Changes to PEPFAR Under the Trump Administration and the Experiences of LGBTQI+ Populations Within Impacted Countries

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Section 1: An Introduction to The U.S. President's Emergency Plan for AIDS Relief (PEPFAR)

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the largest commitment by any nation to address a single disease in history, with the United States investing over $100 billion in global HIV/AIDS prevention, treatment, and care since 2003 (State.gov). First announced by George W. Bush at his 2003 State of the Union, the program immediately gained overwhelmingly bipartisan support, particularly with Christian conservatives (Britannica). This religious endorsement was due to the fact that, at its inception, the program was accepted as a pro-life endeavor carried out largely by faith-based organizations encouraging the "ABCs": "Abstinence," "Be Faithful," and "Condoms" (NIH). Later that year, the FY2004 - FY2008 PEPFAR funding bill, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, passed with a 345-41 majority in the House of Representatives. This bill authorized $15 billion for funding with the requisite that one-third of funds must be used for reinforcing the "ABC" framework, especially as it relates to abstinence.

Initially, President Bush appointed former pharmaceutical executive Randall Tobias to lead PEPFAR from the White House (White House Archives), but the program was later transferred to the State Department. This change was intended to promote HIV oversight across agencies, and indeed, a broad range of agencies, including USAID, HHS, CDC, and NIH, have historically held parts of PEPFAR's implementation (State OIG).

Over time, there have been three separate reauthorizations of PEPFAR. In each reauthorization, rules have been added and removed. In 2008, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, otherwise known as the "Lantos-Hyde Act," authorized $48 billion in funding for the period of FY 2009 - FY 2013. The updated text removed the one-third abstinence stipulation and replaced it with a vaguer clause requiring certain "balanced funding" for prevention. In execution, this provision required the President's Administration to submit a report to

Congress if less than half of prevention funds were spent on "abstinence, monogamy, faithfulness, the correct and consistent use of male and female condoms, reductions in concurrent sexual partners, and delay of sexual debut, and of intended monitoring and evaluation approaches to measure the effectiveness of prevention programs and ensure that they are targeted to appropriate audiences" (Congress.gov). Reauthorizations in 2013 and 2018 did not set specific funding levels, leaving appropriations to be determined through the annual budget process (KFF).

Following its implementation and reauthorizations, PEPFAR was widely lauded as a huge success by public health advocates, especially in sub-Saharan Africa (CFR). The action plan oversaw a diverse range of procedures and programs, including the distribution of pre-exposure prophylaxis (PrEP), HIV testing, HIV treatment clinics, support for orphans and vulnerable children, violence prevention, and support for women and girls in secondary schooling (HIV.gov). As of September 2023, over 25 million lives were saved, 5.5 million babies were born HIV-free, 20.47 million men, women, and children were on antiviral medication, 71.1 million people received HIV testing services, and HIV diagnoses among adolescent girls and young women declined in all geographic areas (State.gov). In Uganda, 1.3 million people living with HIV were receiving PEPFAR-supported antiviral treatment (ART) (CDC); in Nigeria, more than 8.2 million people had received HIV counseling and testing services (U.S. Embassy in Nigeria).

When President Joe Biden assumed office in 2021, he reaffirmed prior commitments to ending the global HIV epidemic, including support for UNAIDS' goal of ending AIDS by 2030 (UNAIDS). In 2022, President Biden was the first sitting president to publicly announce PEPFAR's support for the LGBTQI+ population, unveiling his Country Operational Plan 2022, which would aim to expand local access to care for LGBTQI+ people living with HIV while also working to reduce stigma and discrimination. $3.78 million was earmarked for a co-funded partnership with the UN Development Programme to further the implementation of the Global AIDS Strategy and counteract discriminatory laws that impeded key marginalized populations' access to HIV services (State.gov).

In 2023, halfway through President Biden's presidency, PEPFAR was in another round of consideration for five-year reauthorization. In response, the conservative thinktank, the Heritage Foundation published the report "Reassessing America's $30 Billion Global AIDS Relief Program" (Heritage Foundation), where the authors argued that the relevance of the program was largely obsolete. Moreover, the report questioned President Biden's motivations for continuing the program, accusing him of abandoning the conservative

"ABC" framework in favor of an LGBTQI+ and abortion-driven agenda. This report reflected a growing, albeit unsubstantiated, view among some right-wing politicians that the Biden-Harris administration was using PEPFAR to discreetly support global abortion efforts.

