Tough Times, Tough Choices
Surviving the Aid Collapse

Charting PEPFAR's Next Chapter While Safeguarding its Legacy

CENTER FOR GLOBAL DEVELOPMENT

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KEY MESSAGES

- The Trump administration and key congressional lawmakers are shaping a **new US government approach to the future of PEPFAR**, alongside other global health programs like malaria and tuberculosis. The emerging vision emphasizes country ownership and greater government-to-government support via bilateral Global Health Compacts, paired with a financial drawdown of US assistance.
- The government's proposed approach offers a **broadly reasonable blueprint for PEPFAR's evolution**. Yet, the pace and scale of proposed changes are unprecedented in global health history, posing significant risks to hard-won PEPFAR results. Thoughtful and calibrated risk mitigation measures are needed to prevent financing gaps, service disruptions, and accountability breakdowns.
- We propose a **differentiated three-track framework to operationalize a responsible PEPFAR transition** while meeting the administration's key strategic goals:
  - **Track 1 – Graduation:** For wealthier and stable partner countries able to feasibly absorb PEPFAR funding on a relatively rapid timeline, following a phased shift of service delivery to government systems
  - **Track 2 – Toward self-reliance:** For poorer, higher-burden countries, allowing extended timelines to gradually increase domestic financing while sustaining PEPFAR funding for key treatment and prevention outcomes
  - **Track 3 – Compassionate:** For the poorest and most fragile countries where sustained PEPFAR investment is required, with potential scope for partial service delivery via national systems in some settings.
- This analysis and proposed timeline only apply to PEPFAR, and should not be extended to other global health programmatic areas and investments.
- We urge the administration and congressional leaders to pair adequate **financial, technical, and human resources** with a **prudent operational approach** to implement this next chapter of PEPFAR—protecting public health outcomes and preserving PEPFAR's extraordinary legacy.

1. Introduction and motivation

The President's Emergency Plan for AIDS Relief (PEPFAR) is a great American success story. Since its launch in 2003, PEPFAR has helped transform the global AIDS epidemic from an international crisis, particularly in hardest-hit sub-Saharan Africa, to a manageable (if still challenging) chronic disease. As of end-2024, PEPFAR is credited with saving 26 million lives, preventing 7.8 million babies from contracting HIV at birth, and directly supporting 21 million people on lifesaving antiretroviral therapy (ART).[1] PEPFAR has enjoyed strong bipartisan support since its inception under President George W. Bush. Today, Republicans and Democrats alike are justifiably proud of its impact and committed to protecting its legacy.

Nevertheless, PEPFAR now faces an inflection point—in part due to its remarkable success in reducing AIDS-related deaths and the cost of treatment. PEPFAR was originally conceived (and named) as an emergency response to a global crisis. In 2003, 1.6 million people were dying of AIDS each year, sub-Saharan Africa (home to 76 percent of infections)[2] had a weighted average GDP per capita of just $762 per year,[3] vanishingly few people were enrolled on ART,[4] and PEPFAR spent $1100 annually per person for HIV treatment.[5] Today, AIDS mortality has fallen 55 percent,[6] African economies have roughly doubled in per capita income,[7] 83 percent of HIV-positive Africans are currently on treatment,[8] and treatment costs have fallen about 95 percent, to just $58 per year.[9]

The evolving context places new demands on PEPFAR's future, with increasing pressure from multiple sides for meaningful reform. Yet the HIV response remains fragile, as hard-won gains could still be reversed due to service disruptions and sudden funding drawdowns—a sobering reality illustrated by the US foreign assistance pause and subsequent dissolution of USAID earlier this year.[10] And PEPFAR's future is intertwined with the broader evolution of US health assistance, encompassing other programmatic areas such as malaria, tuberculosis, and outbreak preparedness and response.

For their part, African governments have long paired gratitude for PEPFAR investments with muted frustration at its parallel delivery channels. This includes the widespread use of American NGOs and for-profit intermediaries as implementing partners, in lieu of more direct forms of partnership and funding through national systems, where viable. In recent years, African leaders have articulated more pointed ambitions for "health sovereignty," alignment with national systems, as well as financial and operational sustainability.[11] These calls have increased in urgency since the Trump administration's aid freeze in January 2025, which revealed significant vulnerabilities from overreliance on external assistance.

In the US, congressional leaders are proud of PEPFAR's track record but increasingly skeptical of the feasibility and desirability of sustaining current outlays in perpetuity.[12,13] Even advocates and civil society leaders who have historically advocated for sustained or increased PEPFAR investments appear to accept the need for evolution toward longer term sustainability of the HIV response. For example, the Center for Strategic and International Studies recently called for a five-year transition plan,[14] while Friends of the Global Fight laid out a roadmap for "transition to a new phase of PEPFAR that prioritizes sustainability and gradually draws down U.S. assistance after fiscal year 2026."[15]

In fact, transition has long been a priority for PEPFAR—embedded in previous reauthorization bills and strategies that acknowledge the importance of moving to a long-term plan, at least in principle. As early as 2007, an Institute of Medicine assessment of PEPFAR recommended that "PEPFAR should transition from a focus on emergency relief to an emphasis on the long-term strategic planning and capacity building necessary for sustainability."[16] Yet while transition has been a stated priority, little progress has been made in practice (e.g., PEPFAR has not used formal graduation criteria or explicit eligibility thresholds in the past),[17] even as country contexts and epidemiological trends have evolved. Now, a new high-level strategic approach to PEPFAR is emerging,

with both Congress and the current administration emphasizing the desire for a more explicit approach to PEPFAR transition planning. This presents a critical window to chart a realistic path forward that preserves hard-won gains in the fight against HIV, while advancing country ownership and long-term sustainability.

