Protecting Lives, Sustaining Progress: U.S. Leadership in Global HIV and Maternal and Child Health

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common ground
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Mom and baby at Ntarama Health Center in Kigali, Rwanda. Photo by Eric Bond/EGPAF 2019.

Overview

Investments in global health over the last several decades have resulted in monumental progress toward both controlling the HIV epidemic and preventing maternal and newborn deaths. These investments go beyond improving health outcomes—they are vital to boosting economies, promoting political stability, and strengthening global health security.

New HIV infections have decreased by 61% since their peak in 1996, and deaths related to HIV have decreased by 70% since 2004.[1] There are several factors essential to this achievement: advancements in medication have led to more effective prevention and treatment of HIV, including reducing vertical transmission—also referred to as mother-to-child transmission—along with a focus on prevention and treatment for women and girls, who are especially vulnerable to HIV.

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Despite these gains, there are still considerable gaps in global HIV prevention and treatment efforts. While infants and children make up just 3% of HIV infections, they comprise 12% of all HIV- and AIDS-related deaths. Women and girls are 53% of people living with HIV, form 45% of all new infections globally, and constitute 63% of all new infections in sub-Saharan Africa.[2] And while overall maternal and newborn deaths have decreased (40% and 44% respectively), they are both significantly higher in low-income countries compared to high-income countries, with socioeconomic inequities playing a significant role in the risk of maternal and child mortality and morbidity.[3]

Additionally, substantial efforts are needed to meet the 2030 health targets detailed in the Sustainable Development Goals (SDGs). Goal 3, to ensure healthy lives and promote well-being at all ages, necessitates reducing global maternal mortality to fewer than 70 deaths per 100,000 live births, ending preventable deaths of newborns and children under 5 years of age, and stopping the epidemics of HIV and AIDS, tuberculosis, malaria, and neglected tropical diseases.[4]

Current progress shows that we will fall short of these goals.

Today's projections indicate that **by 2030, the maternal mortality ratio will be 177 deaths per 100,000 live births—2.5 times higher than the SDG targets.**[5] Currently, 60 countries are at risk of missing the SDG under five mortality target, which would result in the projected deaths of 30 million children under five by 2030.[6] At the end of

2024, the world was on target to meet the 2030 goal of ending the HIV and AIDS epidemics. Seventy-seven percent of people living with HIV were on lifesaving treatment, and the number of new infections had decreased by 40% globally between 2010-2024.[7] That progress has not only stalled—it is actively backsliding. There could be as many as 1.4 million new cases of HIV per year by 2030 due to funding cuts enacted in 2025.[8] An estimated $29 billion annually in low- and middle-income countries is needed to eliminate AIDS as a global public health threat.[9]

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A significant factor of improved maternal health and HIV outcomes is investment in global health. Historically, the United States has been the largest donor to global health activities in low- and middle-income countries, providing around $12 billion each year.[10] The most impactful avenue for U.S. investment in global health has been the President's Emergency Plan for AIDS Relief (PEPFAR). This initiative has saved more than 25 million lives and prevented millions of new HIV infections worldwide.[11] The Global Fund to Fight AIDS, Tuberculosis, and Malaria, to which the United States is the largest contributor, has saved 70 million lives since 2002.[12] And from 2012-2023, the U.S. government invested more than $28 million to prevent maternal and child deaths, with United States Agency for International Development's (USAID) maternal and child survival programs credited with saving 7.4 million lives.[13]

Investment has contributed to global economic progress, promoted educational opportunities, and strengthened global health security. However, reduced investments from the United States and other high-income countries have contributed to stalled progress. The dismantling of USAID and deep cuts to global health funding are already reversing decades of health gains, with significant repercussions anticipated for HIV and maternal and newborn health outcomes.

The current U.S. America First Global Health Strategy prioritizes increased country ownership of costs, government to government agreements, and a push to self-reliance. This shift has altered the HIV and maternal and child health landscape drastically. Working within these new U.S. aid guidelines demands innovative and pragmatic ways of streamlining prevention, diagnosis, and treatment for pediatric HIV prevention, child health, and maternal health—all inextricably linked—to effectively remain prioritized. This is crucial to ensure the progress made toward an AIDS-free generation continues, and people living with HIV continue to be seen and prioritized by the U.S. Congress.

The following landscape analysis of maternal and child health, HIV prevention, diagnosis, and treatment, and the historic strength of U.S. leadership in global aid provides an overview of these key areas of global health and recommendations for U.S. Congressional engagement and prioritization.