House Republicans stated they would not support the funding package without clearer guardrails to separate HIV treatment from abortion funding (The Guardian). Democratic lawmakers pointed to the already stringent legal framework that directed PEPFAR's reproductive health guidelines. The Helms Amendment, the Leahy Amendment, and the Siljander Amendment all forbade U.S. global health funding from promoting abortion, and indeed, there was no evidence of the matter happening. In June 2023, Ambassador John Nkengasong, the head of PEPFAR, publicly stated that PEPFAR does not provide a platform for abortion in Africa and that it is "implemented strictly within the context of the laws it was created [by]." Additionally, the PEPFAR program revised its earlier September 2022 document, Reimagining PEPFAR's Strategic Direction, to clarify that "sexual and reproductive health services" has a specific meaning in the PEPFAR context and reiterated that "PEPFAR does not fund abortions, consistent with longstanding legal restrictions on the use of foreign assistance funding related to abortion" (KFF). Despite this, in October 2023, PEPFAR did not receive the full five-year authorization, but instead a one-year extension in anticipation of a Republican administration making conservative adjustments to the language in 2025.

In January 2025, President Donald Trump assumed office and immediately implemented a stop-work order on PEPFAR, claiming an urgent need to examine the program for signs of "waste, fraud, and abuse." Since this stop-work order also halted payments, many implementers had to lay off thousands of staff. On February 1, 2025, PEPFAR received a limited waiver to continue activities under a narrower and more restrictive set of permitted services: HIV treatment and care, prevention of mother-to-child transmission, PrEP for pregnant and breastfeeding women, and HIV testing. Beyond the specific populations listed in the waiver, no one else was allowed to access PrEP; programming for orphans and vulnerable children ceased under this directive.

In March 2025, the Trump Administration publicized its plans to dissolve USAID, which had previously acted as PEPFAR's principal implementing agency, and required PEPFAR to restructure its implementation within the State Department. This upheaval put significant strain on PEPFAR staff, which was only compounded by simultaneous reductions underway at the CDC, the program's second-largest implementing agency (KFF).

All of these actions culminated in the September 2025 release of the "America First Global Health Strategy," a 40-page document published by the State Department that outlined the Trump Administration's aim to

create bilateral health cooperation agreements with countries that benefit from U.S. Global Health Assistance. Secretary Rubio outlined memorandums of understanding (MOUs) that supported the goal of "helping countries move toward more resilient and durable health systems" (America First Global Health Strategy). The America First Global Health Strategy has three main points, which are:

Negotiate bilateral agreements with countries receiving PEPFAR assistance. Agreements will aim to transition most countries to full self-reliance by the end of the agreement period.

Provide 100% of current levels of PEPFAR funding for commodities and for frontline healthcare workers through FY 2026 and reduced funding thereafter.

Rapidly reduce funding for PEPFAR activities other than health commodities and frontline health personnel (i.e., prevention measures).

Aiming to achieve fully independent health program administration within countries whose programs were previously U.S.-administered, the future of PEPFAR is being placed in the hands of recipient countries, currently fifty-six nations (State.gov). However, it remains unclear how implementation will proceed in the term following this announcement, with PEPFAR funds depleting and many countries refusing aid. Multiple countries, including Zimbabwe and Zambia, have refused to sign MOUs with the United States, claiming that the U.S. is using the program to leverage access to rare minerals in exchange for healthcare (Science.org). Though the future of PEPFAR remains to be seen, one thing is certain: the program as it once was, is now over. Now, the focus should be on ensuring that existing funds are being properly administered to the people that need them.

Section 2: The Impacts of the America First Global Health Strategy on Countries with Anti-Homosexuality Laws

Following the America First Global Health Strategy's announcement that recipient countries - not the United States - would administer PEPFAR, advocates and public health officials immediately questioned whether key populations would continue receiving treatment. This is an especially pressing question in countries with codified anti- LGBTQI+ discrimination.

Thirty-four African countries have some form of anti-homosexuality law, and nineteen of those countries receive PEPFAR assistance: Burkina Faso, Burundi, Cameroon, Eswatini, Ethiopia, Kenya, Liberia, Malawi, Mali, Namibia, Nigeria, Senegal, Sierra Leone, South Sudan, Tanzania, Togo, Uganda, Zambia, and Zimbabwe (The Week). Given the oppressive threat to life and livelihood for LGBTQI+ people in these countries, many LGBTQI+ people choose to conceal their HIV status, increasing transmission rates among others and worsening their own symptoms.

