August 30, 2026

Trump Administration Agreements Reshape Global Health Funding

In 2025, the Trump administration froze foreign assistance funding, dismantled USAID, and terminated 80 percent of global health funding awards, causing broad disruption to health programs, including those that support HIV/AIDS, tuberculosis, malaria, and maternal and child health.[1] In the aftermath, new bilateral agreements between the United States and partner country governments provide the main framework for moving global health funds under the State Department's "America First Global Health Strategy," restructuring and supposedly stabilizing health programs that have been supported by USAID and PEPFAR for decades.

The Trump administration, however, has kept the public in the dark about the full details of its plans for the future of U.S. support for global health. The State Department has negotiated these bilateral agreements (memoranda of understanding, or MOUs) on rushed timelines with limited participation from civil society and affected communities, and has refused to release all of the agreements and related planning documents to the public.

Public Citizen filed a lawsuit against the U.S. State Department for failing to produce records responsive to Freedom of Information Act (FOIA) requests seeking 16 MOUs. Through the suit, Public Citizen obtained 15 MOUs, six of which had not previously been made public.[2] One document, which appears to be Uganda's MOU, was withheld in its entirety pursuant to FOIA exemptions related to foreign government information and the foreign relations of the United States. Uganda's MOU was among five previously posted by the State Department.[3]

Below, we analyze the 17 MOUs now publicly available,[4] as well as funding figures from an 18th agreement accessed independently.[5] These MOUs paint a fuller picture of U.S. health assistance and help reveal how the administration plans to spend congressionally appropriated funds for global health.

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[1] Jennifer Kates, Adam Wexler, Anna Rouw, & Stephanie Oum, KFF (Apr. 17, 2025), https://www.kff.org/global-health-policy/analysis-of-usaids-active-and-terminated-awards-list-how-many-are-global-health/

[2] **Botswana**, **Burundi**, Cameroon, Côte d'Ivoire, **Eswatini**, Ethiopia, Kenya, **Lesotho**, Liberia, **Madagascar**, Malawi, Mozambique, Nigeria, Rwanda, **Sierra Leone** (MOUs not previously made public appear in bold).

[3] Public Citizen has made all public texts available here.

[4] The 17th agreement is South Sudan's draft text. South Sudan's agreement was not included in the FOIA suit but has been posted online by others.

[5] The Democratic Republic of the Congo.

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The analysis finds that:

- Compared to pre-2025 spending, the U.S. government plans a 59% reduction — amounting to about $2 billion — in funding under the MOUs to these 18 countries by 2030, despite Congress ordering global health spending to remain relatively steady;
- Across the 18 countries, U.S. government funding is reduced by between 43% and 97% compared to baseline levels by the final year of the MOUs. Those with the steepest reductions in their MOUs by 2030 are Rwanda (97% reduction in U.S. funding compared to pre-2025), Liberia (84%), Burundi (78%), Madagascar (77%), and Sierra Leone (71%);
- Countries that miss steep co-financing requirements may face penalties which could worsen funding cuts, with some countries set to lose much more than others. At the same time, "performance incentives," which draw from an unspecified total pool of funding, could redirect tens of millions of dollars to certain countries, creating an avenue to reward some countries while deepening funding disparities; and
- In addition to funding, co-financing penalties, and performance incentives, agreements vary across several other domains, including plans for sustaining health workforce capacity.

The U.S. government plans a 59% reduction in funding under the MOUs by 2030, compared to historical spending