**Unless otherwise stated, all statistics listed in this report reflect global data.*

HIV

HIV, or human immunodeficiency virus, is transmitted through bodily fluids and targets the body's immune system. If left untreated, HIV can develop into acquired immunodeficiency syndrome (AIDS).[14] The first recorded cases of AIDS were among gay men in the United States in 1981. However, HIV and AIDS likely reached the human population by the 1920s.[15] Deaths due to AIDS were documented as early as 1976 in Norway and 1978 in Haiti, while HIV and AIDS were reported in present-day Rwanda and Democratic Republic of Congo by 1977.[16] Since the beginning of the HIV epidemic in 1981, 91.4 million people have contracted HIV, and 44.1 million have died from HIV- and AIDS-related causes.[17]

In 2024, an estimated 40.8 million people were living with HIV.[18] There were 1.3 million new cases of HIV, and 630,000 people died from HIV- and AIDS-related illnesses. Since 2010, there has been a significant reduction in new cases of HIV in sub-Saharan Africa; however, the region and its countries continue to bear the highest burden of HIV globally, making up more than 60% of all people living with HIV and 50% of all new HIV infections.[19] Progress varies in other regions. In eastern Europe and central Asia, new HIV infections have leveled off after decades of being on the rise, but in the Middle East and North Africa, new HIV infections have almost doubled since 1990.[20] Still, the countries with the five highest prevalences of HIV are all in southern Africa: Eswatini, South Africa, Lesotho, Botswana, and Mozambique.[21]

HIV is treated through an antiretroviral treatment (ART) regimen and is prevented with pre-exposure prophylaxis (PrEP), or with post-exposure prophylaxis (PEP) within 72 hours of HIV exposure. PrEP is a highly effective prevention tool, particularly for groups of people who face a higher risk of contracting HIV, and both PrEP and PEP are made up of the same medicines as treatment regimens.[22]

HIV in Children

In 2024, 1.4 million, or 3% of all people living with HIV, were children.[23] However, children account for 12% of all HIV- and AIDS-related deaths, approximately 75,000 deaths each year.[24] New HIV infections in children have declined by 62% since 2010, though progress has stalled in the last several years.[25] The primary way newborns and children under five contract HIV is through vertical transmission from the mother during pregnancy or breastfeeding. This is effectively prevented by pregnant and breastfeeding women living with HIV taking an ART regimen to improve their health and reduce the chance of transmitting the virus. When pregnant and breastfeeding women living with HIV follow treatment as prescribed, the risk of transmitting the virus to their child drops to less than 1%.[26] For infants who do contract the virus, beginning an ART regimen soon after diagnosis can prevent the devastating long-term health, social, and economic effects of HIV. However, only 57% of children living with HIV are being treated, compared to 77% of adults.[27] **Studies show that without proper HIV testing and treatment, half of all children with HIV will die by their second birthday, and 80% by age five.[28]**

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Even when receiving ART, mortality among children under five was significantly higher than people in older age groups receiving treatment. A recent study found that interruptions in treatment for children five years or younger were higher than for other age groups, which suggests that deaths among young children are likely underreported due to interruptions in treatment or losses to follow-up.[29, 30]

Early diagnosis and initiation of ART is critical for infants and children.[31] Coverage of early infant diagnosis varies greatly across regions; in 2024, it was 74% in eastern and southern Africa, but only 30% in western and central Africa.[32] Early infant diagnosis faces several barriers including the lack of testing facilities, the prohibitive cost of polymerase chain reaction (PCR) testing (essential to identifying viruses), and the difficulty of establishing testing infrastructure in low-resource settings. Additionally, the inability to conduct follow-up testing at various stages of early infancy further hinders the timely identification and intervention of potential health issues.[33] Point-of-care (POC) practices for early infant diagnosis can help avoid delays in receiving results, thus minimizing the potential for losses throughout the different stages of medical care, particularly helpful to those in rural or resource-constrained areas.[34] Research has shown that POC testing for early infant diagnosis can improve rates of testing for infants, increase the proportion of test results returned to caregivers within 30 days, and grow the number of infants with HIV who initiate ART. POC practices also generate health systems savings partly due to decreased costs per test result.[35]

A mother in Mbabane, Eswatini, nurses her newborn for the first time.
Photo by Eric Bond/EGPAF 2019.

Early infant diagnosis of HIV is crucial but does not address all treatment gaps in young children. Follow-up appointments and testing for both mother and baby, particularly at 12 months and 24 months postpartum, are key to capturing new infections among mothers and breastfeeding children.[36] Once diagnosed, it is critical that children remain on treatment to stay healthy through adolescence and adulthood, but this has proven to be difficult to achieve. One reason is the lack of child-friendly HIV treatments, as new ART drugs are primarily formulated for adults.[37] Recent research shows that dolutegravir-based regimens, originally approved for adults, are also effective in treating HIV-positive newborns with no adverse effects related to the medication, expanding the range of treatment options available to both infants and children.[38]

Guidance from the World Health Organization (WHO) recommends pALD—pediatric abacavir, lamivudine, dolutegravir—a tablet taken once a day, simplifying treatment for children living with HIV.[39] **Treatment initiation following early diagnosis has been shown to reduce HIV-related infant mortality by up to 76%.[40]** Initial results from the IMPAACT P1115 trial in 11 countries across Africa, Asia, and the Americas also suggest that initiating ART for

babies born with HIV immediately after birth is highly effective at making the HIV virus undetectable in their bodies, potentially promoting treatment-free remission for 48 weeks or longer.[41] Prompt treatment of HIV protects an infant's immune system from the early effects of the virus and prevents HIV from replicating rapidly during the initial stages of the infection.[42] Significantly, the possibility of treatment-free remission for infants and children marks an important step forward in finding a cure for pediatric HIV.