Extreme examples of anti-homosexuality laws include Uganda's Anti-Homosexuality Act, which was introduced in 2009 and 2013 and ultimately signed into law in 2023. The latest iteration is one of the most severe anti- LGBTQI+ laws in the world, notoriously including the death penalty for "aggravated homosexuality" (Death Penalty Information Center). In Nigeria, same-sex sexual activity and transgender self-expression are criminalized under the Same Sex Marriage (Prohibition) Act of 2013. Penalties for violating this law range from fines to imprisonment, and even capital punishment, for vaguely defined acts such as "carnal knowledge against the order of nature" and "gross indecency" (Human Dignity Trust).

Both laws listed include provisions against "aiding" same-sex relations. This is a broad term that is common in anti-homosexuality laws. In practice, the provision is used liberally to target healthcare providers that serve the LGBTQI+ community. Among clinics, there is a growing fear that providing access to PrEP, ART, or contraceptives could be interpreted as facilitating same-sex conduct, regardless of the actual or perceived gender or sexuality of the patient. When threatened with the possibility of closure, clinics are forced to turn patients away.

This issue is aggravated by the structure of the America First Strategy. The Strategy overemphasizes the role of faith-based institutions in HIV treatment, arguing that "faith-based programs have been successful because faith leaders are highly trusted by the community… [and] go to where people already are, including into rural areas" (America First Global Health Strategy). Strictly in terms of reach, this may be true, but the strategy does not address how these programs operate in countries where LGBTQI+ people are heavily stigmatized by the church, especially in rural areas (The Experiences and Perceptions of the Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual (LGBTQIA) Individuals Lived in Rural Areas within South Africa).

There is a growing level of evidence that these concerns are coming to fruition. Context News reported that "the funding disruptions have intensified stigma, discrimination, and violence against vulnerable groups,

particularly LGBTQI+ people" (Context News). Some individuals directly linked this rise to the Trump Administration's rhetoric, most notably EO 14168. This executive order defines gender in terms of a sex binary, a stance that has legitimized discrimination against transgender people beyond the borders of the United States.

A transgender woman in Tanzania described being verbally and physically attacked when she went to a clinic for HIV care and explained that in her day-to-day life "people speak badly to us" (Physicians for Human Rights). In Senegal, a recent anti- LGBTQI+ crackdown has led to arrests and increased penalties. People living with, or at risk of, HIV are actively avoiding treatment centers out of fear. One queer Senegalese community health worker explained, "I don't dare leave the house anymore… I double-lock all the doors and windows just to avoid being found… people will be afraid to show or keep their medication. Some won't even want to continue their treatment for fear of being seen or associated with it." Other members of the LGBTQI+ Senegalese community described how being perceived as queer has prevented access to care, stating that, "As soon as I go to a hospital to pick up my medication, I'll be labeled a homosexual." Another individual explained the constant threat surrounding basic access to services, stating, "I expect to be arrested at any moment… simply because I'm gay" (Reuters).

In this hostile environment, accessing HIV care becomes life-threatening. This is especially concerning given who is most affected by HIV. In sub-Saharan Africa, gay and bisexual men, including cisgender men who have sex with men, face HIV incidence rates far higher than other populations. Transgender women face even greater disparities. A large meta-analysis across 31 African countries found HIV prevalence among cisgender men who have sex with men (MSM) ranging from 0.14% to 55.7%, while prevalence among transgender women faced even higher rates, up to 71.6% (NIH). The populations most deprived of HIV care are the very populations that need more consistent access to testing, PrEP, and treatment.

Despite the dangers unfolding for the LGBTQ African community, there is very little data available on how the America First Strategy is being implemented across countries. In February 2026, the Council for Global Equality and Physicians for Human Rights filed a Freedom of Information Act (FOIA) lawsuit against the State Department for information on PEPFAR implementation, describing the situation as a "data blackout" (Washington Blade). Without numerical figures, legislators and the American public alike are forced to rely on news outlets for updates on the state of PEPFAR, when news outlets are operating on very little information themselves.

Section 3: Federal Interventions

As the impacts of the America First Global Health Strategy continue to be felt, two things are becoming increasingly clear: First, access to HIV care for LGBTQI+ individuals is being restricted and weaponized in countries with anti-homosexuality laws. Second, there is not enough transparency from the State Department to understand the full extent of the current harm.

