigma and discrimination within public health facilities continue to limit access to services. As a result, many of the HIV services reaching key populations existed primarily because of PEPFAR investment.

Guided by epidemiological evidence and the principle of prioritizing populations at greatest risk of HIV acquisition, PEPFAR established comprehensive service delivery systems specifically designed for key populations. These investments supported peer outreach, HIV testing, PrEP, antiretroviral treatment, sexually transmitted infection services, condom and lubricant distribution, differentiated service delivery, violence prevention and response, community-led monitoring, and stigma reduction initiatives[16]. Much of this work was delivered through community-led organizations that had established trust with communities who were often unable or unwilling to access government health facilities.

The importance of PEPFAR's investment far exceeded its proportion of national HIV budgets. Although spending specifically coded for key population programs represented a relatively small share of total PEPFAR expenditure, these investments reached the populations at highest risk of HIV infection, supported services that governments rarely financed, and strengthened community systems that were essential for prevention, treatment adherence, and retention in care.

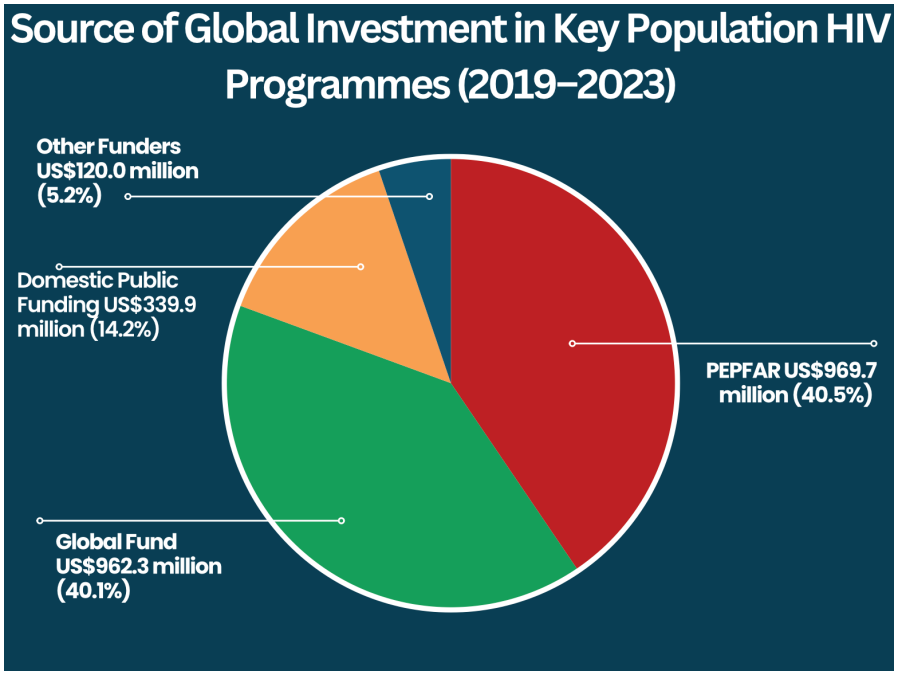
[15] https://gbgmc.org/wp-content/uploads/2025/03/Frozen-Out.pdf
[16] https://plans.gbgmc.org/

The importance of PEPFAR to key population programming before the 2025 funding cuts

This financing filled a critical gap in the global HIV response. Between 2019 and 2023, approximately US$2.4 billion was invested globally in HIV programs primarily benefiting key populations. PEPFAR contributed US$969.7 million (40.5%), making it the largest single donor, closely followed by the Global Fund, which contributed US$962.3 million (40.1%). In contrast, domestic public financing accounted for only US$339.9 million (14.2%), demonstrating the continued need for support of key population programs through international funding[17].

Historically, PEPFAR funding for key populations was channelled primarily through the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Agency for International Development (USAID). USAID supported a large proportion of community-led organizations delivering prevention and human rights programs before being dismantled in 2025, while CDC has announced the end of its support for PEPFAR implementation in most countries by 30 September, 2026. The loss of these two implementation mechanisms has disrupted community-led HIV programming, forced many organizations to reduce or close services, and left few viable alternatives for sustaining programs.

For many key populations, the immediate consequence has been a return to government health facilities that often lack the capacity, resources, or enabling environment to provide stigma-free and rights-affirming services. In many cases, people end up not accessing care at all due to these factors. Without sustained community-led programming and increased domestic investment, there is a significant risk that gains in incidence reduction as a result of HIV prevention, treatment uptake, and retention achieved over the past two decades will be reversed.



[17] https://aidsfonds.org/wp-content/uploads/2024/12/Dangerously-Off-Track-Executive-Summary.pdf

TABLE 3. The Previous KP Funding 2023-2024 in funding compared to previous support[18]

COUNTRY	BUDGETED US FUNDING 2023 (US$ MILLIONS)	BUDGETED US FUNDING 2024 (US$ MILLIONS)	BUDGETED US FUNDING 2025
Botswana	2,608,922	3,057,143	0
Burundi	2,024,381	2,362,679	0
Cameroon	5,504,344	4,213,554	0
Côte d'Ivoire	6,416,471	7,164,435	0
Democratic Republic of Congo	4,759,554	4,997,007	0
Dominican Republic	715,880	446,000	0
Eswatini	1,926,465	2,576,465	0
Ethiopia	6,947,494	10,699,133	0
Haiti	6,669,135	7,059,860	0
Kenya	23,371,515	23,552,159	0
Lesotho	1,644,702	2,399,897	0
Malawi	6,536,001	9,861,888	0
Mozambique	6,807,960	10,287,373	0
Namibia	2,321,599	3,974,128	0
Nigeria	26,546,173	29,463,458	0
Rwanda	2,081,461	2,175,756	0
South Africa	19,964,796	29,701,197	0
South Sudan	843,982	2,430,226	0
Tanzania	20,930,971	26,885,190	0
Uganda	12,600,684	12,247,558	0
Ukraine	10,952,396	17,261,234	0
Vietnam	14,925,751	16,287,681	0
Zambia	12,559,915	15,539,996	0
Zimbabwe	10,266,809	13,664,549	0

Among only the countries listed above, specialised key population programs lost $258,308,566 since the 2025 cuts, equating to roughly the entire 5-year US support budget of Cambodia, El Salvador, Guatemala, Guinea, Honduras and Papua New Guinea in the new MOUs.

[18] https://kpdata.amfar.org/

Why key population data matter

Following the PEPFAR funding cuts, routine key population data collection and PEPFAR-supported Integrated Bio-behavioural Surveys (IBBS), including population size estimation studies essential for planning and resource allocation, were suspended.

The global HIV response has always been driven by data. For key populations, high-quality surveillance and program data are essential for understanding where HIV transmission is occurring, who is being reached, which interventions are working, and where investments should be prioritized. Without reliable data, HIV programs cannot effectively target resources, measure impact, or adapt to changing epidemics.

Before the 2025 PEPFAR funding cuts, PEPFAR was one of the world's largest investors in key population surveillance and monitoring. Through routine program reporting and Integrated Bio-behavioural Surveys (IBBS), PEPFAR generated the evidence needed to design, implement, and continuously improve HIV programs for key populations.