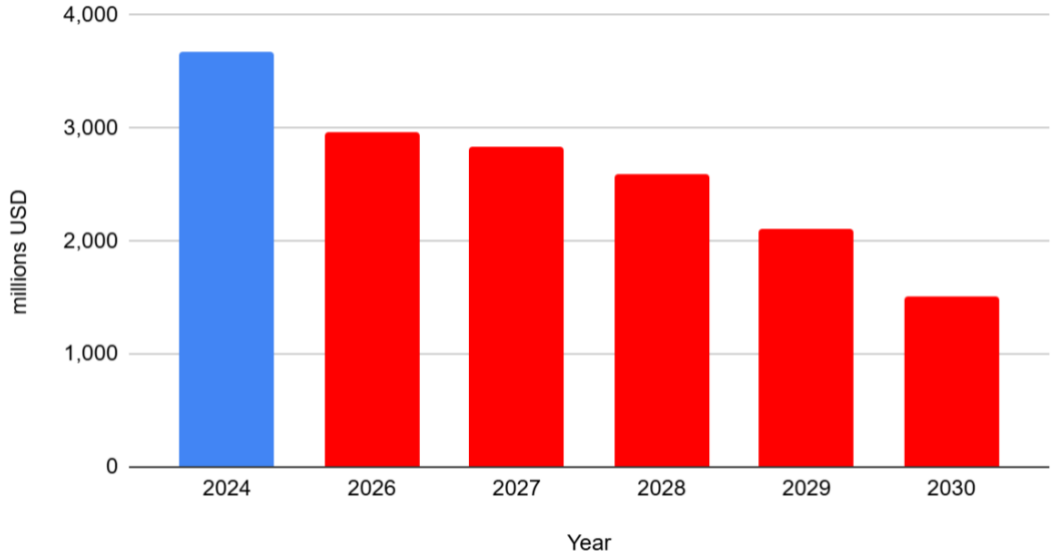
In 2026, in a rebuke to the Trump administration's proposed $6.2 billion cut to fiscal year 2026 global health funding,[6] Congress enacted a near-stable budget.[7] Yet based on the MOUs, the administration's plans to actually spend newly appropriated money won't come close to keeping up with historical levels. Instead, the MOUs warn of a disturbing potential underspend of congressionally appropriated global health dollars.

Compared to historical spending, the U.S. government plans a 59% reduction (amounting to about $2 billion) in funding under the MOUs to these 18 countries by 2030 (figure 1).

[6] White House Releases FY26 Budget Request, KFF (May 2, 2025), https://www.kff.org/global-health-policy/white-house-releases-fy26-budget-request/

[7] FY 2026 National Security, Department of State and Related Programs (NSRP) Global Health Funding in the Consolidated Appropriations Act, KFF (Feb. 4, 2026), https://www.kff.org/global-health-policy/global-health-funding-in-the-fy-2026-national-security-department-of-state-and-related-programs-nsrp-conference-bill-explanatory-statement/; U.S. Global Health Budget Tracker, KFF, https://www.kff.org/interactive/u-s-global-health-budget-tracker/

Figure 1: 18 MOUs represent a 59% cut compared to 2024 baseline by 2030



*Baseline funding is the sum total of the most recent FY25 State/USAID PEPFAR and USAID-GHP request or FY23 actuals across countries and includes bilateral HIV, TB, malaria, nutrition, MCH, GHS, FP/RH; FY25 rescissions cut down FP/RH by $500 million but the FY26 conferenced SFOPS/NSRP bill & report restores that funding; *see* KFF Tracker for similar analysis.

The steep decline in funding compared to baseline levels over the course of the MOUs raises concerns about how, or if, the administration intends to spend appropriated money. While spending outside the MOUs (for example, through the State Department's Annual Program Statement [APS] addenda, which provide supplemental funding to support specific projects)[8] could fill in the funding gap shown in the MOUs, the administration has shown its willingness to delay funding.[9] If the MOUs are any indication, in the coming years, new money intended to fight disease and support health might instead sit unused or be spent in unpredictable ways.

Rapid funding transition makes country-level planning difficult

The U.S. government plans to transition countries away from U.S. funding over just three to five years, even as countries are still dealing with the impact from the Trump administration's cuts.

[8] Bureau of Global Health Security and Diplomacy, Advancing Global Health, Simpler.grants.gov, https://simpler.grants.gov/opportunity/ff23ddd9-0a2e-470b-8881-7d7dc74aed03

[9] This is particularly concerning for HIV funds that may be spent within a period of up to five years, potentially masking the extent to which appropriated funds are spent in a timely manner. *See* K. J. Seung & Vincent Lin, U.S. Global Health Spending Watch (June 15, 2026), https://globalhealthwatch.org/?blog=between-two-systems (showing slower obligations for FY2025 five-year funding than in previous years, when much of the spending occurred in the second year after money was appropriated. This warns that money is not moving at scale, even though it is not under immediate threat of expiry).

Analysis of the country-level changes in U.S. contributions over the course of the MOUs compared to pre-2025 baseline levels shows rapid decreases, and in some cases near-complete planned cessation of U.S. funding by 2030 (figure 2).