Significance of Mother-Baby Pair and Integrated Health Services

The mother-baby pair is an essential unit of care from pregnancy through early childhood, with maternal and child health outcomes inextricably linked. Each healthcare touchpoint from antenatal visits to well-child visits is an opportunity to address the health and wellbeing of both mother and child.[43] **Integrated services are especially critical when the mother has HIV or is at risk of HIV infection, given that transmission from mother to child is a leading cause of pediatric HIV.** Mothers and newborns typically attend their healthcare appointments together, making dually focused services more convenient and accessible for families.[44] Integrated services improve prevention and treatment retention for both women and children, and integrated care for families with HIV that support both the caregiver mother and the child's health simultaneously have better outcomes than child health interventions alone.[45]

Studies also show that the health status of a mother or primary caregiver with HIV has a direct impact on the ability of a child with HIV to consistently suppress the virus. If the health of the mother declines, evidence shows similar declines in child health outcomes due to missed appointments, inconsistent medical treatment, and the mother's decreased ability to both care for her child and navigate the health system.[46] Interventions focused on maternal viral suppression, mental health, and socioeconomic stability greatly improve retention rates for pediatric care and treatment.

Preventing and Treating HIV in Women and Girls

A girl in Bamenda, Cameroon, at a peer support group for adolescents living with HIV. Photo by Eric Bond/EGPAF 2016.

Women and girls comprise a particularly vulnerable population for HIV prevention, diagnosis, and treatment. Women primarily contract HIV through unprotected sex with a male partner who has detectable levels of HIV.[47] **Adolescent girls and young women (AGYW) aged 15-24 are a vulnerable subset of this population, with an estimated 4,000 newly infected with HIV each week; 82% of these infections occur in sub-Saharan Africa.[48]** Within sub-Saharan Africa, AGYW face a higher risk of contracting HIV than men and boys—the opposite is true in the rest of the world.[49] While there are some biological factors that contribute to a higher risk of contracting HIV for women, socioeconomic factors are central to new HIV infections among women and girls.[50] Poverty, lower levels of education, food insecurity, and lack of knowledge of sex and sexuality all add to women's and girls' vulnerability to HIV, which is also increased by exposure to intimate partner violence.[51, 52, 53] These factors contribute to reduced autonomy, engagement in riskier sexual practices such as transactional sex or sex work, age-disparate relationships, and unprotected sex.[54]

Gender-based marginalization contributes to stigma and discrimination, which keep women and girls from accessing prevention and treatment services. Global Stigma Index surveys suggest that more than half of people living with HIV feel ashamed of having HIV, and an estimated 60% of people across a survey of 55 countries felt discriminatory attitudes toward people living with HIV.[55] The stigma HIV-positive pregnant women experience can also contribute to a lack of treatment adherence and an increased risk of transmitting the virus.[56] Efforts to address the resulting barriers to accessing HIV services target laws and policies that limit or deny access to services. These efforts also include addressing gender inequality and gender-based violence, which can impede HIV prevention, testing, and treatment adherence.[57, 58] Integrating gender-based violence services into HIV care can help standardize care, strengthen case documentation and referral procedures, and improve support and outcomes for survivors of gender-based violence.[59]

Women and girls living with HIV face additional health risks during pregnancy, both for themselves and their children.[60] HIV during pregnancy has been linked to miscarriage, stillbirth, perinatal maternal mortality, and low birthweight.[61] It is also linked to maternal anemia and complications associated with a more vulnerable immune system.[62] Pregnant women receiving ART regimes during pregnancy still have higher risk of adverse events than women who do not have HIV.[63] However, studies have shown that adhering to ART during pregnancy and maintaining viral suppression during pregnancy, delivery, and breastfeeding can reduce the risk of vertical transmission to less than 1% while protecting the mother from adverse health impacts caused by high viral loads.[64, 65, 66]

Innovations such as long-acting injectable PrEP have the potential to make HIV treatment more accessible and discreet for women. Furthermore, cabotegravir and lenacapavir, two long-acting injectable PrEP options, are proven to be safe, tolerable, and effective during pregnancy and breastfeeding.