Routine program data tracked performance across the HIV prevention and treatment cascade, including outreach, HIV testing, PrEP initiation, antiretroviral therapy, and retention in care. These data were collected separately for different key population groups and were further disaggregated by age, location, and country. Although detailed datasets were not routinely made public because of confidentiality and security concerns, PEPFAR publicly reported key population prevention indicators such as KP_PrEP and PrEP_NEW, providing important information on access to HIV prevention services. All KP data indicators have been removed since the disruption.

Why key population data matter

PEPFAR also supported IBBS, which remain one of the most important sources of evidence on HIV among key populations. These surveys provided critical information on HIV prevalence, population size estimates, HIV incidence, viral suppression, ART coverage, PrEP use, condom use, stigma and discrimination, experiences of violence, and service utilization. Combined with routine program data, these surveys enabled countries to identify where key populations lived, estimate the number of people requiring services, understand barriers to accessing care, and design interventions that reflected the needs and preferences of affected communities.

Importantly, key population-specific data filled gaps left by routine national health information systems. Because many key populations experience criminalization, stigma, and discrimination, they are frequently underrepresented or invisible in national surveillance systems. Dedicated monitoring and IBBS ensured that these communities remained visible within national HIV responses and that resources could be directed to the populations and locations with the greatest need.

Following the PEPFAR funding cuts, routine collection of key population program data through PEPFAR-supported activities has largely ceased, and implementation of new IBBS has been suspended in many countries. The loss of these data extends beyond monitoring and evaluation. It weakens evidence-based planning, reduces accountability for program performance, limits countries' ability to estimate commodity and service needs, and makes it increasingly difficult to advocate for sustained investment in key population programs. Without reliable surveillance and program data, HIV responses risk becoming less efficient, less equitable, and less effective, particularly for the populations that continue to bear the greatest burden of new HIV infections.

Data under the New PEPFAR MOUs[19]

Unlike previous PEPFAR frameworks, which prioritized program monitoring and surveillance to improve HIV outcomes for key populations, the new MOUs emphasize access to national health information systems, including disease surveillance platforms, electronic medical records, laboratory information systems, warehouse management systems, and biological materials. These provisions have raised concerns about data governance, national sovereignty, privacy, security, and benefit-sharing. Kenya, the first African country to sign the bilateral agreement with the United States under the America First Global Health Strategy (AFGHS), had its agreement halted by Kenyan courts after a petition filed with the court argued that the framework violated Kenya's constitutional safeguards on privacy and transparency and breached data protection and digital health statutes by permitting broad foreign access to sensitive health data.

[19] https://carnegieendowment.org/research/2026/03/kenya-data-protection-america-first-global-health-strategy

Erasing Key Populations Through Data: The Disappearance of KP Reporting in PEPFAR programs

There was zero reporting on KP data in the recently released PEPFAR MER data[20].

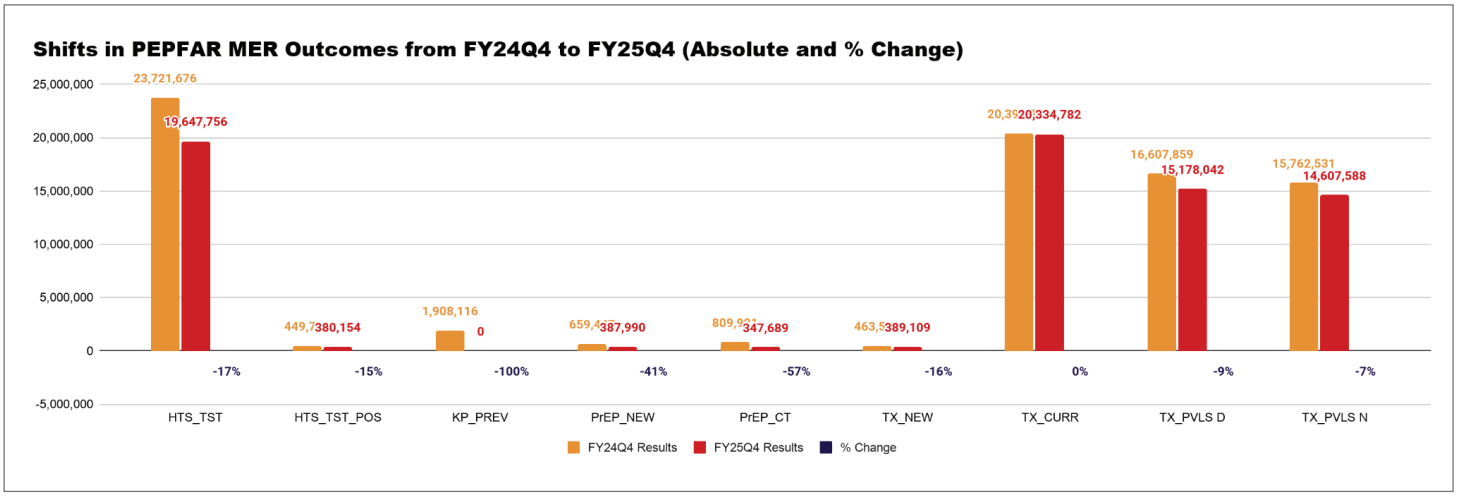
One of the most significant changes following the 2025 PEPFAR funding and policy shifts has been the disappearance of publicly reported data on key populations. Although key populations remain disproportionately affected by HIV, the most recent PEPFAR progress reporting contains no publicly reported key population-specific indicators, making it impossible to assess how the program is performing for the populations at greatest risk of HIV acquisition.

Historically, PEPFAR reported program performance according to the U.S. Government fiscal year, with Quarter 1 covering October to December, Quarter 2 January to March, Quarter 3 April to June, and Quarter 4 July to September. The major policy changes and funding disruptions following the January 2025 Executive Order occurred during FY2025 Quarter 2, making data from this period particularly important for understanding the immediate effects of the funding cuts.

However, the most recent FY2025 data released through the PEPFAR dashboard include only Quarter 4 results. Earlier working datasets had contained data for all four quarters, but these were not included in the final public release[21]. As a result, PEPFAR's public record does not capture program performance during the first nine months of FY2025, when many community-led organizations experienced funding suspensions, service disruptions, and program closures.

Equally concerning, none of the publicly released FY2025 datasets include key population-specific program indicators that had previously been used to monitor HIV prevention and service delivery among key populations. The absence of these data limits the ability of governments, donors, researchers, and communities to assess whether services reached those most affected by HIV, identify emerging gaps in coverage, or hold programs accountable for maintaining equitable access during a period of major policy transition.

The comparison presented below therefore examines selected overall (not KP specific) PEPFAR program indicators between FY2024 and FY2025. Although these indicators are not disaggregated by key population, they provide the best publicly available picture of how the program has changed following the funding cuts and highlight the growing evidence gap created by the loss of key population reporting.