Figure 2: 18 MOUs relative to 2024 baseline, by country

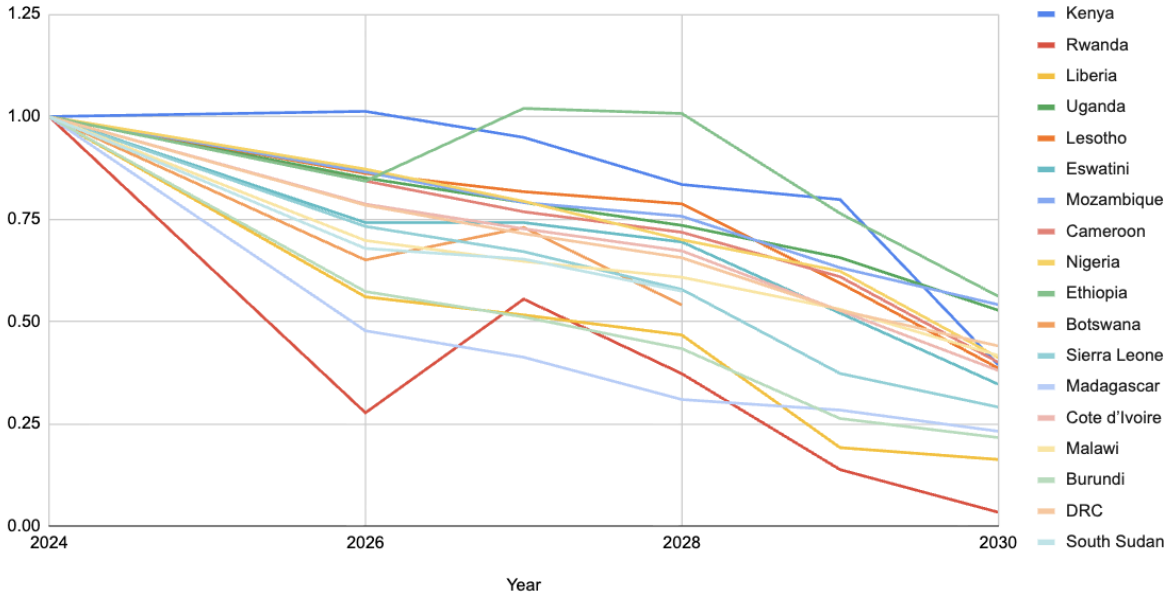


*Figure 2 shows 2024 funding as 100% of the baseline and charts variation relative to that point over the five year period. Baseline funding is the sum total of the most recent FY25 State/USAID PEPFAR and USAID-GHP request or FY23 actuals across countries and includes bilateral HIV, TB, malaria, nutrition, MCH, GHS, FP/RH; FY25 rescissions cut down FP/RH by $500 million but the FY26 conferenced SFOPS/NSRP bill & report restores that funding; *see* KFF Tracker for similar analysis.

Across all 18 countries, U.S. government funding is reduced by between 43% and 97% compared to baseline levels by the final year of the MOUs.[10] Those with the steepest reductions in their MOUs by 2030 are Rwanda (97% reduction in U.S. funding compared to 2024 baseline funding levels), Liberia (84%), Burundi (78%), Madagascar (77%), and Sierra Leone (71%).

Additionally, while co-financing commitments (the amount of funding the co-signatory government is expected to contribute for each year of the agreement) could help with program stability, the planned decreases in U.S. funding are larger for several countries than the funding increases from partner governments. For more than half of countries (11 out of 18), co-financing commitments fall short of the U.S. government's cuts over five years compared to baseline U.S. government funding. Countries may also struggle to meet these funding expectations. For example, Malawi would have to mobilize new funding equal to 56% of the country's total health expenditure to meet its annualized co-financing commitment.[11] Countries also face co-financing requirements from the Global Fund and Gavi, representing a substantial additional burden; for

[10] Botswana and South Sudan have three-year MOUs. All other countries have five-year MOUs, running through 2030.
[11] Based on 2023 World Bank health finance data.

instance, in Uganda, annualized co-financing obligations from Global Fund, Gavi and the U.S. MOU on average equal 44% of the total government health budget for 2026.[12]

Funding decreases by the U.S. over such a short period, uncertainty around potential future contributions from the U.S. government outside of the MOUs, and steep co-financing requirements from multiple donors make it harder for countries to sustain health programming and plan for the future.