Without treatment, the chance that HIV is transmitted during pregnancy, birth, or breastfeeding ranges from 15 to 45%, with most transmissions occurring during delivery or breastfeeding.[67,68] Since 2011, vertical transmission of HIV has dropped dramatically due to access to prevention of mother-to-child transmission (PMTCT) services, and due to more pregnant women with HIV initiating a lifelong regimen of antiretroviral medicine. It is estimated that 2.1 million deaths and 4.4 million HIV infections have been prevented due to these programs.[69] In 2024, 84% of pregnant and breastfeeding women received ART, although within certain regions, such as western and central Africa, coverage was as low as 60%.[70]

Over the last several years, pharmacological advances in ART and PrEP have made HIV a manageable chronic condition.[71] Innovations such as long-acting injectable PrEP have the potential to make HIV treatment more accessible and discreet for women. Furthermore, cabotegravir and lenacapavir, two long-acting injectable PrEP options, are proven to be safe, tolerable, and effective during pregnancy and breastfeeding.[72] Studies have also found that some PrEP options such as the dapivirine vaginal ring and oral PrEP are effective at preventing HIV during pregnancy and pose minimal risk to the fetus and newborn during and after delivery.[73] ART medications have similarly evolved from daily oral medication regimens to long-acting injectable treatment and immunotherapeutic strategies to promote adherence to ART, increase treatment efficacy, decrease stigma, and eventually achieve long-term remission.[74] Preventing new HIV infections in women, girls, and children relies on increasing access to PrEP and other prevention strategies, ensuring adherence to preventative ART regimens—particularly during pregnancy and breastfeeding—and promoting early detection and treatment of HIV in infants and young children.[75]

Innovations in early infant diagnosis of HIV, such as point-of-care testing, especially improve early detection of HIV in resource-constrained areas. Digital health strategies, including online services and text message follow-ups, have also helped reach those communities.[76] Such programs have been effective at reducing stigma and building trust in healthcare systems.[77] Additionally, integrated services for mothers and babies at risk of HIV infection, increased resources for HIV-infected mothers and caregivers that support their health and wellbeing, and more healthcare facility touchpoints for mothers and children are key to reducing pediatric HIV and increasing rates of viral suppression among children. Finally, preventing HIV among women and adolescent girls relies on access to contraception and other sexual and reproductive health services to avoid unintended pregnancies, and prevent and treat sexually transmitted infections. It is also crucial to acknowledge and address the role of gender-based violence in the prevalence of adolescent girls and young women at risk for HIV infection, and provide reproductive health services before, during, and after delivery.[78]

A mom in Berea, Lesotho, attends a support group for young mothers and her children get a health check-up. Photo by Eric Bond/EGPAF 2024.

Maternal Health

Each day, nearly 700 women die from causes related to pregnancy and childbirth, which amounted to 260,000 maternal deaths in 2023.[79] Maternal deaths are defined as a death due to complications related to pregnancy or childbirth that occur during the pregnancy or within six weeks after the end of the pregnancy.[80] Though deaths related to pregnancy and childbirth can occur after this period, these deaths are classified as late

Mom and baby in Dezda, Malawi. Photo by Eric Bond/EGPAF 2024.

maternal death.[81] Since 2000, global maternal deaths have decreased by 40%, with maternal mortality decreasing by 1.6% every year between 2016 and 2023.[82]

Ninety-two percent of all maternal deaths occur in low- and middle-income countries, with sub-Saharan Africa accounting for 70% of all maternal deaths.[83] In 2023, the average maternal mortality rate across sub-Saharan Africa was 454 maternal deaths per 100,000 live births.[84] Across high-income countries, maternal mortality is much lower with an average of 10 deaths per 100,000 live births, with the exception of the United States, which has the highest ratio of maternal mortality of high-income countries at close to 19 deaths per 100,000 live births.[85, 86] Racial disparities in the United States contribute greatly to the elevated rate of maternal death—the maternal mortality ratio is 3.5 times higher among Black women than for white women.[87]

When a mother dies, families and communities suffer, as women play key roles as caregivers, wage earners, and community leaders. The persistence of preventable maternal death points to the need to solve structural inequities by addressing the root causes of maternal death.

Causes of Maternal Mortality

Nearly 75% of all maternal deaths occur due to hemorrhage, infection, high blood pressure, complications from delivery, and unsafe abortion.[88] Hemorrhage, or severe postpartum bleeding, contributes significantly to maternal mortality, particularly in low- and middle-income countries where 85% of postpartum hemorrhage deaths occur.[89] Hypertension, or high blood pressure during pregnancy, has risen 15% globally from 1990 to 2021.[90] However, treatment for these cases has lagged. For example, in the United States, only 60% of people with hypertension during pregnancy receive treatment.[91] Infection during pregnancy, or sepsis, contributes to 11% of maternal deaths globally.[92] Sepsis can be the underlying cause of issues like postpartum hemorrhage, and sepsis can be the result of pregnancy and childbirth complications, like gestational diabetes, hypertension, or Cesarean delivery.[93]

Additionally, anywhere from 8 to 11% of maternal deaths are attributed to unsafe abortion.[94] An estimated 45% of abortions worldwide are unsafe, meaning they are performed by someone lacking the necessary skills or in an unsafe setting.[95] Though the legal status of abortion varies across countries, unsafe abortions occur in all regions of the world, even in countries where the procedure is legal.[96]