Against this backdrop, some US lawmakers and the Trump administration appear to be shaping an emerging US government approach to PEPFAR's future, alongside the broader US approach to global health. Legislation advanced by some Republican members of the House Foreign Affairs Committee in September 2025 proposes multi-year, bilateral "Global Health Compacts" with partner countries as a vehicle to "perpetuate the wind down of PEPFAR," including a significant budget reduction by end-FY2028.[18] The Trump administration offers a complementary vision in its America First Global Health Strategy,[19] also released in September. Specifically, it appears to pair on-budget, government-to-government aid with significant implied cuts, all while emphasizing a bilateral compact model and the importance of country ownership and sustainability. The strategy also emphasizes continued (near-term) US support for what the administration designates as "frontline" costs, comprising medications, other health supplies, and healthcare worker salaries, while phasing out spending on "non-frontline" costs related to technical assistance, program management, and other similar expenses.[20]

Overall, the Global Health Strategy presents a broadly reasonable blueprint for PEPFAR's evolution and eventual wind down, at least in some relatively wealthier partner countries. Still, the emerging approach articulated by the administration and Congress presents considerable short-term risks in the absence of adequate mitigation measures:

1. First, in most contexts, the strategy proposes an almost immediate transition of *service delivery* to national systems (from primarily parallel delivery by implementing partners). This is a reasonable (and perhaps overdue) step for some countries, and a medium-term goal for others. Yet many partner governments have limited capacity and experience in directly providing HIV prevention, testing, and treatment/care services. An abrupt and poorly planned transition risks significant disruption to the continuity of care for essential treatment and prevention services, which could in turn result in considerable backsliding on key public health outcomes. The strategy also implies that little to no technical assistance will be available to countries to support this transition, further exacerbating potential risks.

2. Second, the strategy proposes that financing should primarily be provided to partner governments *on-budget*, channeled directly through national budget systems. While this would be a welcome step for sustainability and country ownership, adequate safeguards and accountability mechanisms are required to ensure US financing is used for its intended purpose and sustains key health outcomes. Furthermore, in specific contexts, such as fragile settings and humanitarian emergencies, governments may be unable or face political disincentives to reach particular segments of the population. In such settings, services may be best delivered through non-governmental channels, including faith-based organizations. The continued viability of on-budget support will also hinge on the overall strength of the US bilateral relationship with the national government. A significant deterioration of that relationship, such as through a coup or a serious trade dispute, could lead to sudden and potentially life-threatening pauses in US global health assistance.

3. Third, the administration has so far emphasized HIV prevention programming for pregnant and breastfeeding women. Without dedicated attention, prevention efforts aimed at other vulnerable communities—who bear a disproportionate burden of HIV risk and often face high access barriers—may be disrupted or cease entirely.

4. Fourth, the strategy does not lay out a clear future for targeted PEPFAR programs, including the DREAMS initiative to reduce new HIV infections in vulnerable adolescent girls, support to orphans and vulnerable children, and community-based prevention and treatment programs—despite some evidence that these efforts offer relatively high value for money.[21]

5. Finally, the strategy's vision for government-led service delivery is probably realistic (though not without risk) for relatively more stable and wealthier partner governments—but it may not apply to (1) the poorest countries, where HIV services remain genuinely unaffordable and challenging to deliver within national health systems; or (2) fragile and conflict-affected states where governments may lack incentives, capacity, and access to deliver consistent and high-quality services.

In this brief, the latest in our *Tough Times, Tough Choices* series, we propose a constructive path forward for PEPFAR that aims to mitigate these risks while (1) aligning with the administration's key strategic goals; (2) gradually reducing PEPFAR's geographic and financial footprint; and 3) preserving PEPFAR's extraordinary legacy of success via American generosity in the poorest countries and most fragile contexts. Importantly, we emphasize that this analysis and approach apply exclusively to PEPFAR and should not be extrapolated to other program areas or forms of global health cooperation.

Specifically, we propose a three-track approach offering differentiated support across country categories:

- **Track 1: Graduation:** Offered to relatively wealthier and stable partner countries where rapid absorption of PEPFAR funding is fiscally feasible. Track 1 provides time-limited, on-budget, government-to-government support, *contingent upon* (1) keeping existing PEPFAR-supported patients (as of the FY2024 baseline) virally suppressed and alive; and 2) sustaining prevention of mother-to-child transmission (PMTCT) services. Following a one-year programmatic transition period during which service delivery would gradually shift to government systems, support would be phased out over the following two years, alongside progressively increasing domestic government spending. Countries would graduate by end-FY2028.
- **Track 2: Toward self-reliance:** Offered to stable but relatively poorer and higher-burden countries. Following a one-year programmatic transition period, countries in Track 2 would gradually assume increasing responsibility for funding their own health services over a longer time horizon, while sustaining key treatment and prevention outcomes. Countries with relatively lower dependence on PEPFAR financing (Track 2a) would graduate on a five-year timeline (by end-2031). For countries with relatively higher dependence on PEPFAR financing (Track 2b), we propose an extended transition timeline based on feasible increases in government health expenditure.
- **Track 3: Compassionate:** Offers sustained PEPFAR services in a relatively small number of the poorest countries and those experiencing fragility and conflict. PEPFAR would maintain current investments in Track 3 countries, with *partial* shifts of delivery to government systems where feasible.

