Unraveling Trust: The Human Impact of Shifting U.S. Global Health Priorities

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Composed of 10 professionals representing both U.S. and international perspectives, the CUGH working group synthesizes technical knowledge and real-world programmatic experience to inform strategic guidance on global health priorities. Members bring complementary strengths in research and implementation, policy development, capacity building, community engagement, and clinical service delivery. Guided by principles of evidence, equity, and partnership, the working group provides independent, actionable recommendations with a consideration for local needs, national priorities, and across contexts.

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ABSTRACT

This white paper investigates the far-reaching consequences of abrupt U.S. global health funding changes, based on an online survey of 97 global health professionals conducted from April to June 2025. The survey gathered perspectives from individuals involved in U.S. funded global health projects across 47 countries across all six WHO regions. It reveals a deeply interconnected network of initiatives spanning infectious diseases, reproductive health, NCDs, health systems strengthening, and research, underscoring the critical role of stable funding.

Historically, U.S. global health aid has been a cornerstone of international development, driven by humanitarian, economic, diplomatic, and security interests, epitomized by initiatives like PEPFAR. However, in early 2025, sweeping executive orders suspended U.S. foreign development assistance, causing immediate and widespread disruption. This included halting life-saving programs such as HIV treatment, malaria control, and emergency nutrition, leading to confusion, uncertainty, and harm in affected communities.

The survey findings detail both the extensive benefits of sustained global health funding and the severe repercussions of its disruption. Benefits included scientific advancements, job creation, enhanced global health security, and strengthened diplomatic relations, alongside significant goodwill fostered through local empowerment, transparent partnerships, and visible community impact. Conversely, the abrupt cuts led to disrupted health services, increased morbidity and mortality, loss of local expertise, and strained international partnerships. The benefits of global health funding include significant knowledge transfer and increasing local ownership of programs such as HIV service delivery. U.S. investment has played a critical role in halting disease spread and strengthening health systems.

These data reveal emotional and relational effects on stakeholders and target communities. Respondents reported a widespread loss of trust in the U.S. as a reliable partner, with communities experiencing broken commitments and resentment. The sudden withdrawal also resulted in waste of resources and human capital, undoing years of collaborative efforts to improve health and build local capacity. Critically, respondents warned that these disruptions undermine both national and international security by weakening global health systems and disease surveillance, increasing epidemic risk, and diminishing U.S. influence. The paper concludes by advocating for stability, transparency, and the important role of United States engagement and investment in global health as strategic imperatives for global well-being, international cooperation, and security.

INTRODUCTION

The United States (U.S.) has long been the world's largest bilateral donor in global health, driven by a combination of humanitarian, economic, diplomatic, and security interests.[1,2]

Since the mid-20th century, U.S. global health aid has evolved significantly, beginning with post–World War II reconstruction and formalized through the establishment of the U.S. Agency for International Development (USAID) in 1961. Early programs focused on maternal and child health, malaria, and family planning.[3] A major turning point came during the global HIV/AIDS crisis, leading to the launch of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003—one of the largest disease-specific aid initiatives in history.[4] Over time, U.S. engagement expanded to include tuberculosis, malaria (through the President's Malaria Initiative), pandemic preparedness, and health systems strengthening.[1,5]

The early 2000s also marked a surge in global health investment, catalyzed by the Millennium Development Goals and later the Sustainable Development Goals (SDGs), which promoted a vision of shared global responsibility for health and development.[6] However, the COVID-19 pandemic disrupted this momentum, exposed critical weaknesses in global health governance, and strained international solidarity. In its aftermath, rising nationalism and isolationism have increasingly undermined both the humanitarian and biosecurity foundations of global health, jeopardizing collective action on transnational threats such as climate change, future pandemics, and environmental degradation.[7]

In early 2025, a suspension of foreign development assistance was announced through a U.S. Executive Order mandating a 90-day review of global health funding.[8] This action paused funding across multiple U.S. government agencies, affecting a range of global health initiatives implemented by international non-government organizations, academic institutions, and local partners. Notices of work suspensions soon followed, resulting in disruption to programs delivering critical services such as HIV prevention and treatment, malaria control, and food assistance to prevent severe malnutrition. For example, recent reports of delays in distribution have led to spoilage of 500 tons of nutritious high energy biscuits intended for malnourished populations.[9]

Field staff who work each day to ensure access to life saving treatment such as the medicines to control HIV were left confused and uncertain about what they could or could not do. Yet, the impact of U.S. funding to HIV through PEPFAR has rarely been questioned. In fact, it has historically received broad bipartisan support and has often been heralded as the largest commitment by any nation to address a single disease in history. In the early 1990s many countries in sub Saharan Africa were on the verge of economic collapse. Large percentages of their productive adults were too ill to work or had died of AIDS. The AIDS orphan crisis was widespread. Remarkably today, HIV is a manageable chronic illness. U.S. investment in research and a large-scale response through PEPFAR has made this happen. This commitment through PEPFAR has changed the face of AIDS with over 20 million people having received life-saving treatment. PEPFAR's success is also evident through recently completely national surveys showing countries reaching HIV epidemic control (ICAP PHIA).[10] The impact of PEPFAR is profound in lives saved but also in the ability to effectively control an epidemic without a vaccine. Paradoxically, this success is now seen, by some, as a liability. On January 27th, access to PEPFAR platforms was blocked including access to databases which hold 22 years of information on the highly acclaimed U.S. funded HIV response.