[20] https://gbgmc.org/wp-content/uploads/2026/05/GBGMC-PEPFAR-ANALYSIS-2026-1.pdf
[21] The impact of the United States foreign aid freeze on HIV service delivery in PEPFAR-supported countries: a facility-level analysis of 2024–2025 programme data, AmFAR

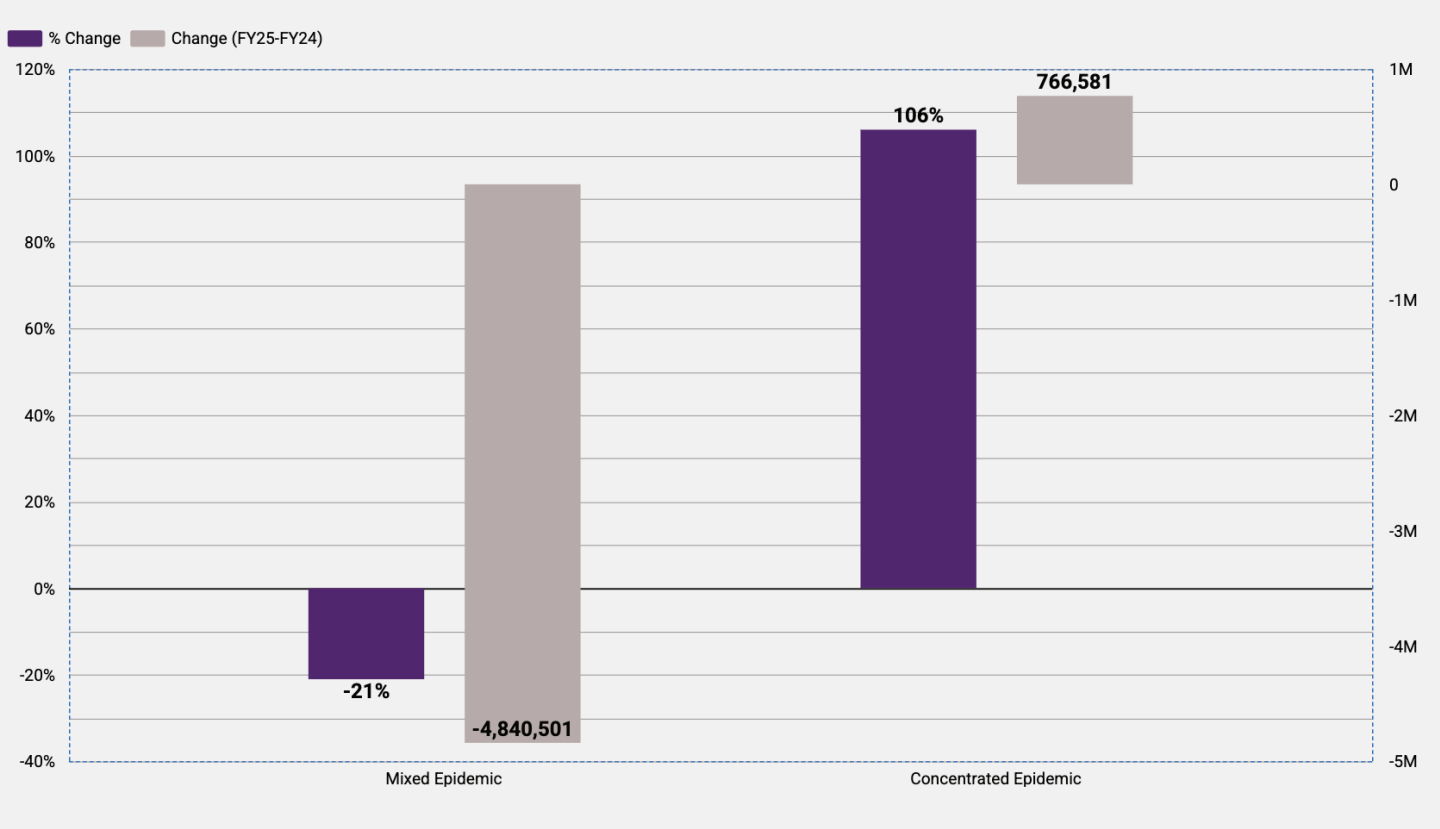
Human-rights based HIV prevention, care and treatment previously supported by PEPFAR

Comprehensive Key Population Program Support	HIV testing services
Peer outreach Online outreach and health promotion Community-led service delivery Decentralised drug distribution (DDD) (mobile outreach and drop-in centers) Community-based organizations capacity strengthening Geographic coverage Enabling environment Legal environment assessment Social enterprise Social contracting support	Community HIV testing Index testing where appropriate Recency testing Self testing HIV counselling Linkage to care following diagnosis
Prevention	**HIV treatment**
HIV risk-reduction education Condom and lubricant distribution Choice-based PrEP service delivery PrEP delivery through community programs Follow-up and continuation support Linkage to prevention services STI risk reduction education and syndromic treatment	Linkage to ART ART initiation Treatment adherence Viral load monitoring Retention in care Advanced HIV disease programs
Medication-assisted therapy (MAT)	**Key population surveillance and epidemiology**
Medication-assisted treatment (e.g., opioid substitution therapy where permitted) Long-term retention on treatment	Population size estimates (PSEs) HIV prevalence estimates Geographic mapping of key populations Strategic Direction Summary (SDS) data Integrated Bio-behavioural Surveys (IBBS) used for planning in many countries Service coverage surveys

Human-rights based HIV prevention, care and treatment previously supported by PEPFAR

Program monitoring and accountability	Enabling environment
KP_PREV - Number of key population members reached with HIV prevention interventions. **KP_MAT - Number of people who inject drugs receiving medication-assisted therapy.** **Key population disaggregates within:** • **HTS_TST (HIV testing)** • **PrEP_NEW & PrEP_CT (new PrEP initiations and continuations)** • **TX_NEW (new ART initiations)**	**Community HIV testing** **Index testing where appropriate** **Recency testing** **Self testing** **HIV counselling** **Linkage to care following diagnosis**

Testing Magnitude of Change in PEPFAR MER Results FY24Q4 to FY25Q4 (Absolute and Percent Change) in Concentrated Epidemics



HIV testing is the foundation of the HIV response for key populations and the critical entry point to prevention, treatment, and long-term care. Ensuring that key populations have access to a range of testing options, including community-based testing, HIV self-testing, and facility-based services is essential for identifying new infections early, linking people to treatment, and preventing onward HIV transmission. Before the funding cuts, PEPFAR invested heavily in differentiated testing approaches designed to reach populations who often faced criminalization, stigma, and discrimination within public health systems. Community-led organizations delivered peer outreach, mobile testing, drop-in center services, and HIV self-testing programs that provided safe and trusted access points for people who might otherwise avoid government health facilities. These approaches consistently reached populations at highest risk of HIV and produced higher HIV positivity rates than untargeted testing strategies, making them among the most efficient and cost-effective HIV investments[22].

The closure or scaling back of many community-led programs reduced opportunities for peer-led and community-based testing, forcing many key populations to rely on public health facilities that often lack the capacity, expertise, or enabling environment to provide stigma-free services. As a result, many people

[22] https://iris.who.int/bitstream/handle/10665/360601/9789240052390-eng.pdf

Testing Magnitude of Change in PEPFAR MER Results FY24Q4 to FY25Q4 (Absolute and Percent Change) in Concentrated Epidemics

at highest risk of HIV are less likely to test, delaying diagnosis, treatment initiation, and access to prevention services such as PrEP.

The latest publicly released PEPFAR program data do not include key population-specific testing indicators. This is a major gap and makes it impossible to determine how many members of key populations are currently being tested, whether testing coverage has declined, or whether those diagnosed with HIV are successfully being linked to treatment. The absence of these data weakens accountability and limits countries' ability to identify emerging service gaps and respond effectively.