The rest of this brief proceeds as follows. First, we outline key principles and parameters that define our proposed path forward. Second, we offer a roadmap to operationalize the three-track approach, assigning countries to their respective tracks, determining realistic timelines for the gradual phase-out of PEPFAR support, and designing accountability mechanisms that ensure countries sustain key services throughout this period. Third, we highlight caveats and outstanding risks. We conclude by reiterating the opportunity, urging the administration to fulfill the promise of its proposed vision with a prudent operational approach.

2. Key principles for PEPFAR's next chapter

We start from four key principles:

1. First, our proposal aims to meet the **administration's topline goals to reduce PEPFAR's spending and geographic footprint.** The Global Health Strategy suggests two relevant goals: 1) significantly reducing US spending in most countries, paired with increased government cofinancing; and 2) reducing the number of countries receiving PEPFAR funding to 35 or fewer by FY2030.[22] However, we also note a related practical constraint—limited human resources and contracting capacity within the State Department—which may favor fewer, larger investments.

2. Second, our proposal aims to achieve the **administration's strategic objectives and principles** for how PEPFAR, and global health aid more broadly, should be delivered in the future. Our review of the strategy and a recent draft House bill[23] points to the following objectives:

   - Delivery should be organized via *multi-year bilateral "Global Health Compacts"* that "move countries to self-sufficiency at an appropriate pace" and allow integration across disease areas and with country health systems.
   - Compacts should include explicit timelines for *increased domestic contributions* to the AIDS response, as well as programmatic benchmarks for key service delivery indicators.
   - At first, compacts should "continue to cover 100 percent of all *frontline costs* that the U.S. government is currently supporting in all countries."
   - PEPFAR should "[increase] utilization of *government-to-government (G2G) funding* for service delivery and technical assistance where appropriate," with more limited use of traditional implementing partners.

3. Third, we want to ensure **continuity of lifesaving services**. Most narrowly, this can be defined as HIV testing and the continuity of ART and PMTCT. By maintaining a broader range of evidence-based and cost-effective services, both the US and partner governments could see cost savings in the long run by containing the overall size of the HIV epidemic. Crucially, continuity of services is needed in the short term—for example, by executing a responsible, gradual, and well-planned transition from the status quo to the initiation of the Global Health Compact approach. Continuity of services is also necessary in the medium to long term—for example, by ensuring sufficient combined PEPFAR and partner government financing, alongside adequate incentives, monitoring, and accountability, for countries to sustain key services throughout the compact duration.

4. Finally, we aim to preserve the remarkable legacy of PEPFAR by **sustaining support for the world's poorest and most vulnerable communities**. Some countries, despite their best intentions, are still simply too poor to afford the HIV services their citizens need; others are struggling with ongoing conflict, instability, and fragility that prevent (or disincentivize) governments from delivering basic health services. Continued US support to these communities showcases the best of American generosity, and we should maintain our commitment to the health and welfare of people who would otherwise be unable to access lifesaving HIV services.

In the next section, we explore how to operationalize these principles into a coherent, streamlined vision for PEPFAR's next chapter.

3. Operationalizing a new strategic vision for PEPFAR's future

A note of caution

We begin with a major point of caution: the speed and scope of changes implied by the Global Health Strategy are unprecedented in the history of global health, creating significant inherent risks to service continuity and HIV disease control outcomes.

Transition from external assistance ("graduation") is not, in itself, without some successful precedent, and most global health financing mechanisms anticipate an eventual sunsetting of external support. Gavi, the Vaccine Alliance, for example, has an explicit Eligibility and Transition Policy[24] that governs the speed and scale of funding reductions, commensurate with increases in GDP per capita of partner countries. "Accelerated transition" occurs gradually over eight years (previously five) once a partner country meets Gavi's explicit income threshold, currently set at $1,820 per capita. To date, 19 countries have transitioned out of Gavi support for vaccination.[25] While COVID-19 complicates the analysis, research suggests that most have maintained or experienced minimal declines in vaccination coverage in the medium-term aftermath, albeit with significant heterogeneity.[26,27]

However, we acknowledge that the Gavi experience does not offer an apples-to-apples comparison. Gavi expenditure is far lower than PEPFAR spending, and therefore easier for national governments to absorb. As of 2017, almost all countries approaching the accelerated transition threshold received Gavi support equivalent to five percent or less of the countries' health budgets;[28] for PEPFAR, the equivalent figure can be as high as 54 percent even for middle-income partners.[29]

Perhaps most importantly, Gavi's support primarily finances vaccine procurement, with distribution led mainly by national governments and supported by other global partners, such as UNICEF. Therefore, Gavi transition does not require the dissolution of parallel systems and transition to government-led service delivery on *any* timescale, far less than the six months currently proposed by the administration.

Taken together, the administration's proposed rapid transition of PEPFAR programs—alongside other global health services—to country-led service delivery marks a significant shift. We caution that an overly rushed timeline may not allow for sufficient scrutiny of governments' capacity for service delivery and financing; the development of adequate financial, accountability, and operational safeguards; or structured and orderly patient handover.

The above analysis is not necessarily intended to discourage the administration's approach, but rather to proceed with due diligence, caution, and an operational strategy that mitigates risk while acknowledging its intrinsic existence.

Operationalizing principles and contingency measures

We consider operational principles to mitigate three distinct but interrelated sources of risk:

1. **Programmatic risk during transition to Global Health Compacts:** Countries must be prepared with human resources, supply chains, laboratory capacity, and data systems, among other key health system functions, to assume direct responsibility for service delivery. Some countries do not yet have adequate domestic capacity in these areas. Other countries can, in theory, deliver on these functions, but a sudden and unplanned transition risks creating chaos, confusion, and service delivery interruption. In countries with relatively high health system capacity—which we heuristically define as high-income and stable middle-income countries—responsible programmatic transition can likely be achieved through an explicit and structured one-year process. In countries with lower health system capacity—which we define as low-income countries and fragile/conflict-affected states—such a programmatic transition may not be realistic in whole or part, at least in the immediate term. In

such settings, we suggest either a partial shift toward government-led delivery (following a one-year transition period) or maintaining traditional PEPFAR service delivery through implementing partners, including faith-based organizations.