Harsh penalties and vague incentives make funding more unpredictable

At the same time as the Trump administration plans to decrease its funding, aggressive co-financing commitments and potential penalties increase the risk of funding shocks and could mean even steeper declines in support compared to previous years.

If countries do not meet co-financing expectations, the U.S. government reserves the right to reduce or cease funding. The MOUs also state that the co-investment may not include funding from other donors or multilateral organizations, but must be funds "raised directly" by the country.

Consequences for failing to meet co-financing commitments range from reducing U.S. funding by $1 for every $1 (or equivalent) of the shortfall from the co-signatory country's expected funding contributions,[13] a 2:1 reduction (in which the U.S. would reduce funding by twice as much as the shortfall),[14] another linear amount,[15] or no specified penalty amount.[16] There is no transparent logic guiding the application of penalties across countries.

Although some countries softened language surrounding U.S. government funding reductions in some cases (such as by including that funding reductions should take place after good faith discussions), the inclusion of the penalties at all raises questions about the predictability of funding under the Trump administration's strategy.

[12] Clinton Health Access Initiative (CHAI), HIV Services Are Still Falling: A Year into the Funding Crisis, New Data Shows Little Recovery (June 8, 2026), https://www.clintonhealthaccess.org/wp-content/uploads/2026/06/HIV-Market-Impact-Memo-June2026.pdf; Kalipso Chalkidou, Financing Health: Where is the money coming from?, World Health Organization (June 2026).
[13] Ethiopia, Kenya, Mozambique, Cameroon, and Malawi.
[14] Uganda and Côte d'Ivoire.
[15] Nigeria, according to section 5.1.1.
[16] Rwanda, Liberia, Lesotho, Eswatini, Sierra Leone, Madagascar, Burundi, Botswana, and South Sudan.

Many of the MOUs also include "performance incentives" for meeting process and outbreak response metrics.[17][18]

The performance incentive included for some countries refers to an unknown funding pool, which will be used to calculate the size of payments to eligible countries. The MOUs indicate in most cases that the performance incentive will be available in 2027 or 2028 and corresponds to a distribution proportional to the size of a country's population relative to the population of all eligible countries.

In most cases, the MOUs also provide a cap for each co-signatory country's potential performance incentive based on a pre-set per person dollar amount ($1,[19] $2,[20] $5,[21] or $10[22] per person per year) or an absolute maximum of $75 million.[23] Two agreements do not note an incentive cap.[24] Rwanda's MOU is unique among the 17 agreements analyzed. It does not include specific eligibility years, indicates that performance incentives are connected to the achievement of a smaller set of metrics (HIV and malaria metrics), and states that funds may be used in the Government of Rwanda's strategic investment in the health sector, including Kigali Health City and AI application for healthcare (instead of generally stating that funds may be applied to any health-related costs under the MOU). The two strategic investment areas mentioned are also those where U.S. commercial partnerships and investment interest are indicated.[25]

While the size of the potential pool of money is not stated, the performance incentives suggest potentially tens of millions of dollars allocated for this purpose.

[17] Agreements for Liberia, Botswana, Burundi, Madagascar, Sierra Leone, and South Sudan do not include references to performance incentives.
[18] Many MOUs also include potential penalties for failing to meet metrics. This is often included as a general statement that the U.S. government plans to reduce funding if countries fail to maintain outcome and process metric baselines or achieve outbreak response targets.
[19] Uganda ($45,900,000 cap, based on population size stated in Uganda's MOU).
[20] Mozambique ($69,263,532 cap), Cameroon ($61,281,634), Côte d'Ivoire ($62,331,308), Malawi ($45,600,000). Mozambique's MOU does not include its population size; value for cap is based on 2024 World Bank population data.
[21] Lesotho ($10,582,135 cap).
[22] Eswatini ($12,605,420 cap).
[23] Ethiopia and Nigeria.
[24] Kenya and Rwanda.
[25] Article 2.6.4, Future Strategic Opportunities in the U.S.-Rwanda Partnership Beyond the MOU, Multispecialty Hospital and AI Application for Healthcare.

