



Counting the Costs of Global HIV Funding Disruptions

PEPFAR's exceptional momentum has been slowed down by a new administration with radically different ideas about global health funding.

March 2, 2026 By Krishen Samuel

In a session on U.S. government funding cuts at the [Conference on Retroviruses and Opportunistic Infections \(CROI 2026\)](#) last week in Denver, Jennifer Kates, PhD, of the Kaiser Family Foundation, started by asking a crucial question: "What's the impact on people?"

But the question is challenging to answer. "The data systems that were available to look at the impact had been taken down," Kates said. "Or even if they weren't, staff who would be able to access the information were no longer there. It's very hard to find people out of care, when they're out of care." She emphasized the importance of modelling studies to capture an accurate current snapshot and a preview of what's to come.

The Undoing of PEPFAR's Success?

Before PEPFAR began in 2003, there were fewer than 50,000 people on antiretroviral therapy in sub-Saharan Africa, with more than two million global HIV-related deaths every year. After nearly 23 years of PEPFAR, 21 million people are on treatment in the region, with 600,000 annual global HIV-related deaths. While PEPFAR can't be credited with all the success of the past two decades, it's certainly been responsible for a sizeable part of it. PEPFAR has also been unique politically—it has traditionally had [healthy bipartisan support](#).

While PEPFAR has essentially been flat funded for the past few years, the \$5 billion annual contribution still comprised a massive 80% of all international donor funding for global HIV efforts. The bulk of this funding—91%—went directly to sub-Saharan Africa. But in terms of the overall U.S. federal budget, PEPFAR accounted for only 1%.

While many people think specifically of HIV testing, prevention treatment and care, PEPFAR funds also contributed to strengthening health systems, such as creating and maintaining laboratory infrastructure and data systems to ensure that resources reach the people who need them. Care was not limited to HIV: areas such as tuberculosis (TB), cervical cancer and gender-based violence screening also fell under PEPFAR's remit, and it included socioeconomic programs including cash

transfers and nutrition support. Part of PEPFAR's immense success was its holistic, multi-pronged approach that worked on numerous levels, from the individual to the broader health system. It's estimated that PEPFAR has saved a staggering [26 million lives](#) thanks to this approach.

But soon after President Donald Trump's inauguration in 2025, PEPFAR's exceptional momentum [was slowed down by a new administration](#) with radically different ideas about global health funding—particularly for HIV. While some funding has been allowed to continue, scientists and communities are still gauging the damage caused by the stop-work order and limited waivers.

Nonclinical Care Hit Hard

Ellen Brazier, PhD, of the City University of New York, presented data from a rapid survey of clinics and programs in 32 countries, conducted by the International Epidemiology Databases to Evaluate AIDS (IeDEA) research consortium.

This survey encompassed seven regions and was sent out to 30 PEPFAR-funded and 11 non-PEPFAR countries in mid-2025. Survey questions asked about disruptions in areas such as HIV-related services, medication availability, laboratory services and clinic operations, resolution of these disruptions at the time of the survey and any mitigation strategies employed.

Overall, responses came in from most of 32 the countries surveyed (78%), representing 68 individual clinics and eight programs (a program could have multiple associated clinics). Most of the responding sites (88%) were in countries supported by PEPFAR at the start of 2025. Nearly half (47%) reported some disruption in HIV services:

- 28% reported medication availability challenges
- 34% reported disruptions to laboratory services, such as viral load testing
- 47% reported clinic operation disruptions, including adherence support, patient tracing, record management staffing and other operational requirements.

Limited mitigation measures were put in place. In terms of resolving these disruptions by mid-2025, there was a great deal of variation by region. For instance, while southern Africa had not fully resolved disruptions (e.g., a quarter of clinics and programs had not resolved disruptions in pre-exposure prophylaxis, or PrEP), clinics in Latin America reported that they had done so by mid-year. However, Brazier explained that there are very few PEPFAR-supported countries in Latin America, and many clinics were tertiary level hospitals that would often have other buffers in place.

Overall, Brazier emphasized the high variability seen in the resolution of disruptions. While some were fully resolved, the effects of losing personnel such as data managers and other non-clinical staff would still be felt for some time. These nonclinical functions, such as maintaining laboratory equipment and identifying clients who don't return for follow-up visits, are not simply

complementary—they are essential to the clinical aspects of providing HIV care. In terms of direct clinical aspects, the loss of PrEP for populations such as young women and female sex workers was highlighted.

Lindsey Filiatreau, PhD, of Washington University in St. Louis, presented research from South Africa. In addition to PEPFAR-specific roadblocks, South Africa was singled out in one of [Trump's executive orders from February 2025](#)—one that essentially ended U.S. support for the country due to tensions fueled by the spread of misinformation regarding the supposed [“genocide” of white farmers](#).

Filiatreau's research team aimed to quantify the real-world impacts of PEPFAR funding disruptions to HIV service delivery, clinic operations and staffing in one of the provinces with the highest HIV prevalence, Kwa-Zulu Natal.

To do this, they drew on data from the broader Uhambo Lwami study, sampling 36 out of 519 clinics across six regions of Kwa-Zulu Natal. This represented a sample of 179,586 people with HIV from a population of 1,622,247 across all the clinics.

The researchers explored interruptions to areas including HIV testing, PrEP provision, HIV treatment, TB and HIV care, condom supply and many nonclinical areas such as data entry, patient tracing and systems management.

At the clinic level, 39% reported any service, operations or staffing interruption. However, when considering the number of clients these clinics serve, over half of all clients living with HIV in the province (51%) were impacted by these disruptions. While disruption to areas such as HIV testing and treatment services affected approximately 10% of clinics and 27% of clients, loss of staff such as data capturers impacted 27% of clinics and 36% of clients.

As with Brazier's findings, Filiatreau emphasized the “silent” clinic functions, such as data entry and patient tracing, that were commonly impacted. The disintegration of patient monitoring systems ultimately impacts clinical care, even when medications are available. Thus, access to data capturing, routine monitoring and support systems is essential.

“Our findings demonstrate that funding disruptions have effects beyond interruptions to [antiretroviral therapy] supply, new infections and increasing deaths,” Filiatreau stated. She also spoke about the erosion of trust in the health system—not just by health system users, but by the many employees whose contracts were suddenly terminated. These staff were hesitant to go back when clinics reopened and they were needed. “We'll have substantial rebuilding to do. These things [HIV services]...can be taken away overnight, but they can't be rebuilt overnight.”

A version of this report was also published by [aidsmap](#).

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