Social determinants of health also play a vital role in maternal mortality worldwide. **Household income and poverty, education level, proximity to obstetric care, and discrimination based on race and gender are all crucial factors associated with maternal mortality.[97]** Women and girls in low-income countries face a much higher risk of maternal death than those in high-income countries. In high-income countries, the probability that a 15-year-old will eventually die of a pregnancy-related cause is 1 in 7,933, as opposed to 1 in 66 in low-income countries.[98]

Long-term temperature shifts, heat waves, and extreme weather events greatly reduce access to obstetric care and pose significant risks to maternal and newborn outcomes, including preterm birth, stillbirth and miscarriage, and hypertension.[99, 100] Maternal health outcomes are also affected by global trends such as a rise in humanitarian crises and conflicts and the COVID-19 pandemic. In 2023, 37 countries classified as being in conflict or fragile accounted for 61% of maternal deaths, even though they represented just 25% of live births.[101] This translates to a 15-year-old in one of these countries having a 1 in 51 chance of dying from pregnancy-related causes.[102]

Globally, HIV accounted for less than 1% of maternal deaths in 2023, representing a steady decline.[103] However, HIV-related maternal mortality is substantially higher in sub-Saharan Africa—for example, nearly 6% of all maternal deaths in Southern African countries are due to HIV.[104] Additionally, pregnant women living with HIV have a higher risk of late pregnancy-related death, whether or not they are adhering to an ART regimen.[105]

Strategies to Prevent Maternal Death

Access to comprehensive antenatal and postnatal care is crucial to identify pregnancy complications, improve maternal health outcomes, and address any difficulties that arise after delivery. However, attending the recommended number of

visits is not enough—the quality of these visits, including through respectful maternity care, is also vital.[106] High-quality, respectful antenatal care has been associated with a 41% decline in neonatal mortality, particularly in sub-Saharan Africa. Furthermore, expanding preventative health measures to address underlying health conditions, such as non-communicable diseases and malnutrition, is key to healthy pregnancies.[107]

Addressing postpartum hemorrhage is essential to mitigate preventable maternal death. Recent shifts in global guidelines call for intervening when blood loss reaches 300 mL rather than the previously recommended 500 mL, using calibrated drapes to quantify blood loss.[108] Initial implementation revealed that detecting hemorrhage early and a bundled treatment plan reduced severe hemorrhage by 60%, substantially reducing the risk of death from bleeding.[109] **Postnatal care is imperative to ensure new mothers stay complication-free and have maternal illnesses addressed, and yet one third of women do not receive this fundamental care in the first days after delivery.[110]**

A key indicator of progress toward maternal death prevention is access to skilled birth attendants. Though 87% of births in 2024 were attended by a skilled practitioner (doctors, midwives, and nurses), this coverage varies widely across regions. Access to comprehensive sexual and reproductive health services is also effective at preventing unwanted pregnancy and maternal death.[111] A comprehensive sexual and reproductive health package includes access to contraception; antenatal, childbirth, and postnatal care; infertility care and treatment; legal abortion services and care; prevention, detection, and treatment of sexually transmitted infections, including HIV, syphilis, and hepatitis B; and care for other reproductive health conditions (cervical cancer, obstetric fistula, female genital cutting, etc.).[112] Historically, pregnant and breastfeeding women have been excluded from clinical research trials leading to policy and treatment options that fail to account for their distinct needs.[113] Ultimately, addressing the central causes of maternal death—both biomedical and social determinants—is essential to ending preventable maternal mortality.

Vehicle parked at the Senkatana Centre of Excellence in Maseru, Lesotho. Photo by Madeline Morris/EGPAF 2023.

History and Impact of Investments in HIV and Maternal Health

History of U.S. Investments

The U.S. government has been involved in foreign assistance for more than a century. A significant portion of this aid was devoted to global health with the goal of improving the health of people in low- and middle-income countries, while also promoting U.S. global development goals, foreign policy priorities, and national security concerns.[114] U.S. involvement in global health activities began in the late 1800s, when in partnership with other nations, the United States helped establish international health organizations, standards, and treaties to promote international trade and travel, and to manage external disease threats.[115] The United States provided $12.4 billion to global health initiatives in FY2024, making it the largest donor to global health in low- and middle-income countries. Notably, it provided 42% of all international health assistance from major donor governments in 2023.[116]

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U.S. global health funding is primarily bilateral, with the United States working directly in and with aid-recipient countries; however, some investment is multilateral, made through international organizations supported by multiple national governments.[117] Global health funding has been implemented primarily through the U.S. Department of State, the U.S. Agency for International Development (USAID), and the U.S. Department of Health and Human Services (HHS). It is estimated that U.S. foreign assistance programs have saved more than 90 million lives in the last 10 years, including 30.4 million children under the age of five.[118] U.S. foreign

A health worker at Ndhiwa Sub County Hospital in Homabay, Kenya, gives pediatric check-up, and captures data on a tablet. Photo by Kevin Ouma for EGPAF 2023.

assistance has been a vital tool to strengthen national security by building the capacities of health ministries around the world, including surveilling infectious diseases that could enter the United States or become pandemics.[119]

The main priorities for global health funding are HIV and AIDS, tuberculosis, malaria, neglected tropical diseases, family planning and reproductive health, maternal and child health, nutrition, and global health security. The United States contributes to HIV prevention and treatment primarily through PEPFAR and the Global Fund to Fight AIDS, Tuberculosis (TB), and Malaria. The Global Fund is an independent, multilateral entity established to raise resources to end HIV, TB, and malaria. The United States historically has been its largest single donor.