Acknowledgment & Messaging

The United States Congress needs to take swift action to protect the lives of LGBTQI+ Africans. The first step is immediate acknowledgment from Congress and the Executive Branch that the barriers to HIV care for LGBTQI+ African populations exist and are unacceptable. Currently, discussion of the impacts of the America First Global Health Strategy and restrictions on PEPFAR has largely remained within LGBTQI+ advocacy spaces and left-aligned congressional offices. This limits the reach of the issue and allows it to be framed as a partisan LGBTQI+ issue, when instead, it should be framed as both a human rights and a public health issue. Targeting the LGBTQI+ community undermines the entire mission of PEPFAR that has historically been a bipartisan agreement.

Even the most right-aligned Congressmen acknowledge that epidemics do not respect borders. Eliminating disease abroad eliminates disease within the United States; and beginning with populations disproportionately impacted by HIV is both the most effective and most humane place to start. Given the marginalized status of those most impacted, it is equally important to emphasize the human rights indignity at play, which can be acknowledged on both sides of the political spectrum. Famously, Republican Senator Ted Cruz stated, “Any law criminalizing homosexuality or imposing the death penalty for ‘aggravated homosexuality’ is grotesque & an abomination . . . ALL civilized nations should join together in condemning this human rights abuse” (USA Today).

Intertwined in these messages should be an explicit rejection of the notion that prevention tools such as condoms and PrEP promote same-sex behavior. They are standard, evidence-based HIV prevention tools, and removing or limiting them only makes the epidemic harder to subdue.

Oversight

There is currently very little publicly available information on the implementation of the America First Global Health Strategy, including the text of the MOUs between recipient countries and the United States. These MOUs have largely been withheld from legislators and the public alike, limiting Congress's ability to exercise meaningful oversight. As such, the second recommendation must be strong and unyielding congressional demands for transparency regarding the MOUs currently being implemented.

In addition, Congress should require regular reporting from the State Department on how PEPFAR funds are being used and whether key populations are able to access services, especially in countries with anti-homosexuality laws. Oversight should also examine how the Strategy's reliance on faith-based organizations is playing out in practice. Congress needs to know whether churches receiving funds are providing care to all populations or whether certain groups are being excluded. Without proper supervision, there is risk of a chilling effect; if providers believe they could lose funding or face legal consequences for serving LGBTQI+ patients because the MOUs are so ambiguously defined, it is likely that services would be restricted beyond what is required. This is especially true in the context of the "global gag rule," formally known as the Mexico City Policy, which restricts U.S. global health funding to foreign NGOs that provide or promote abortion-related services. The policy has also been expanded under the Trump Administration to encompass broader restrictions tied to "gender ideology" and LGBTQI-related programming (Williams Institute). Oversight is therefore a necessary aspect of Congress's role, as it is one of the only ways to determine which services are being withheld and from which groups.

Attaching Riders to the Appropriations Process

Congress has direct authority over funding and can use appropriations riders to dictate how global health funds should be implemented. This is a unique design of the appropriations process and is utilized every year. At a minimum, appropriations language should clarify that HIV prevention, testing, and treatment funded by the United States must be accessible to all populations, including LGBTQI+ individuals. By refusing these terms, so would a country refuse the appropriated U.S. dollars. This would give providers clearer protections and reduce ambiguity in countries where legal environments are already volatile.

It is also important to protect prevention tools, such as condoms and PrEP, in appropriations language. These are standard components of HIV prevention and restricting them undermines public health outcomes. By

preserving medical tools, these appropriations riders would also help address the broader policy constraints that create politically charged work environments for providers.

Recommendations Summary:

These three strategies would meaningfully support life, liberty, and the pursuit of happiness for all people. These principles reflect the original intent of the program and, even as PEPFAR is effectively gone, can still guide the realities of foreign HIV prevention and treatment in the years going forward.

Section 4: Conclusion

As the 2030 deadline for full country autonomy rapidly approaches, the Trump Administration appears to exhibit a laissez-faire attitude regarding how United States funds are implemented in the meantime. Turning a blind eye to the misery of hundreds of thousands of LGBTQI+ Africans living with HIV in countries with anti-homosexuality laws is not only wrong, but it will also be costly. The year 2030 happens to be another significant date: the goal date to eradicate AIDS. Should the United States continue to let key populations suffer in silence, the AIDS eradication deadline will undoubtedly fail. These next five years represent the most authority that the United States will have in terms of PEPFAR administration abroad. Now is the time to transform the pleas of LGBTQI+ Africans into congressional strategies that may still save the lives of Africans and Americans alike.

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