Failure to sustain targeted HIV testing among key populations threatens progress toward the UNAIDS 95-95-95 targets and epidemic control. Broad population-wide testing alone is unlikely to identify sufficient numbers of undiagnosed people living with HIV in concentrated epidemics. Targeted, community-led testing consistently delivers higher testing yield, more efficient use of resources, and earlier linkage to treatment. Protecting and restoring these services is therefore not only a public health imperative but also a sound investment that reduces future treatment costs and strengthens the overall efficiency of national HIV responses.

PREVENTION

INDICATOR	2024 (Q4) Results	2025 (Q4) Results	% Change
Number of key populations reached through individual and small group HIV prevention interventions designed for the target population (KP_PREV)	1,908, 116	N/A	N/A

In many countries, PEPFAR financed the majority of HIV prevention services overall, but especially for key populations. In several high-burden countries, including Kenya, Uganda, Nigeria, South Africa, Eswatini, Zambia, and Mozambique, more than half of targeted HIV prevention services for key populations were supported through external financing, with PEPFAR serving as the principal donor. According to UNAIDS, as of May 2025, as many as 3.5 million people from key populations were no longer covered by specialized HIV prevention programs which PEPFAR had funded[23].

[23] https://unaids.org/sites/default/files/2026-04/20260331_HIV_PREVENTION_2030-report.pdf

Testing Magnitude of Change in PEPFAR MER Results FY24Q4 to FY25Q4 (Absolute and Percent Change) in Concentrated Epidemics

PEPFAR invested in a comprehensive package of combination prevention services tailored to the needs of key populations. These included peer outreach, HIV testing, condom and lubricant distribution, oral and long-acting PrEP, linkage to HIV treatment, Medically Assisted Treatment (MAT), violence prevention and response, community-led monitoring, and referrals to broader health and social services. Much of this work was delivered through community-led organizations that provided safe, trusted, and stigma-free access to prevention services for populations who frequently faced discrimination within public health facilities. To monitor the reach of these investments, PEPFAR used the KP_PREV indicator, which measured the number of members of key populations reached through individual and small group-level HIV prevention interventions. This indicator enabled countries to monitor prevention coverage, identify service gaps, estimate commodity needs, and ensure that prevention resources reached populations at greatest risk of HIV acquisition.

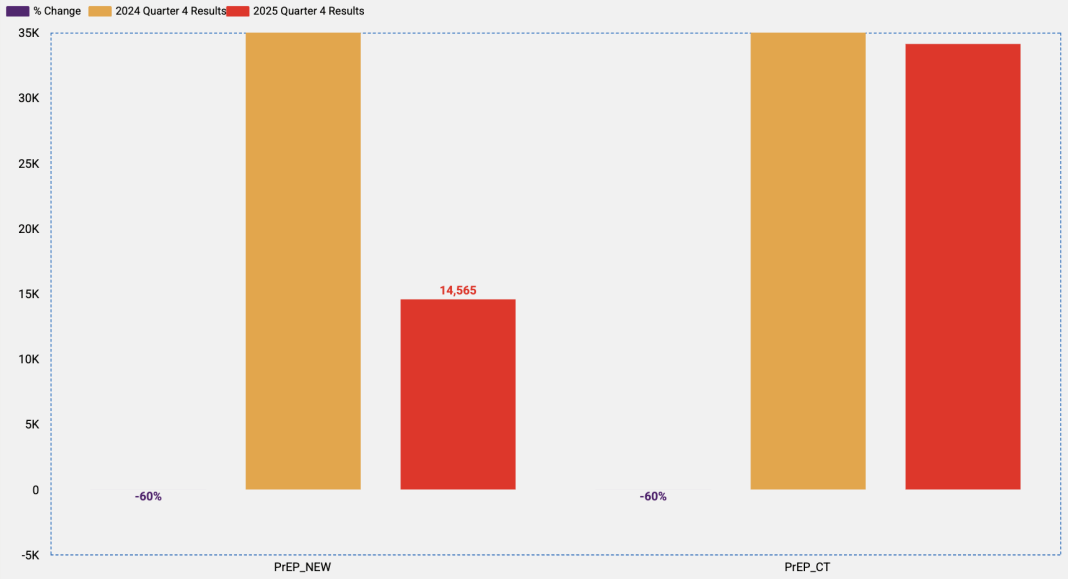
Following the 2025 funding changes, however, key population prevention indicators are no longer publicly reported. The disappearance of KP_PREV makes it impossible to assess whether prevention services specific to key populations continue to reach populations at greatest risk, whether prevention coverage has declined, or whether countries are maintaining investments in community-led HIV prevention. Without these data, governments and donors have limited ability to forecast commodity needs, monitor program performance, or identify emerging gaps in service delivery.

Even before the funding cuts, HIV prevention investments were inadequate. Around US$ 1.7-2.1 billion was available for primary prevention in low and middle-income countries in 2024, which was about one third of the $5.3 billion required annually by 2030[24].

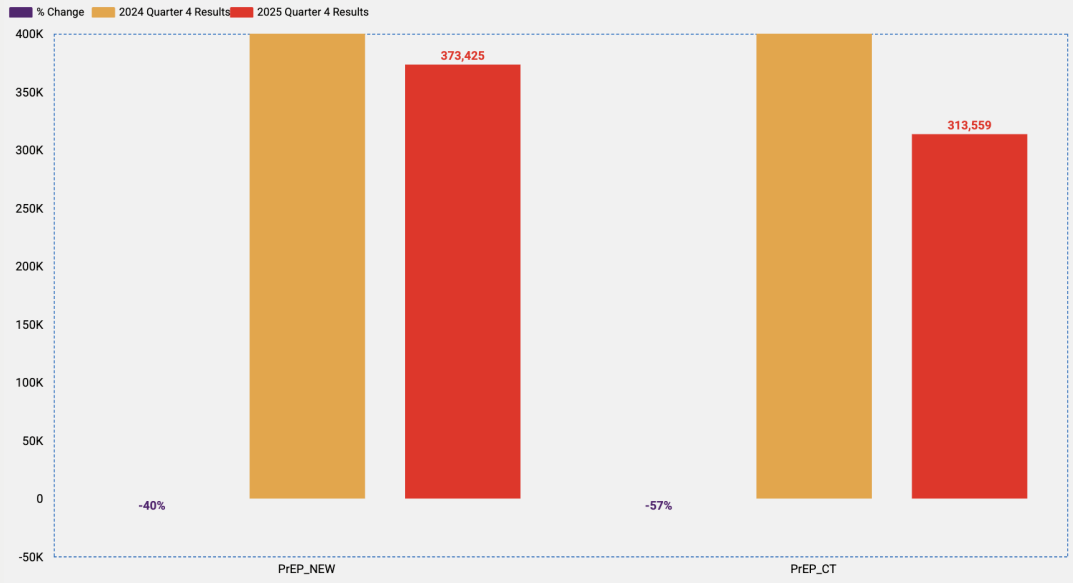
[24] https://unaids.org/sites/default/files/2026-04/20260331_HIV_PREVENTION_2030-report.pdf

a. PEPFAR and Pre-Exposure Prophylaxis (PrEP)

Magnitude of Change in PEPFAR MER Results FY24Q4 to FY25Q4 (Absolute and % Change) in Concentrated Epidemics



Magnitude of Change in PEPFAR MER Results FY24Q4 to FY25Q4 (Absolute and % Change) in Mixed Epidemics



a. PEPFAR and Pre-Exposure Prophylaxis (PrEP)

PEPFAR played a central role in the global expansion of PrEP, making it one of the most important HIV prevention interventions available to key populations. In fact, as of the end of 2024, PEPFAR was responsible for supporting the delivery of about 90% of the global PrEP supply. Progress was monitored through the PrEP_NEW indicator, which measured the number of people newly initiated on oral pre-exposure prophylaxis during the reporting period. In FY2024, PEPFAR substantially exceeded its target, initiating 2,438,656 people on PrEP against a target of 1,857,666[25]. This overachievement demonstrated the strong demand for PrEP and the success of community-based delivery models in reaching people at substantial risk of HIV.