In the early 2000s, nearly 36 million people were living with HIV, and almost 22 million people had died from HIV- and AIDS-related causes. At that time, ART was available in high-income countries but not to most people living in African countries.[120] The United States first became involved in HIV prevention and treatment in 2002 through the International Mother and Child HIV Prevention Initiative. This initiative targeted women of reproductive age living with HIV, with the goal of reducing vertical transmission by up to 40% in 14 countries across Africa. Within one year, PMTCT services were provided in all 14.[121]

In 2003, President George W. Bush established PEPFAR and signed it into law with bipartisan Congressional support. By 2005, more than 400,000 people across 15 countries were receiving ART.[122] In 2014, PEPFAR launched DREAMS (Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe), an initiative to reduce new HIV infections among adolescent girls and young women.[123] **To date, PEPFAR is the largest commitment by any one nation to address a single disease and is widely considered to be the most effective global health intervention of all time.[124]**

The United States has supported global maternal and child health efforts for more than 50 years, beginning with researching child survival, bolstering nutrition initiatives, and controlling the spread of malaria. USAID developed its first dedicated maternal health program in 1989, and efforts have since centered the goal of ending preventable maternal and child deaths.[125] Until 2022, USAID regularly released the Acting on the Call report to provide a roadmap to prevent maternal and child deaths. This included the agency's activities promoting maternal and child health, as well as future directions and innovations to provide life-saving health services.[126] The reports also highlighted HIV indicators related to maternal and child health in countries with a high prevalence of HIV. In 2023, USAID released the Preventing Child and Maternal Deaths strategy, which detailed a renewed commitment to ending preventable maternal and child deaths.[127] The United States has also historically supported family planning and reproductive health efforts, which are directly linked to improving maternal and child health. Maternal health is also addressed through other global health programs such as PEPFAR, PMTCT, and the U.S. President's Malaria Initiative; nutrition programs such as Feed the Future; and international institutions which fund other maternal and child health programs.[128]

Disruptions in U.S. Foreign Assistance in 2025

The landscape of U.S. global health funds shifted dramatically in 2025 under President Donald Trump's second term. After initial blanket freezes and stop-work orders, some programs, including PEPFAR and those implementing maternal and child health services, were given limited waivers to continue lifesaving work.[129] **However, as of September 2025, an estimated 65% of USAID's PEPFAR awards for FY2025 were terminated.[130] The dissolution of USAID, which was the primary global health implementing agency, and the shift of its work to the State Department, has left significant gaps in staffing for remaining global health programs.** These cuts have affected funding that was already appropriated, disbursed, and spent. This has resulted in food stocks going to waste, essential medications expiring, and threats to destroy millions of dollars' worth of contraceptives.[131, 132, 133] The potential backsliding in global health improvements poses a threat to the long-term impact of U.S. investments in global health over the last 20 years.

PEPFAR has saved more than 25 million lives and has averted millions of new HIV infections.

In September 2025, the State Department released its America First Global Health Strategy detailing the shift in focus to HIV, TB, malaria, polio, and global health security. Under this strategy, the United States has re-negotiated bilateral, multi-year agreements (Memorandums of Understanding, or MOUs) with countries receiving funding with mandatory co-investment by countries. The United States signed its first MOU with Kenya on December 4, 2025, and as of February 27, 2026, has signed MOUs with 24 countries.[134, 135] However, essential services such as many HIV prevention activities and most maternal and child health programs outside of established PMTCT projects could be discontinued under this strategy, threatening its stated goals.[136]

The withdrawal of most U.S. foreign assistance has prompted global leaders to rethink how global health is funded. In addition to U.S. aid reductions, other wealthy countries such as France, Germany, and the United Kingdom have reduced their aid budgets.[137] This marks the first time in the last 30 years that all four countries have cut their foreign aid budgets at the same time. These cuts could result in 22.6 million more deaths by 2030.[138]

New guidance from the WHO calls for low- and middle-income countries that have historically relied on external aid to turn to domestic resources to build self-reliant health systems.[139] However, abruptly reducing aid, cancelling programs, and issuing fluctuating guidance to implementing partners creates gaps in health services and threatens the progress made toward both improved health outcomes and self-reliance. 2026 U.S. policy changes further imperil this progress, including with the United States' recent withdrawal from the WHO and the reinstated Promoting Human Flourishing in Foreign Assistance policy, also known as the expanded Mexico City Policy, potentially impacting $40 billion in foreign aid.[140, 141]