Additional programmatic risks could also arise from underprioritizing HIV prevention services, especially among vulnerable communities that are at high risk of developing new HIV infections. A broader approach to prevention will be critical to leverage the potential of breakthrough prevention drugs, such as lenacapavir (already the subject of a State Department rollout plan),[30] and ensure the incidence of new infections does not increase during the transition period.

2. **Financial risk for the poorest and highest-burden countries:** A rapid drawdown in PEPFAR funding could create insurmountable financing gaps for the HIV response in many of PEPFAR's partner countries. In the poorest countries, HIV services remain unaffordable without assistance. In Burundi, for example, the $58 annual cost of HIV treatment would be over 10 times the government's total per capita health expenditure.[31]

   Other countries, like Zimbabwe and Tanzania, are significantly wealthier but face an exceptionally high HIV burden. As a result, current PEPFAR expenditure still accounts for about half of available government health funding for *all* disease areas and health needs. In these contexts, PEPFAR funding cannot be readily absorbed into government budgets or quickly replaced through domestic revenue sources. While we anticipate country-led delivery will see significant cost savings compared to the current implementing partner-led model (Box 1), the fiscal challenge is nevertheless exacerbated by the relatively expensive cost structure of some PEPFAR programs and the tenuous fiscal positions of many partner countries, driven by overlapping factors such as aid cuts, debt distress, and related macroeconomic challenges.

   To address these risks, PEPFAR should tailor compacts to countries' fiscal capacity and epidemic burden—that is, in relation to the budgetary feasibility for countries to absorb PEPFAR spending in all or in part over the coming years. Relatively wealthier and lower-burden countries can likely transition on a faster timeline than those that are comparatively poorer and have higher burdens. PEPFAR must also recognize that the lowest-income countries, and those experiencing conflict and fragility, will be unable to domestically finance the HIV response in the near term. In these settings, PEPFAR should maintain baseline support levels.

3. **Accountability risk for service continuity and sustained programmatic outcomes:** The administration is right to push more funding and service delivery through national systems, but it must pair country ownership with robust accountability mechanisms to ensure partner countries fulfill their part of the bargain. In a worst-case scenario, funding provided through government-to-government arrangements could be broadly absorbed into countries' budgets without them in turn providing essential services—or with them providing services at an insufficient level of quality to sustain programmatic outcomes. Safeguards and accountability measures must be embedded into compact design to ensure that the HIV response is robustly maintained during the compact period, and to set countries up for long-term epidemiological and programmatic sustainability even after graduation. For example, an explicitly defined but tailored set of epidemic control benchmarks (e.g., viral suppression rates, progress toward the 95-95-95 goals, HIV incidence trends, etc.) should be incorporated into compact graduation criteria, alongside fiscal timelines, to protect against the risk of public health backsliding.

BOX 1. CAN WE EXPECT SIGNIFICANT SAVINGS FROM COUNTRY-LED SERVICE DELIVERY?

In the Global Health Strategy, the administration suggests that country-led service delivery will enable significant cost savings compared to current arrangements. The document notes that just 40 percent of PEPFAR spending goes to frontline costs (i.e., health worker salaries and commodity costs), with the remainder spent on technical assistance, program management, and other forms of overhead. The strategy further implies that most non-frontline costs are "inefficiencies," and it commits only to covering 100 percent of frontline costs, while "work[ing] to rapidly decrease this funding that is not focused on commodities or frontline healthcare workers."

Indeed, we anticipate some significant savings from a move to country-led service delivery. US-based implementing partners charge the US government Negotiated Indirect Cost Rate Agreements, which primarily cover headquarters-based overhead. While the rates are confidential and opaque, researchers have estimated they may account for five to 12 percent of overall PEPFAR spending.[a] US government program management costs have also typically comprised around four to nine percent of overall country-level costs,[b] and could likely be scaled down substantially with fewer grants and contracts to oversee.

Country-led service delivery may also have a lower cost footprint due to lower health worker salaries and facility costs. In Zambia, for example, the strategy reports that delivery through provincial governments led to overall savings of 44 percent per person living with HIV while also achieving superior programmatic outcomes. Finally, there may be opportunities to significantly reduce the overall footprint of non-service-delivery costs—for example, training, data collection, and technical assistance—which have historically accounted for 47 percent of PEPFAR's spending.[c]

The exact degree of savings that can be achieved from country-led service delivery is probably large, but difficult to precisely quantify. We anticipate that 40 percent overall savings—reflecting partial reductions in overhead, management costs, service delivery costs, and volume of non-service-delivery costs—offers a reasonable estimate.

a. Honermann, Brian, Alana Sharp, Jennifer Sherwood, et al. 2018. "Calculating Indirect Costs from International PEPFAR Implementing Partners." *PLoS ONE* 13 (10): e0206425. https://doi.org/10.1371/journal.pone.0206425.

b. From 2022 PEPFAR COPS: 6.9 percent in Haiti; 8.7 percent in Nigeria; 5 percent in South Africa; 4 percent in Zimbabwe. U.S. President's Emergency Plan for AIDS Relief. n.d. "Country and Regional Operational Plans." Accessed November 10, 2025. https://www.state.gov/country-and-regional-operational-plans/.

c. Razavi, Moaven, Collins Gaba, Jennifer Kates, and Allyala Nandakumar. 2025. "Which PEPFAR Investments Drive HIV Outcomes? Informing PEPFAR Transition and Scale-Down." Kaiser Family Foundation, September 17. https://www.kff.org/global-health-policy/which-pepfar-investments-drive-hiv-outcomes-informing-pepfar-transition-and-scale-down/.