Agreements vary across several other domains

In addition to funding, co-financing penalties, and performance incentives, agreements vary across several other domains.[26] Additional observations from the country agreements include:

- In the available MOUs, the U.S. reduces support for the health workforce, leaving seven countries in the African region with fewer health workers by 2030, taking into account both US and partner government commitments. These are Burundi, Cameroon, Eswatini, Kenya, Lesotho, Madagascar and Malawi.[27] This is a major concern since the African region currently has only 46% of the health workers it needs, and by 2030 it is projected to face a health workforce shortage of 5.85 million workers.[28] In a number of countries, the reduced number of funded positions for community health workers (CHWs) is quite substantial, as for instance in Malawi, where 3,436 positions are eliminated (72%), and Madagascar, where 8,200 positions are eliminated (39%). In Burundi all U.S. funded CHW positions are terminated, with no plan for the government to absorb them. Cameroon has a severe shortage of CHWs, as well as nurses, yet funded positions for both cadres are reduced by 20%.[29]
- The majority[30] of available MOUs reduce the duration of controversial data sharing agreements and specimen sharing agreements (providing the U.S. government access to a specified set of data systems related to the functioning of the MOU and to viral

[26] Several domains are documented in an earlier Public Citizen report that observed diverging terms across agreements when compared with the template MOU and plotted them in a negotiation tracker. The tracker has been updated with the new agreements.

[27] Eswatini's agreement shows fewer lab workers, doctors, nurses, CSWs and CHWs by 2030; while it states CHW tasks will be shifted to nurses and that other CHWs will be absorbed by NGOs, nurses have a distinct scope of work and no NGO is a party to the agreement. Kenya's agreement shows the number of frontline healthcare workers declining by 53% in 2028 when U.S. support for this workforce ends; the agreement includes a commitment by Kenya to funding continuity for many cadres, but there is no commitment to absorb the large number of U.S. funded CHWs. MOUs signed by Botswana and Rwanda do not include specific numerical commitments per cadre.

[28] State of the health workforce in Africa 2026: plan, train and retain. Brazzaville: WHO Regional Office for Africa (2026), https://www.afro.who.int/publications/state-health-workforce-africa-2026-plan-train-and-retain

[29] It is worth noting that, despite significant reductions in U.S. funding, some governments commit to increasing the number of health workers by 2030, namely Côte d'Ivoire, Liberia, Mozambique, Sierra Leone and Uganda, based on the available MOUs.

[30] Of the 17 available MOUs, only the Madagascar and Rwanda agreements retain the 25-year data sharing agreement duration from the template MOU (though without access to the data sharing agreements themselves, it is difficult to know if this duration may be altered in the final text); other MOUs reduced the duration to between five and ten years, sometimes with the possibility of renewal. All MOUs that include information on the duration of the specimen sharing agreement reduce it to between five and ten years, sometimes with the possibility of renewal. For some countries, the agreement durations cannot be discerned from the MOU text. Additionally, some MOUs reference a data sharing agreement but remove references to a specimen sharing agreement (Sierra Leone, Botswana, Liberia). South Sudan's draft agreement does not reference either a specimen sharing or data sharing agreement.

specimens and related data collected as part of public health surveillance, respectively), though they also retain an acknowledgement in some form that failure to fulfill sharing agreement terms could result in reductions in planned funding. These agreements are contentious because they may act as a condition of ongoing funding and the U.S. government originally sought expansive access to data for up to 25 years (well beyond the three to five year period of funding under the MOUs). These agreements stand apart from the MOU itself, and most are not available in wider circulation, making a full assessment of final terms impossible in most cases. In some cases, the data and specimen sharing terms have contributed to stalled negotiations, endangering health funding.[31]