The latest publicly available PEPFAR data, however, show a massive decline in PrEP initiations (-41%) and continuations (-57%), from 659,447 to 387,990; and 809,921 to 347,689[26]. Although the program has not reported key population-specific data, this decline is likely associated with the disruption of community-led service delivery following the funding cuts. UNAIDS in its HIV Prevention: A Global Access Framework for 2030 reported that as of May 2025, as many as 2.5 million people had lost access to PEPFAR-supported pre-exposure prophylaxis (PrEP)[27]. Many organizations responsible for demand creation, peer navigation, follow-up, and PrEP delivery have reduced or ceased operations, limiting access to prevention services for populations who previously relied on these programs.

These changes come at a particularly critical moment as countries roll out new long-acting HIV prevention technologies, such as Lenacapavir. Successful rollout of six-month injectable PrEP will require much more than commodity procurement. It depends on

[25] https://mer.amfar.org/location/World/PrEP_NEW (all four quarters) [26] https://data.pepfar.gov/
[27] https://unaids.org/sites/default/files/2026-04/20260331_HIV_PREVENTION_2030-report.pdf [28] https://gbgmc.org/country-profiles/

a. PEPFAR and Pre-Exposure Prophylaxis (PrEP)

community awareness, trusted peer educators, demand generation, appointment support, retention systems, and differentiated service delivery models, all functions that were largely delivered through community-led key population programs[28]. Without rebuilding these delivery systems, countries risk slower uptake, higher discontinuation rates, weaker retention, and inequitable access to one of the most promising HIV prevention innovations to date.

The loss of key population-specific prevention data further compounds these challenges. GBGMC and AVENIR Health estimates suggest that approximately 11.5 million key population life-years of PrEP alone will be needed by 2030 to maximize the public health impact of PrEP among populations at highest risk[29]. Achieving and monitoring this level of coverage will not be possible without restoring key population-specific reporting systems and ensuring sustained investment in community-led prevention programs.

The current direction of PEPFAR has resulted in the erosion of the community-led systems that have underpinned successful HIV prevention among key populations. It has weakened community trust, disrupted peer-led networks, reduced access to critical HIV prevention commodities and services, eliminated prevention monitoring systems essential for program planning and commodity forecasting, diminished accountability, and undermined the infrastructure needed to successfully introduce new prevention technologies such as long-acting PrEP. Without restoring these systems, countries risk reversing decades of progress, leading to increases in preventable HIV infections, delayed diagnosis, lower PrEP uptake and persistence, poorer treatment outcomes, and ultimately higher long-term costs for national HIV programs.

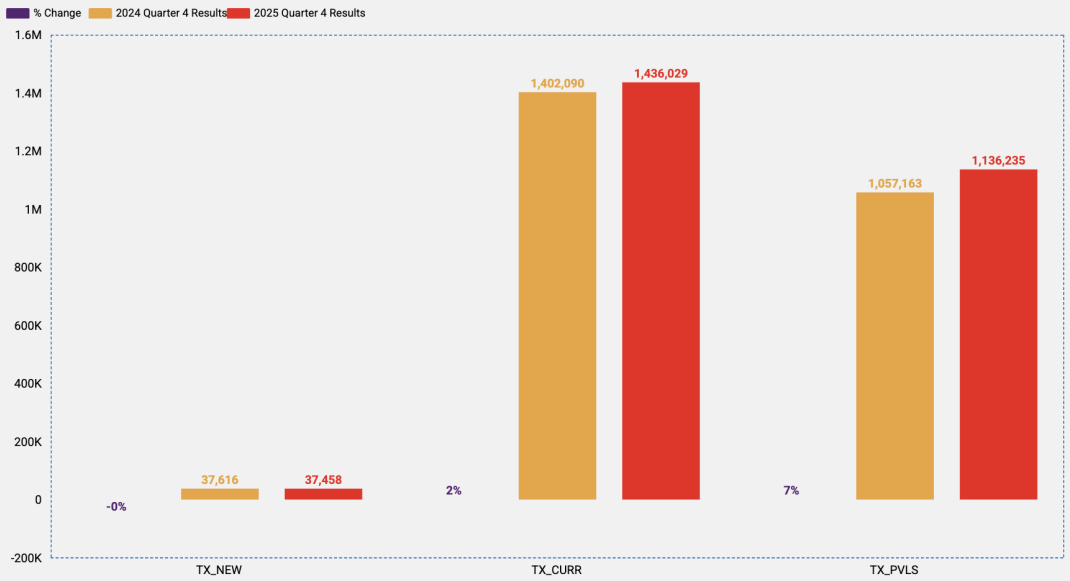
New PEPFAR MOUs

The new MOUs contain limited program reporting requirements and no explicit reporting framework for HIV prevention, including long-acting PrEP (Lenacapavir), making it difficult to measure the impact and accountability of U.S. Government funding

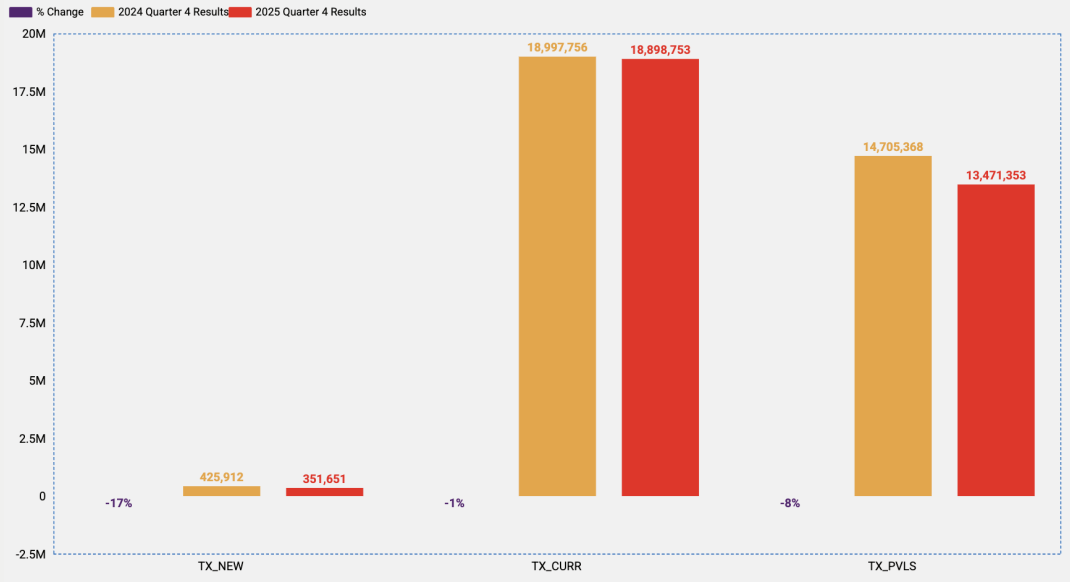
[29] https://globalblackpride.org/wp-content/uploads/2025/10/GBGMC_KP_Forecast_1006_lowres.pdf