Specifically, PEPFAR's government-to-government support should, in most cases,[32] be provided on a results-based basis, with funding contingent on sustaining key programmatic outcomes (treatment adherence, viral suppression, and PMTCT). PEPFAR should build explicit results-based mechanisms into the country compacts and engage academic or other third-party partners to independently verify that results have been achieved. An illustrative and simplified example of how this could work in practice is provided in Box 2.

BOX 2. APPLYING RESULTS-BASED FINANCING TO GLOBAL HEALTH COMPACTS – A SIMPLIFIED EXAMPLE

Country X is a lower-middle-income country with a relatively low HIV burden. In Country X, we assume for the sake of illustrative simplicity that PEPFAR only funds HIV treatment. Currently, it spends $1,000,000 per year to keep 10,000 people on treatment and virally suppressed, or $100 per person.

Country X would be placed on Track 1 (Graduation); see below for further details. In the first year (FY2026), PEPFAR would negotiate a results-based Compact with Country X. At the beginning of Year 2 (FY2027), government-to-government funding would begin. We assume that country-owned service delivery would offer 40 percent cost savings compared to traditional implementing partners, so total FY2027 payments should be $600,000, or $60 per person on treatment and virally suppressed. FY2028 would be a further 50 percent drawdown to $300,000, or $30 per person.

At the end of Year 2, an independent provider would verify the number of people still on treatment and virally suppressed. If Country X kept all 10,000 individuals on treatment and virally suppressed, it would receive the next payment ($300,000) in full. However, if services were interrupted, payments would be proportionately reduced. For example, if only 9,000 people were still on treatment and virally suppressed, Country X would owe $60,000 back to the US from the FY2027 payment, and $30,000 would be deducted from the amount owed for FY2028, accordingly. In total, the FY2028 payment would be $300,000 minus $90,000, or $210,000.

This structure has several advantages. First, it provides a clear financial incentive for countries to sustain HIV services; they will only continue to receive US government support if they do so. Second, it provides visibility and accountability for achieving programmatic results, contributing to bilateral accountability between Country X and the US government, as well as democratic accountability between Country X and the citizens it serves. Third, it provides an incentive for countries to reduce delivery costs while maintaining high-quality services. Countries are paid the same amount per result regardless of input costs, pushing them to find efficiencies without sacrificing outcomes—and helping make services more affordable to countries as PEPFAR support winds down.

A differentiated three-track approach for diverse country contexts

We propose a differentiated three-track approach that aligns with the administration's vision for country ownership and financial drawdown, all while mitigating risk to protect health outcomes and preserve PEPFAR's legacy (see Table 1). We tailor PEPFAR's approach in different countries based on two high-level criteria: (1) their ability to deliver PEPFAR services through national health systems, reflected broadly by income level and fragility/conflict status; and (2) their ability to finance PEPFAR services using domestic funds, reflected by income level and the size of PEPFAR spending relative to overall government health expenditure.

These tracks should be understood as a general framework for the path forward—but in practice, the administration should carefully tailor timelines and delivery modalities to the specific needs and contexts of individual countries in the context of compact negotiations.[33]

TABLE 1 Overview of proposed three-track approach

TRACK	# OF COUNTRIES	PEPFAR PLANNED ALLOCATION (FY2024)	CRITERIA	APPROACH
1	27	$795,541,703	• HICs and UMICs • Non-FCAS LMICs where PEPFAR spending is <5% of current government health expenditure[a]	• FY2026: Preparing programmatic transition • FY2027: Full programmatic transition • Two-year financial drawdown starting in FY2027 • End FY2028: Graduation
2a	7	$1,067,042,000	• Remaining stable LMICs where expected post-transition PEPFAR spending is <10% of current government health expenditure[b]	• FY2026: Preparing programmatic transition • FY2027: Full programmatic transition • Five-year financial drawdown • End FY2031: Graduation
2b	6	$1,262,215,200	• Remaining stable LMICs where expected post-transition spending PEPFAR is >10% of current government health expenditure	• FY2026: Preparing programmatic transition (100%) • FY2027: Full programmatic transition • Gradual drawdowns premised on two percent annual increases in per capita government health expenditure • End FY2034-2041: Graduation
3a	6	$656,615,050	• Stable LICs	• FY2026: Preparing partial programmatic transition • FY2027: Partial transition to on-budget financing associated with some cost savings; otherwise maintain spending levels with regular review and reevaluation
3b	9	$796,594,750	• Fragile/conflict-affected LICs • Special cases (by default, might be reconsidered): Ukraine, Haiti, Venezuela	• Sustain current spending levels and programmatic approach with regular review and reevaluation
TOTAL	55	$4.6 billion		

a. We assume that post-transition costs will be 40 percent lower than traditional PEPFAR implementing arrangements (see Box 1).
b. We assume that post-transition costs will be 40 percent lower than traditional PEPFAR implementing arrangements (see Box 1).