The Impact of U.S. Investments

Reports show that since its inception, PEPFAR has saved more than 25 million lives and has averted millions of new HIV infections. **Investments in PEPFAR also have been associated with declines in overall mortality in countries that received its support: PEPFAR-supported countries saw 25% lower maternal mortality and 35% lower child mortality compared to the expected mortality without PEPFAR's intervention.[142]** Global investments in HIV prevention and treatment have also contributed to more accessible treatment, increased economic and political stability, engagement across sectors, and greater inclusion. PEPFAR's implementation has reduced the cost of ART in low- and middle-income countries, from $1,200 per person per year in 2003 to $58 in 2023.[143] Additionally, technological innovations developed through PEPFAR funding have generated significant benefits beyond HIV. Investments in laboratory networks, workforce training, and public health infrastructure have strengthened health systems, enabling them to play a critical role in pandemic preparedness, demonstrated through the development and rollout of the COVID-19 vaccine.[144] These investments have enabled stronger responses to infectious diseases such as Ebola, H1N1, and tuberculosis, which in turn inform treatment and prevention strategies for Americans facing similar diseases.[145] PEPFAR has also promoted collaborative models that include community members and private sector partners, particularly through public-private partnerships such as DREAMS.[146] Furthermore, global health funding at large has improved resources and services for key populations, including women and girls, and has developed initiatives centered in human rights.[147]

It is estimated that U.S. investments in global health have prevented the deaths of more than 1 million women of reproductive age in the last 10 years.[148] However, the reduction in international aid alongside discontinued support for PEPFAR could cause up to 10 million new HIV infections and up to 3 million additional HIV-related deaths in the next five years alone.[149] The cuts have also put pregnant women, particularly those in low-resource or fragile settings, at an increased risk of pregnancy-related complications. **Estimates suggest that over the course of one year without funding, there could be as many as 34,000 more preventable maternal deaths and 17.1 million more unintended pregnancies worldwide.[150]**

Political instability and violent activity in PEPFAR countries in sub-Saharan Africa fell by 40%, compared to 3% in non-PEPFAR countries in the region.

Global Health Security

Health is inextricably linked with security. While global health security efforts initially focused on infectious disease surveillance and containing disease outbreaks, it now connects social, political, economic, and educational factors that

shape health and well-being.[151] The HIV epidemic and the prevalence of preventable maternal death are two critical threats to global health security. The high prevalence of HIV in countries contributes to strains on healthcare systems, national economies, and social and political stability.[152] Conversely, strengthening countries' economic and educational outcomes through expanded global health access can bolster national security.

Research shows that PEPFAR was associated with a 2.1 percentage point increase in the per capita gross domestic product (GDP) growth rate in countries it supported.[153] Beyond PEPFAR, investments to end the HIV epidemic and prevent HIV-related deaths bolster the working-age population, contributing to economic participation and growth.[154] Within countries with a higher burden of HIV and maternal mortality, creating social support systems can help reduce new HIV infections and improve maternal and child health, which in turn can lead to greater economic empowerment.

Every dollar invested in ending preventable maternal deaths returns $8.40 in economic, health, and societal benefits

Investments to respond to the HIV epidemic also promote educational opportunities for women, children, and adolescents. When mortality among parents with HIV declines, there are fewer children orphaned by HIV and AIDS, leading to higher rates of school enrollment.[155] Healthier parents living with HIV can care for their HIV-infected children better, keeping them connected to the health care system with regular visits and treatment and when caregivers are healthy, children (with or without HIV) have higher rates of primary school attendance.[156] PEPFAR has also been associated with a 9% decline in the number of girls out of school, highlighting the positive effects of investments in HIV prevention and treatment on adolescent girls and young women.[157]

Investing in women's health contributes to global economic progress. Studies show that closing the health gap between men and women would contribute up to $1 trillion to the global economy by 2040.[158] For maternal health investments in particular, estimates suggest that every dollar invested in ending preventable maternal deaths returns $8.40 in economic, health, and societal benefits.[159] Ensuring access to contraception to prevent unintended pregnancy and strengthening health systems to prevent maternal deaths, give women and girls a better chance to continue their education, develop professional skills, and achieve economic independence.

Women's and girls' health and rights are also critical to ensuring global health security. Women have often been at the center of disease outbreaks and are disproportionately affected by crises.[160] Global weakening of women's rights undermines global peace and security and threatens progress toward reducing maternal deaths.[161] Studies show that greater gender equality is associated with a lower likelihood of violent conflict.[162] Maternal mortality is also driven by gender inequality and reduced access to safe, quality, and respectful health services. Additionally, improving women's

Mother and child meet with health worker at Mbita Sub County Hospital in Homabay, Kenya. Photo by Kevin Ouma for EGPAF 2023.

political representation is a proven strategy to promote national security and lower maternal mortality.[163] **Despite the available research on the positive relationship between maternal health outcomes, gender equality, and national stability, women's equality and health are often deprioritized in or omitted entirely from security discussions.**