Treatment

Shifts in PEPFAR MER Outcomes from FY24Q4 to FY25Q4 (Absolute and Percent Change) in Concentrated Epidemics



Shifts in PEPFAR MER Outcomes from FY24Q4 to FY25Q4 (Absolute and Percent Change) in Mixed Epidemics



Treatment

With PEPFAR support, more than a dozen high HIV-burden countries achieved or approached epidemic control, contributing significantly to global progress toward the Sustainable Development Goal of ending AIDS as a public health threat by 2030. This success was underpinned by sustained investments in community-led HIV programs that enabled key populations to access testing, treatment, and long-term care through trusted and differentiated service delivery models. In many countries, treatment coverage among key populations exceeded 90% among those who knew their HIV status, demonstrating that tailored approaches could achieve outcomes comparable to, or better than, those seen in the general population.

These gains are now at risk[30, 31] . Although these data are not disaggregated by key population, the widespread closure and disruption of community-led programs removed the safe spaces through which many key populations accessed life-saving treatment, adherence support, and peer navigation. In many settings, individuals were expected to transition to general public health facilities despite longstanding evidence that stigma, discrimination, criminalization, and fear of disclosure reduce service uptake and retention among key populations. While PEPFAR no longer publicly reports key population-specific treatment data, the combination of declining overall ART numbers and the loss of community-based service delivery raises serious concerns that progress achieved among key populations is being reversed. Without dedicated monitoring, differentiated service delivery, and sustained investment in community-led programs, countries risk increasing treatment interruptions, weakening viral suppression, and undermining progress toward epidemic control.

The transition toward greater country ownership of the HIV response is not a new policy direction. For more than a decade, both PEPFAR and the Global Fund have encouraged governments to increase domestic investment in HIV programs to improve sustainability and reduce long-term dependence on external donors[32]. As of 2023, PEPFAR and UNAIDS had reinvigorated the effort to develop sustainability roadmaps, which several countries had already completed and had even started implementing. The new bilateral MOUs accelerate this transition by requiring partner governments to progressively increase domestic health financing while U.S. support declines over the five-year implementation period.

However, this transition presents a unique challenge for key population programs. The shift to government-to-government implementation risks dismantling many of the community-led services specifically designed to reach populations most affected by HIV. Unlike previous sustainability efforts, the new MOUs contain no explicit commitments to protect or finance key population programs or ensure their continuity during the transition. As a result, many community-led programs that were abruptly closed are unlikely to be restored, increasing the risk that key populations programs will remain underfunded or disappear altogether, reversing years of progress in reaching those at greatest risk of HIV.

[30] https://davisvanguard.org/2026/05/pephar-cuts-zambia-hiv/
[31] https://www.nytimes.com/2026/04/25/health/pepfar-hiv-aids-zambia.html
[32] https://www.ncbi.nlm.nih.gov/books/NBK207016/

The ability to meet co-financing agreements

Many partner countries already face significant challenges meeting existing domestic financing commitments. The Global Fund Office of the Inspector General (OIG) has repeatedly found that countries struggle to fulfil agreed co-financing obligations. As of September 2024, only 46% of disease components had met the minimum co-financing requirements during Grant Cycle 6, while only 59% had met the minimum requirements for Grant Cycle 7 at the commitment stage. Many remaining components required waivers, exemptions, or reduced co-financing obligations because of fiscal constraints. The OIG further identified 34 countries facing significant macroeconomic challenges and concluded that additional countries were also at risk of failing to meet future co-financing commitments[33].

These findings are consistent with broader health financing trends across Africa. According to the World Health Organization, more than 70% of countries in the WHO African Region (33 of 47 countries) financed less than 45% of current health expenditure through domestic government spending in 2021, illustrating the limited fiscal space available for expanding health investment[34]. At the same time, approximately 72% of Global Fund investments are concentrated in sub-Saharan Africa, highlighting the continued dependence of many countries on external financing for HIV, tuberculosis, and malaria programs.

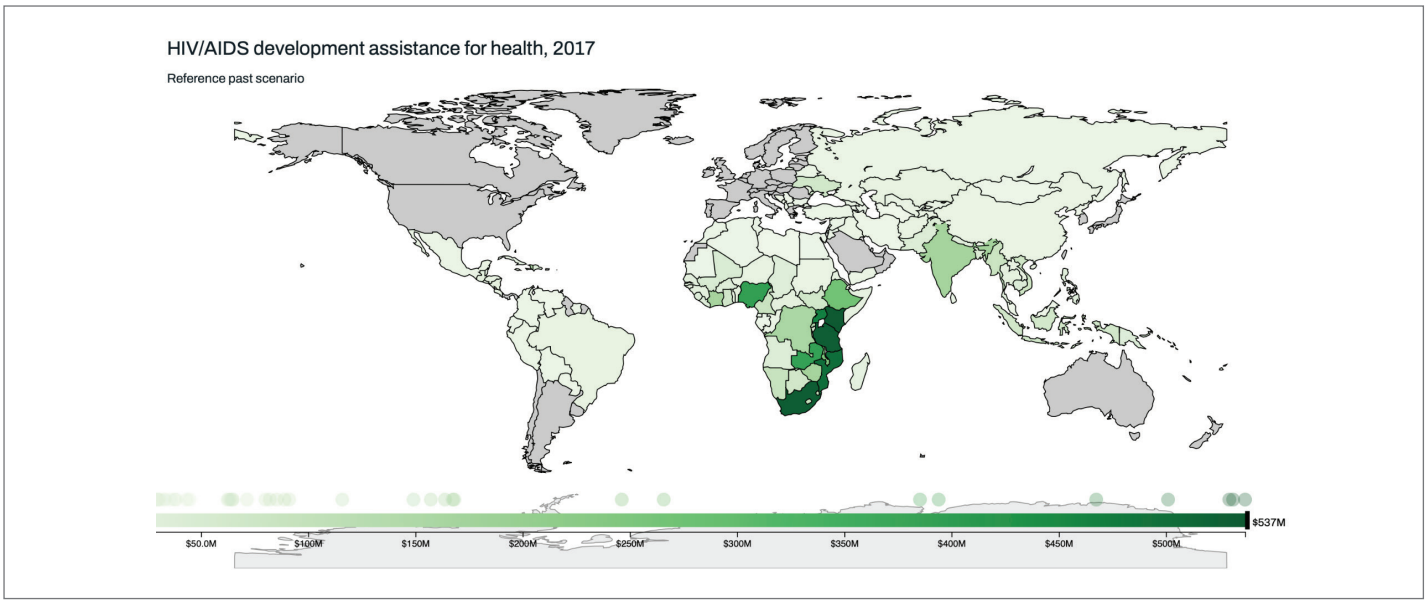
The domestic financing expectations contained within the new PEPFAR MOUs are, in many cases, even more ambitious than previous Global Fund co-financing requirements. If countries have struggled to meet existing obligations despite years of technical support and gradual transition planning, there is considerable uncertainty about their ability to achieve substantially higher investment targets over a shorter timeframe.