BOX 3. SUMMARY OF KEY DESIGN FEATURES AND PARAMETERS

- Minimum one-year programmatic transition period in all countries (FY2026)
- Service delivery through national systems wherever possible, starting in FY2027, financed through government-to-government on-budget support
- Expectation that delivery through national systems will see 40 percent cost savings compared to status quo implementing partner arrangements
- Results-based financing within health compacts; continued US government-to-government support is contingent on sustaining key programmatic outcomes (e.g., treatment and viral suppression, PMTCT)
- Progressive and predictable drawdown of US government PEPFAR support in stable middle-income countries; graduation within two to five years after programmatic transition for most countries in this category, with extended transition timelines in countries where PEPFAR dependence is highest
- Sustained traditional PEPFAR service delivery (through implementing partners, including faith-based organizations) in the poorest countries and fragile/conflict-affected states, with annual review and reevaluation
- No planned funding reductions in the poorest and most severely fragile/conflict-affected states, with annual review and reevalation.

Track 1: Graduation

The *Graduation* track would be offered to 27 relatively wealthy and stable countries (see Table 2). This includes most upper-middle-income and high-income countries, as well as select stable lower-middle-income countries where PEPFAR investments account for less than 2.5 percent of total government health spending. Broadly, these countries have both the fiscal and institutional capacity to absorb PEPFAR financing and service delivery into national systems within a relatively short timeframe.

Planning for programmatic transition would take place in FY2026 (the current fiscal year). At the beginning of FY2027, PEPFAR investments would move *on-budget*. At this point, all service delivery would occur within national health systems, with government-to-government funding under the auspices of a Global Health Compact. There will necessarily be variability in the degree to which countries can complete this transition, which, as noted above, carries several programmatic risks. Therefore, a formal pre-transition needs assessment should be conducted in all Track 1 countries during FY2026 to map core vs. non-core activities and help identify context-specific capacity gaps that transition funding should address.

In FY2027, the US government would fully fund existing PEPFAR services through a results-based funding approach. As discussed above, we estimate that this would represent a 40 percent cost savings compared to status quo implementation arrangements. As of start-FY2029, Track 1 countries would fully graduate from PEPFAR support.

TABLE 2 Track 1 (Graduation) countries

COUNTRY	WORLD BANK INCOME GROUP (FY2026)	WORLD BANK FCAS* CLASSIFICATION (FY2026)	PEPFAR PLANNED ALLOCATION (FY2024)	PEPFAR EXPENDITURE (2022) AS % OF GGHE-D** (2022)	NUMBER OF ADULTS AND CHILDREN RECEIVING ART THROUGH PEPFAR SUPPORT (2024)
Angola	LMIC	Non-FCAS	$23,556,000	0.57%	19,816
Botswana	UMIC	Non-FCAS	$57,337,895	4.71%	194,536
Brazil	UMIC	Non-FCAS	$3,500,000	0.00%	28,901
Cambodia	LMIC	Non-FCAS	$650,300	1.18%	N/A
Colombia	UMIC	Non-FCAS	$2,970,670	0.02%	4,331
Dominican Republic	UMIC	Non-FCAS	$25,000,000	0.70%	44,860
El Salvador	UMIC	Non-FCAS	$10,575,763	0.52%	15,551
Ghana	LMIC	Non-FCAS	$12,860,000	0.75%	21,290
Guatemala	UMIC	Non-FCAS	$17,464,405	0.54%	19,394
Honduras	LMIC	Non-FCAS	$8,684,212	0.70%	12,229
India	LMIC	Non-FCAS	$24,360,000	0.04%	435,344
Indonesia	UMIC	Non-FCAS	$10,815,000	0.06%	47,782
Jamaica	UMIC	Non-FCAS	$15,678,512	1.30%	12,175
Kazakhstan	UMIC	Non-FCAS	$3,410,000	0.05%	5,636
Kyrgyzstan	LMIC	Non-FCAS	$4,345,000	1.15%	4,965
Laos	LMIC	Non-FCAS	$2,245,000	1.55%	10,291
Nepal	LMIC	Non-FCAS	$10,225,000	0.65%	22,536
Nicaragua	LMIC	Non-FCAS	$2,208,576	0.24%	5,520
Panama	HIC	Non-FCAS	$12,521,600	0.31%	18,289
Peru	UMIC	Non-FCAS	$1,429,330	0.02%	2,219
Philippines	LMIC	Non-FCAS	$13,170,000	0.08%	49,930
Senegal	LMIC	Non-FCAS	$7,149,000	2.42%	13,132
South Africa	UMIC	Non-FCAS	$453,638,372	1.73%	5,335,997
Tajikistan	LMIC	Non-FCAS	$3,900,000	1.88%	6,995
Thailand	UMIC	Non-FCAS	$12,830,000	0.05%	53,329
Trinidad and Tobago	HIC	Non-FCAS	$2,207,068	0.17%	6,168
Vietnam	LMIC	Non-FCAS	$37,900,000	0.37%	95,139

Notes:
*Fragile and Conflict-Affected Situations (FCAS)
**Domestic general government health expenditure (GGHE-D)

Track 2: Toward self-reliance

This track would be offered to 13 mostly stable lower-middle-income countries that remain moderately to highly dependent on PEPFAR financing, but which have demonstrated potential to assume greater responsibility for both financing and service delivery (see Table 3).

As in Track 1, countries in Track 2 would have a one-year programmatic transition period accompanied by a pre-transition needs assessment (FY2026). This would be followed by a shift to *on-budget* government-to-government financing through Global Health Compacts. However, these countries would see a slower drawdown in PEPFAR financing compared to Track 1, reflecting the higher fiscal burden of HIV services relative to government health expenditure.

We further divide Track 2 by degree of dependence on PEPFAR financing. In countries where PEPFAR financing currently accounts for 15 percent or less of government health spending (Track 2a), support would gradually phase out over five years, with graduation at end-FY2031. Assuming 40 percent savings from government-led service delivery, this would require countries in this band to increase health expenditure by a maximum of two percent per capita per year to cover the additional fiscal liability. In most countries, doing so would be roughly in line with recent per capita GDP growth rates.