U.S. global health funding, while centered on improving health outcomes, also serves as an important diplomatic tool to exercise soft power abroad. Studies have found that **between 2004 and 2015, political instability and violent activity in PEPFAR countries in sub-Saharan Africa fell by 40%, compared to 3% in non-PEPFAR countries in the region.[164]** The success of PEPFAR has expanded the number of U.S. allies and supporters in partner countries, particularly in regions experiencing conflict.[165] From 2007 to 2011, polling on global public opinions found that PEPFAR countries had an average approval rating of U.S. leadership of 68%, compared to the global average of 46% at that time.[166]

Recommendations

The United States has long stood as the world's foremost leader in global health. PEPFAR alone has saved 25 million lives and coordinated U.S. investment has delivered a 40% reduction in maternal deaths since 2000. As the United States transitions toward a new model of bilateral, country-led health partnerships under the America First Global Health Strategy, the decisions made today will determine whether that progress holds—or reverses. Independent projections warn that funding disruptions could result in 22.6 million additional deaths by 2030.[167]

The following recommendations provide a framework for preserving U.S. leadership on HIV and maternal and child health while advancing a sustainable, country-owned future:

1. Oversee a responsible transition of PEPFAR and other global health funding that honors Congressional intent

- Ensure that already appropriated PEPFAR and global health funds are fully disbursed in accordance with Congressional intent, without administrative delays that disrupt lifesaving services.
- Support country-led implementation plans that build durable local capacity—including strengthened health systems and laboratory infrastructure capable of detecting and characterizing HIV, tuberculosis, malaria, syphilis, and other pathogens of concern.
- Condition global health funding to the State Department on measurable safeguards to prevent loss of pediatric HIV, maternal health, and child survival gains during integration and country-led transition efforts; this includes transparent reporting to Congress on maternal and child outcomes, continuity of services, and investment in global health-focused innovations.

2. Protect pediatric HIV prevention and treatment programs and progress

- Dedicate funding for early infant diagnosis programs, especially investment in point-of-care testing infrastructure to reach children outside of major health centers.
- Prioritize procurement of and expanded access to child-appropriate antiretroviral formulations, including for infants, to enable immediate antiretroviral therapy (ART) initiation for all children diagnosed with HIV to prevent disease progression to AIDS.
- Direct the U.S. State Department to encourage adoption of protocols for retesting mothers and children for HIV that extend well beyond the traditional six-week postnatal visit, covering the full breastfeeding period and into early childhood to close critical gaps in pediatric diagnosis.

3. Invest in quality maternal and newborn health

- Create new funding pathways for integrated mother-child care models that do not separate maternal and infant health to maximize each encounter with the health system and prevent inefficient care that leads to missed diagnoses and poor outcomes.
- Direct U.S. global health programs to prioritize interoperable data systems that track mom-baby pairs across the care continuum; integrate HIV and broader MNCH services to improve outcomes; ensure accountability; and identify measurable reductions in mortality.

- Prioritize the education, training, and remuneration of skilled birth attendants, including nurses and midwives; and promote the understanding and delivery of respectful maternity care.
- Champion maternal health innovations—like those to reduce postpartum hemorrhage—and ensure the availability, access, and uptake at health facilities, particularly in remote settings.
- Maintain robust funding for comprehensive sexual and reproductive health services, including education, testing, and treatment of sexually transmitted infections, support for survivors of gender-based violence, and access to a full range of voluntary family planning options.

4. Accelerate innovation to eliminate pediatric HIV

- Expand and prioritize access to long-acting HIV prevention options for pregnant and breastfeeding women and adolescent girls and young women—including lenacapavir and other highly-effective prevention options—in high-burden countries, supporting both product development and equitable distribution to reach those most at risk.
- Allocate sufficient funding to accelerate development, clinical evaluation, and scale-up of new pediatric HIV formulations, including novel delivery methods that would uniquely benefit infants and young children, and for research on treatment-free remission for children living with HIV, building on promising findings from the IMPAACT P1115 trial.
- Direct agencies to ensure pregnant women living with HIV are systematically included in clinical studies to generate country-specific data on eliminating vertical transmission.
- Invest in digital health platforms that create additional touchpoints with the health system for children and mothers, particularly in remote and underserved communities.

5. Require accountability and transparency in global health partnerships

- Mandate that relevant bilateral, global health agreements include time-bound, country-specific targets for HIV prevention, treatment coverage, viral suppression rates, maternal mortality reduction, and vertical transmission elimination, with progress reported to Congress and results disaggregated by age and gender when appropriate.
- Standardize U.S. data reporting requirements across aid recipient countries to ensure consistency, comparability, and the ability to track results at a program and population level.
- Establish joint accountability frameworks aligned with recognized global standards that clearly define partner roles and responsibilities and include defined consequences for non-performance or deviations from agreed terms.

Baby in her mother's lap at Sobhuza Clinic in Kwaluseni, Eswatini. Photo by Eric Bond/EGPAF 2023.

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