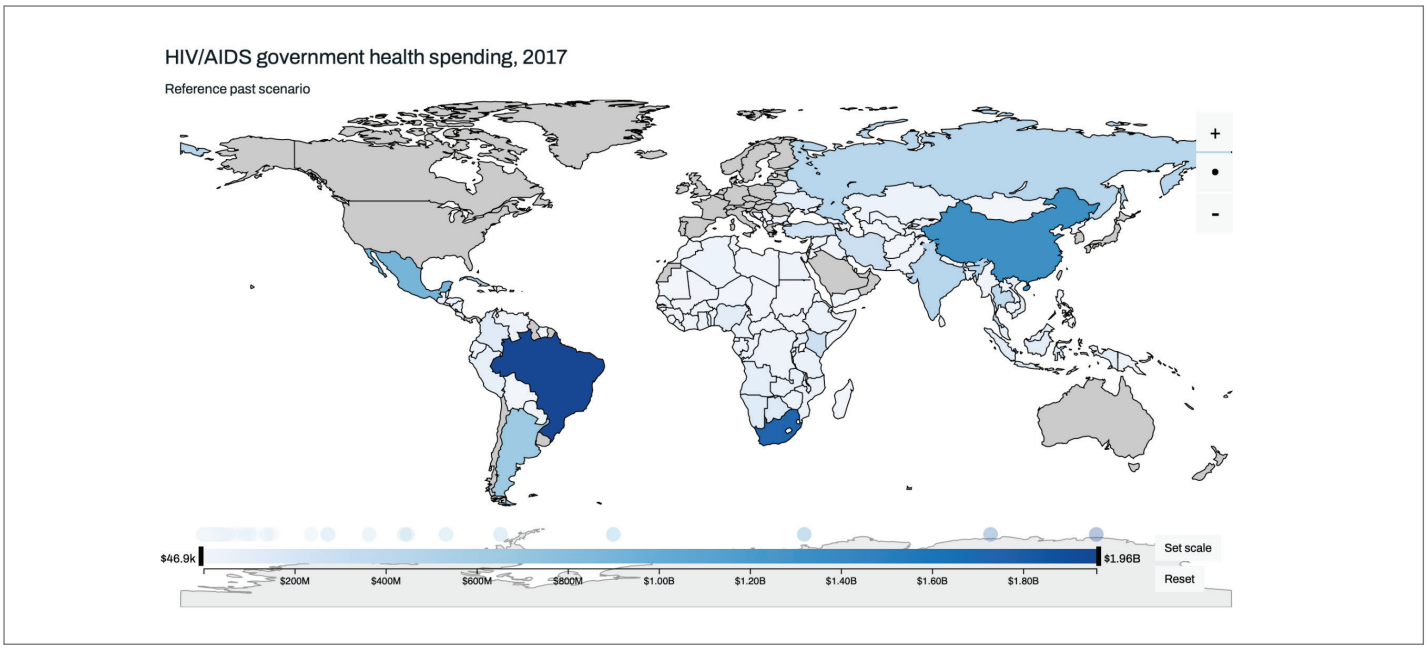
For key population programs,which have historically been among the least likely to receive domestic funding, the risk is particularly acute. There is already evidence from Global Fund transition countries that key population programs are among the first services to lose funding after donor transition[35]. It is also important to note that domestic funding does not always equal domestic financing for KPs. Countries may increase their HIV budgets while still allocating nothing to key populations. Without dedicated financing and explicit political commitment, these services may be the first to be reduced or eliminated as governments prioritize commodities, health workers, and broader health system functions. This could result in increased commodity stockouts, disruption of community-led service delivery, reduced prevention coverage, treatment interruptions, and widening inequalities in access to HIV services for the populations most affected by the epidemic.

The future of key population programs will therefore depend not only on whether countries increase domestic health spending, but on whether governments are willing to explicitly finance community-led HIV services, protect the rights of key populations, and maintain the differentiated service delivery models that have been central to the success of the HIV response. Without these commitments, the transition envisioned under the new MOUs risks reversing decades of progress toward epidemic control.

[33] https://www.theglobalfund.org/media/15167/oig_gf-oig-24-013_report_en.pdf
[34] The Global Health Observatory, WHO - accessed 17 May 2024
[35] https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf

HIV development Assistance for Health, 2017 [36]





Whether or not countries meet co-financing agreements, which is unlikely, key populations remain at the greatest risk of losing access to HIV services. Even where domestic financing increases, there is no guarantee that governments will allocate resources to key population programs.

[36] https://vizhub.healthdata.org/fgh/

PEPFAR commodities procurement through Wambo

Among the most significant proposed changes is the restructuring of the U.S. global health procurement and supply chain. The United States has announced the termination of the Chemonics-led Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) mechanism, which has delivered more than US$5 billion worth of HIV, tuberculosis, malaria, and other health commodities to approximately 90 countries, primarily in sub-Saharan Africa and Asia. Beyond procurement, GHSC-PSM has provided commodity forecasting and quantification, order placement, supply planning, logistics management information systems, warehousing, inventory management, quality assurance, customs support, transportation, last-mile distribution, and broader supply chain strengthening. These functions have been essential to ensuring a reliable supply of HIV medicines, diagnostics, condoms, lubricants, PrEP, laboratory commodities, and other critical products reaching both public health facilities and community-based service providers.

The termination of this mechanism without a clearly articulated transition plan will create significant risks of commodity shortages, procurement delays, and disruptions in the delivery of life-saving medicines and diagnostics. Countries already began experiencing these effects when the funding freeze began[37, 38]. Reports indicate that the U.S. Government is considering using the Global Fund's wambo.org platform for future procurement of HIV, tuberculosis, and malaria commodities.

However, no formal transition plan has been publicly announced. While wambo.org[39] has demonstrated considerable strength as a pooled procurement platform, it has not historically operated as a comprehensive end-to-end supply chain system responsible for warehousing, customs clearance, inventory management, and last-mile distribution[40]. A rapid transition without adequate planning could therefore increase the risk of stockouts, delayed deliveries, and interruptions in treatment and prevention services.

For key population programs, a transition to the Global Fund procurement platform may present some opportunities as advocates continue to push for accountability within the PEPFAR system. Unlike the current U.S. policy environment, the Global Fund continues to explicitly support key population programming and procurement of commodities required for community-led HIV prevention and treatment services. However, any transition should be deliberate, transparent, and centered on continuity of care rather than speed alone. Sufficient time must be allowed to assess new implementation partners, maintain robust forecasting and supply chain oversight, and ensure uninterrupted access to medicines and prevention commodities. Failure to preserve these systems risks undermining years of investment in resilient HIV supply chains and could ultimately increase the risk of procurement failures, stockouts, waste, fraud, and disruptions in services for populations most affected by HIV.

For key populations, the effectiveness of any procurement system should ultimately be measured not only by whether commodities are purchased, but by whether they consistently reach the communities that need them through trusted, stigma-free delivery systems. Procurement alone does not guarantee access.