TABLE 3 Track 2 (Toward self-reliance) countries

COUNTRY	WORLD BANK INCOME GROUP (FY2026)	WORLD BANK FCAS CLASSIFICATION (FY2026)	PEPFAR PLANNED ALLOCATION (FY2024)	PEPFAR EXPENDITURE (2022) AS % OF GGHE-D (2022)	NUMBER OF ADULTS AND CHILDREN RECEIVING ART THROUGH PEPFAR SUPPORT (2024)
Track 2a: Five-year drawdown					
Benin	LMIC	Non-FCAS	$6,100,000	6.56%	23,549
Cote d'Ivoire	LMIC	Non-FCAS	$115,273,000	10.12%	260,618
Ethiopia	LMIC	FCAS	$111,850,000	11.19%	513,856
Kenya	LMIC	Non-FCAS	$346,250,000	12.99%	1,336,300
Namibia	LMIC	FCAS	$86,440,500	14.77%	216,947
Nigeria	LMIC	Non-FCAS	$396,033,500	11.87%	1,537,786
Papua New Guinea	LMIC	FCAS	$5,095,000	0.68%	8,283
Track 2b: Extended drawdown					
Cameroon	LMIC	FCAS	$90,903,000	26.24%	404,975
Eswatini	LMIC	Non-FCAS	$70,415,200	41.25%	213,159
Lesotho	LMIC	Non-FCAS	$73,500,000	43.87%	243,264
Tanzania	LMIC	Non-FCAS	$430,975,000	47.20%	1,515,977
Zambia	LMIC	Non-FCAS	$390,522,000	44.47%	1,254,010
Zimbabwe	LMIC	FCAS	$205,900,000	53.67%	1,214,535

In countries with relatively higher dependence on PEPFAR financing (Track 2b), the timeline would be extended. We propose a transition timeline aligned with realistic increases in government expenditure, whereby Track 2b countries increase domestic per capita health spending by two percent per year. Under this scenario, initial analysis suggests that Cameroon could graduate by FY2034; Eswatini, Lesotho, and Zambia in FY2038; Tanzania in FY2039; and Zimbabwe in FY2041. We urge the administration to regularly review and recalibrate timelines in these countries in line with observed growth, government resource mobilization capacity, and commitment over the next decade.

Track 3: Compassionate

The *Compassionate* track would be offered to the 15 poorest and most vulnerable countries—those classified as "low-income." It would also encompass some countries affected by severe conflict and fragility, where national systems are not yet able to sustain financing or HIV service delivery without external support (see Table 4). In these contexts, PEPFAR would continue to deliver at least some essential prevention, care, and treatment services through its traditional model—primarily using non-governmental partners, including faith-based organizations.

TABLE 4 Track 3 (Compassionate) countries

COUNTRY	WORLD BANK INCOME GROUP (FY2026)	WORLD BANK FCAS CLASSIFICATION (FY2026)	PEPFAR PLANNED ALLOCATION (FY2024)	PEPFAR EXPENDITURE (2022) AS % OF GGHE-D (2022)	NUMBER OF ADULTS AND CHILDREN RECEIVING ART THROUGH PEPFAR SUPPORT (2024)
Track 3a: Partial programmatic transition					
Liberia	LIC	Non-FCAS	$9,250,000	15.51%	20,544
Malawi	LIC	Non-FCAS	$179,620,000	147.35%	936,493
Rwanda	LIC	Non-FCAS	$63,725,050	16.46%	130,238
Sierra Leone	LIC	Non-FCAS	$7,850,000	12.58%	24,072
Togo	LIC	Non-FCAS	$10,980,000	20.04%	49,130
Uganda	LIC	Non-FCAS	$385,190,000	69.81%	1,416,800
Track 3b: Traditional PEPFAR approach					
Burkina Faso	LIC	FCAS	$9,950,000	1.65%	46,398
Burundi	LIC	FCAS	$26,125,000	38.58%	65,699
Democratic Republic of the Congo	LIC	FCAS	$117,644,750	24.09%	173,275
Haiti*	LMIC	FCAS	$112,020,000	161.06%	138,770
Mali	LIC	FCAS	$9,360,000	3.30%	30,872
Mozambique	LIC	FCAS	$416,875,000	76.51%	1,944,761
South Sudan	LIC	FCAS	$41,520,000	83.54%	60,381
Ukraine*	UMIC	FCAS	$59,500,000	n/a	118,529
Venezuela*	UMIC	FCAS	$3,600,000	0.13%	n/a

Notes:*Non-LICs with fragility and/or conflict

We further sub-categorize Track 3 as follows:

- **Track 3a:** Low-income countries (LICs) categorized as non-fragile and non-conflict-affected. In these countries, partial programmatic transitions would be initiated beginning in FY2026, with only a share of financing moving on-budget through Global Health Compacts, based on a thorough country-by-country feasibility analysis.
- **Track 3b:** Fragile and conflict-affected countries—primarily LICs but also some non-LICs as special cases (e.g., Haiti, Ukraine, and Venezuela). PEPFAR's current programmatic approach and financing levels would be maintained, with the primary goal of ensuring uninterrupted delivery of lifesaving services and protecting the most vulnerable and marginalized communities.

Partial transition to government implementation could result in modest annual cost savings starting in FY2027. Otherwise, current funding levels should be maintained indefinitely, subject to regular review of whether improved government programmatic and fiscal capacity allows for additional programmatic and financial transition.