- Most MOUs retained in some form a provision from the State Department's template related to the acceptance of U.S. FDA approvals for medical countermeasures (*e.g.*, vaccines and therapeutics) used in outbreak response;[32] far fewer MOUs included the broader separate commitment to modify national regulations to allow for recognition of U.S. FDA approvals for all medical products.[33] Accelerated approval during outbreaks can support swift deployment of medical countermeasures newly identified for the health emergency. A requirement of regulatory recognition for all U.S. FDA-approved products effectively ensures that U.S. companies have market access, which may be the intention of the broader provision, given that the State Department's guidance document that accompanied the template MOU clarified that this provision should be included for countries with "large domestic markets" or "for which there are other strategic reasons." The U.S. government's recent attempts to compel countries to automatically accept U.S. regulatory approvals, as shown in the MOU template and in similar provisions in recent trade agreements,[34] raise concerns about U.S. pressure on countries' regulatory autonomy and the inclusion of such terms in agreements for renewed health funding.
- The new HIV pre-exposure prophylaxis (PrEP) drug lenacapavir is referenced in eight of the MOUs available to date.[35] Two agreements include specific funding amounts for the purchase of lenacapavir in 2026.[36] The inclusion of lenacapavir in these agreements aligns

[31] For example, in Zimbabwe and Ghana negotiations reportedly stalled over the terms. In Zambia, negotiations also stalled; Zambia's foreign affairs minister said negotiations broke down due to "unacceptable" data sharing terms "in violation of our citizens' right to privacy" and "the insistence on preferential treatment of U.S. companies over Zambia's critical minerals."

[32] Six MOUs incorporated the template provision (Madagascar, Rwanda, Mozambique, Liberia, Kenya, Ethiopia), six modified the provision (Sierra Leone, Malawi, Botswana, Côte d'Ivoire, Cameroon, Nigeria), and five removed the provision (Uganda, Lesotho, Eswatini, Burundi, South Sudan).

[33] Two MOUs accepted the provision as proposed (Rwanda, Liberia), Six modified the provision (Sierra Leone, Botswana, Cameroon, Uganda, Nigeria, Kenya), and nine removed the provision (Ethiopia, Mozambique, Lesotho, Côte d'Ivoire, Eswatini, Burundi, Madagascar, Malawi, South Sudan).

[34] For example, annex III, article 2.4(5), U.S.-Malaysia Agreement on Reciprocal Trade (Oct. 26, 2025), https://www.whitehouse.gov/wp-content/uploads/2025/10/MALAYSIA-ANNEX_APPENDIX.pdf

[35] Sierra Leone, Botswana, Eswatini, Cameroon, Ethiopia, Rwanda, Lesotho, Kenya.

[36] Botswana's agreement indicates that commodities funding under the agreement will shift to Botswana over the course of the agreement, apart from lenacapavir, for which "the U.S. Government plans to continue procurement over the duration of this MOU." In 2026, the agreement notes that $550,000 will purchase lenacapavir and $300,000 will support its rollout. Sierra Leone's agreement indicates $200,000

with several partner governments' goals to roll out the drug, as well as the Trump administration's aim to promote products made by American companies and its commitment, in partnership with the Global Fund, to reach three million people with lenacapavir over the next three years.[37] However, current supply commitments fall well below the potential need for HIV prevention medication, which is estimated at as many as 20 million people.[38] At the same time, plans for the rollout of lenacapavir are occurring against the backdrop of the U.S. government's health cuts. Among facilities receiving PEPFAR support between 2024 and 2025, the number of people starting PrEP decreased by 33%, the number of healthcare workers delivering HIV services declined by 24%, and HIV testing declined by 18%.[39] Robust service delivery, outreach, and testing programs are necessary for the successful implementation of PrEP interventions.

The MOUs include rapid decreases in planned U.S. government global health support over the next five years and agreement terms that are not primarily guided by health, including conditionalities that may worsen funding cuts. Congress has ordered new global health funding. Failing to spend these funds based on health needs will only lead to preventable harm.

from the U.S. government for lenacapavir in 2026. A third agreement (Kenya's) includes $20,000,000 for antiretroviral therapy and lenacapavir. Eswatini's agreement does not include a specific funding amount, though it does state that the country will target women ages 15–34.

[37] AVAC, Source of Lenacapavir for PrEP Supply to Early Adopter Countries, https://avac.org/resource/infographic/lenacapavir-supply/ (showing current PEPFAR and Global Fund supply commitments by country; there are plans to add additional supplies in the coming months).

[38] UNAIDS, Global HIV response falters as reemergence looms (July 27, 2026), https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2026/july/20260727_PR_UNAIDS_special_report_AIDS2026

[39] Brian Honermann, Anna Grimsrud, Elise Lankiewicz, Jennifer Sherwood & Greg Millett, 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, Journal of the International AIDS Society (2026), https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.70182