[37] https://www.unaids.org/sites/default/files/2025-05/UNAIDS_focused-analysis_HIV-commodities_en.pdf
[38] https://pmc.ncbi.nlm.nih.gov/articles/PMC12997708/
[39] https://www.wambo.org/
[40] https://www.cgdev.org/publication/usaids-role-global-health-supply-chain-programs-and-implications-aid-cuts-rapid-review

Conclusion

The changes to the U.S. global HIV response since January 2025 represent one of the most significant shifts in PEPFAR's history. The transition from direct implementation through community-based partners to government-to-government financing, the introduction of the America First Global Health Strategy, new bilateral Memoranda of Understanding (MOUs), reduced public reporting of key population data, and proposed restructuring of global procurement systems collectively signal a scary shift for key population programs.

While greater country ownership and sustainable domestic financing have long been shared objectives of PEPFAR, the Global Fund, and partner governments, the current transition is occurring without sufficient safeguards for the populations most affected by HIV. The disappearance of key population-specific monitoring and reporting, suspension of Integrated Bio-behavioural Surveys (IBBS), disruption of community-led service delivery, closure of trusted safe spaces, and uncertainty surrounding future procurement systems threaten to reverse decades of progress. Without dedicated investment, differentiated service delivery, and robust accountability, countries risk increasing HIV transmission, treatment interruptions, and health inequities while undermining progress toward ending AIDS as a public health threat by 2030.

The future success of the HIV response will depend not only on whether countries increase domestic health financing, but on whether governments, donors, and global partners continue to prioritize and adequately finance the KP programs that have consistently delivered the greatest impact for populations at highest risk. Epidemic control cannot be sustained if the communities driving the epidemic are no longer visible in policies, budgets, program implementation, or data.

Timeline of U.S. Government Decisions Affecting PEPFAR (2025-2026)

STAGE	WHAT CHANGED FOR KEY POPULATIONS
Before January 2025	PEPFAR supported comprehensive KP programs including peer outreach, drop-in centers, HIV testing, condoms and lubricants, PrEP, ART support, violence response, community-led monitoring, IBBS, KP-specific data systems, and differentiated service delivery.
January 2025	Funding pause immediately halted many community-based KP programs. Staff layoffs and closure of community organisations began.
Early 2025	HIV treatment waivers restored portions of ART services but not the broader prevention and community infrastructure. Prevention programs remained severely disrupted.
2025	USAID dismantling removed one of the principal funding channels for community-led HIV programs.
2025	CDC-supported community programming scheduled to end in most countries by September 2026, further reducing implementation capacity.
2025 -2026	Peer educators, outreach workers, drop-in centers, mobile clinics, and safe spaces closed or significantly reduced in many countries. Routine collection of KP program data and many PEPFAR-supported Integrated Bio-behavioural Surveys (IBBS) ceased or were postponed.
2025	Transition toward government ownership, domestic financing, and six priority cooperation areas. No explicit mention of key population programming.
2026	Governments expected to increase health financing while U.S. funding declines. Several MOUs permit reduction or termination of U.S. funding if domestic commitments are not met. Greater reliance on ministries of health with reduced roles for civil society and community organisations.

Timeline of U.S. Government Decisions Affecting PEPFAR (2025-2026)

STAGE	WHAT CHANGED FOR KEY POPULATIONS
2025 - 2026	Approximately 32 bilateral MOUs publicly signed.New five-year funding framework replaces previous planning architecture for participating countries.
2025 - 2026	Only Q4 data released.KP_PREV and other key population indicators disappeared from publicly reported PEPFAR results, reducing accountability for KP outcomes.
2025 - 2026	New MOUs shifted priorities toward health systems, commodities, surveillance, laboratories, and government ownership, with no explicit commitment to key population programs.
2026	Uncertainty over procurement and distribution of HIV commodities while transition options, including Global Fund wambo.org, are considered.
Future Risk	Without dedicated financing and explicit policy commitments, key population programs are likely to become increasingly dependent on limited domestic funding despite longstanding evidence that such programs are often the first to lose support during donor transition.

Recommendations

To the United States Government and PEPFAR

- Explicitly restore key population programming as a priority within bilateral MOUs, implementation plans, and future funding decisions.
- Protect dedicated funding for community-led key population prevention, treatment, human rights, and differentiated service delivery programs.
- Reinstate public reporting of key population indicators, including KP_PREV, PrEP_NEW by population, and other key population-specific Monitoring, Evaluation, and Reporting (MER) indicators.
- Ensure that any transition to new procurement systems includes comprehensive plans for forecasting, warehousing, last-mile delivery, and uninterrupted access to HIV commodities.
- Maintain meaningful engagement of community-led organizations in program design, implementation, monitoring, and accountability.
- Restore the position of PEPFAR as the good bipartisan program with accountability to both congress and those it served.

To Partner Governments

- Develop dedicated domestic budget lines for key population programs rather than relying solely on general HIV financing.
- Integrate community-led organizations into national HIV responses through formal contracting and sustainable financing mechanisms.
- Protect differentiated service delivery models, including peer outreach, drop-in centers, community ART delivery, HIV self-testing, and violence response services.
- Reform laws, policies, and practices that criminalize or discriminate against key populations and impede access to HIV services.
- Ensure national HIV strategic plans include measurable targets and accountability mechanisms for key population programs

Recommendations

To the Global Fund

- Increase prioritized investments in key population and community-led programs in Grant Cycle 8 and future funding cycles.
- Strengthen co-financing requirements that specifically protect investments in key population services during donor transition.
- Expand transition planning support to help countries sustainably finance community-led HIV programs.
- Ensure procurement and supply chain reforms maintain uninterrupted access to prevention and treatment commodities for key populations.
- Continue supporting community-led monitoring as a core accountability mechanism.

To UNAIDS, WHO and Other Global Health Partners

- Support countries to maintain standardized key population surveillance, monitoring, and reporting systems.
- Invest in regional and national research and implementation science, to identify service gaps and guide program improvements.
- Develop global guidance on sustaining key population programs during donor transition and increasing domestic financing.
- Support countries in forecasting future prevention commodity needs, including long-acting HIV prevention technologies.

To Donors and Philanthropic Organizations

- Increase strategic investment in community-led organizations that have lost PEPFAR funding.
- Support organizational sustainability, leadership development, and long-term institutional strengthening of key population networks.
- Invest in innovation, digital service delivery, legal advocacy, and human rights programs that are unlikely to receive government funding.

Recommendations

To Community and Key Population Networks

- To Community and Key Population Networks
- The success of the fight against HIV is not siloed. It has to include key populations. People living with HIV and KPs need to work collectively to advocate for a better response
- Challenge bad MOUs and governments that are not willing to publicly share their agreements. Silence costs lives[41].

The future of the HIV response will not be determined solely by the amount of funding available, but by who is prioritized, how services are delivered, and whether the communities most affected by HIV remain at the center of decision-making.

Sustaining epidemic control requires more than commodities and health systems, it requires continued investment in the community-led programs, trusted service delivery models, and evidence-driven approaches that have made the greatest contributions to reducing HIV infections and improving health outcomes among key populations. Protecting these investments is essential not only for key populations, but for achieving the global goal of ending AIDS as a public health threat by 2030.

[41] https://carnegieendowment.org/research/2026/03/kenya-data-protection-america-first-global-health-strategy