Our proposal allows for a pragmatic and feasible drawdown in PEPFAR's funding as countries gradually take on additional co-financing responsibilities. It would also significantly reduce PEPFAR's geographical footprint, in line with the administration's stated goal. By end-FY2028, only 28 countries would receive PEPFAR funding, shrinking further to 22 countries in FY2032.

4. Outstanding risks and unresolved questions

Even with careful operationalization of our proposed approach, a compact-based transition will face risks and challenges. Several unresolved questions also require further consideration. We discuss a *non-exhaustive* list below.

- **Technical assistance:** The Global Health Strategy suggests a limited future role and minimal scope of US technical assistance within the Global Health Compact model. The administration should carefully assess technical assistance needs to support country capacity during the transition period and incorporate these into its planning process, including suitable technical assistance providers and sources of financing.[34]
- **Accountability and oversight:** Moving toward national delivery models may lessen the US government's direct access to detailed expenditure and performance data, which has traditionally played a key role in PEPFAR oversight by the Department of State and Congress. The main question, therefore, is how to keep credible oversight without creating excessive administrative workload and reporting overlaps—and how responsibilities should evolve as transition timelines progress. Compact design should set clear expectations for country-level reporting, using and strengthening existing national data systems where possible, while ensuring that US agencies retain sufficient capacity for independent verification.
- **Protecting the most vulnerable:** A sudden or poorly planned transition could disproportionately affect key and vulnerable populations, for example, through the disruption or discontinuation of targeted prevention and outreach programs, which are often implemented through local civil society and community-based service providers. A successful compact model should explicitly safeguard services for all communities. As needed, PEPFAR could set aside a small portion of resources to support continued service provision via non-governmental actors, including faith-based organizations. Alternatively, it could include service continuity for these communities as a results-based metric under the compacts.
- **Role of other US government agencies and the Global Fund:** Successful design and implementation of this approach will require effective coordination and division of responsibilities—both within the US government and with other bilateral and multilateral donors and partners (as acknowledged by the Global Health Strategy).

- **Links to broader health system functions:** Abrupt reductions in PEPFAR spending could potentially have adverse ripple effects across the health system, for example, by destabilizing shared health system resources such as laboratory infrastructure, supply chains, community health worker platforms, and data systems. PEPFAR spending reductions should be considered within the context of the broader health system, including a thorough ex-ante assessment of health system dependencies.

- **Compact negotiation structure and process:** To a significant extent, the success of the Global Health Compact model will hinge on the content and approach defined within the compacts themselves. While there are substantial advantages to relatively fast compact development—including earlier clarity for partner countries and longer transition timelines—speed should not be achieved at the cost of due diligence or thoroughness. Compact negotiations should be informed by thorough assessments of country readiness and capacity, and solicit and incorporate input from partner governments, as well as civil society and patient advocacy groups. They should also include sufficient development and review time to ensure the technical soundness of the approach and realistic transition planning.

5. Conclusion

In this brief, we offer a blueprint for a responsible PEPFAR transition, demonstrating that the United States can protect PEPFAR's legacy while also reducing its future financial and geographic footprint. Our proposed path forward offers a realistic and fair deal for all parties: the US draws down its engagement without abruptly abandoning partner countries and communities; partner countries are asked to pay and do more, commensurate with their ability to do so; and governments are empowered to deliver on behalf of their citizens. A results-based financing approach holds all parties accountable for sustaining key services and programmatic outcomes throughout the transition period.

We urge Congress and the administration to dedicate the necessary fiscal, technical, and human resources for the successful implementation of this blueprint—and to deliver on the promise of the Global Health Strategy.

Annex: Data notes and sources

INDICATOR	NOTES	SOURCE
PEPFAR planned allocation (FY2024)	Proposed PEPFAR Country/ Regional Operational Plans (COPs/ ROPs) indicate FY2024 spending, disaggregated by country	U.S. President's Emergency Plan for AIDS Relief. n.d. "Country and Regional Operational Plans." Accessed November 10, 2025. https://www.state.gov/country-and-regional-operational-plans/.
World Bank income group classifications (FY2026)		The World Bank. n.d. "World Bank Country and Lending Groups." Accessed November 12, 2025. https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.
PEPFAR expenditure (2022) as percentage of domestic general government health expenditure (GGHE-D) (2022)	PEPFAR enacted allocation for FY2022 as a percentage of total domestic government health spending in 2022, disaggregated by country	U.S. Department of State. n.d. "FY 2022 Congressional Budget Justiciation Supplementary Tables - Foreign Operations." Accessed November 12, 2025. https://www.state.gov/fy-2022-international-affairs-budget/. World Health Organization. 2025. "Global Health Expenditure Database." November. https://apps.who.int/nha/database.
Number of adults and children currently receiving antiretroviral therapy (ART) through PEPFAR support (2024)		President's Emergency Plan for AIDS Relief (PEPFAR). n.d. "PEPFAR Panorama Spotlight." Accessed November 12, 2025. https://data.pepfar.gov/datasets#MDD.
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22 According to the strategy, the administration expects that a "majority of 71 U.S.-supported countries will transition to full self-reliance during the term of the [Global Health Compact]." We interpret this to mean that there should be no more than 35 countries receiving PEPFAR funds by FY2030, the conclusion of five-year compacts.

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33 We specifically note Angola, Papua New Guinea, Ukraine, and Venezuela as special cases that require individualized attention.

34 The strategy estimates that together "non-frontline" costs including technical assistance as well as program management and overhead costs comprise 60 percent of current PEPFAR spending. Specifically, we suggest that a pre-transition needs assessment in FY2026, as recommended earlier, could help inform more targeted technical assistance needs throughout the transition period.

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