The impact of the administration's stop work orders are most acute in programs like PEPFAR where access to daily treatment is essential to minimize the risk of developing drug resistance, mother to child transmission of HIV, malaria and tuberculosis control, and emergency nutrition programs. On February 1st, PEPFAR received a limited waiver to continue life-saving HIV services, including treatment, Prevention of Mother to Child Transmission (PMTCT), and HIV testing but much damage had been done in the preceding days. Patients

were uncertain if drugs would be available and with the dismantling of USAID, integral community programs which assist clients to access and remain on treatment ceased activities. Many healthcare workers who provide clinical care would no longer receive their salaries and travel to supervise the work at clinics and hospitals was abruptly halted.

The purpose of this white paper is to report the findings from an online survey aimed at understanding the landscape of global health projects affected by funding cuts, characterize these effects, and gather the perspectives of stakeholders associated with these projects and the impact of these cuts directly on program staff and the target populations of the funded projects. The survey is meant to gather information in the immediate aftermath of the funding cuts, garner immediate reactions from key stakeholders, and inform policy makers and officials on the wide range of consequences associated with policy decisions relative to individual health outcomes, the state of development in fragile and low resource settings, and potential downstream effects on trust of U.S. partnerships and national and international security.

METHODS

Design

We conducted a cross-sectional online survey of individuals with a role in a funded global health project from an international agency or country, which was administered using SurveyMonkey and disseminated for convenience sampling through the Consortium of Universities for Global Health (CUGH) newsletter and by email distribution list from April to June 2025. The survey was primarily distributed through a newsletter with an approximately 40,000-subscriber list globally. However, the specific reach of the survey within the newsletter is unknown and likely reaches a wider audience.

Measurement

The anonymous survey contained 17 items including 4 questions delineating partner countries, funding source, and funding disruption; 5 multi-select questions of broad categorizations of project dimension, theme, good will, donor country benefit, and downstream effects of funding disruption, as well as 8 open-ended questions to discern details about project focus, funding disruption impact on community and staff, potential program response by implementing and donor partners to mitigate negative impact of funding disruption, recommendations to strengthen global health partnerships and avoid future disruptions, and additional thoughts. The survey was developed with iterative feedback among key members of a CUGH working group over three weeks in March 2025. The survey was created in English and translated into French, Spanish, and Portuguese, refined in these languages by fluent speakers, and back translated with the use of DeepL, a high-accuracy neural machine translation service, to ensure that the original meaning and key terminology were retained.

Analyses

Quantitative Analysis

Descriptive statistics were computed by aggregating responses into percentage distributions representing the proportion of total surveys or subgroup respondents who selected each response category.

Qualitative Analysis

Free-text responses, which allowed respondents to provide voluntary comments, were systematically reviewed and analyzed to extract prominent themes, providing insights into the underlying perspectives shared by respondents. Notable comments and additions that were particularly illustrative or representative of broader respondent perspectives were selected based on their relevance, clarity, and ability to provide deeper insights into the quantitative findings. These comments were then discussed in the context of the overall study findings.

RESULTS

The survey was completed by 97 respondents, the overwhelming majority of whom were affiliated with programs funded by the U.S. (n=85, 89.5%). Other donor countries included Bangladesh and Canada (n=2 each, 2.1%), as well as six respondents grouped under “Other” (n=6, 6.3%), representing Ethiopia, Kenya, Nigeria, Norway, Switzerland, and Tanzania. Respondents reported partnerships spanning 47 unique countries, reflecting how deeply interconnected global health collaboration is.

Analysis by Survey Category

Partnerships. Partnerships covered all six World Health Organization (WHO) regions: Africa (21 countries), Americas (11), South-East Asia (4), Europe (3), Eastern Mediterranean (3), and Western Pacific (5). The most frequently cited partner countries were Nigeria and Bangladesh (n=9 each, 6.7%), followed by Tanzania and Uganda (n=6 each, 4.5%), Kenya and Nepal (n=5 each, 3.7%), and Ethiopia and Guatemala (n=4 each, 3.0%). From the African region, respondents reported working in a wide array of countries: Nigeria, Tanzania, Uganda, Kenya, Ethiopia, Botswana, Zambia (n=3 each), Ghana, Malawi, Mozambique, Sierra Leone, South Africa, and South Sudan (n=2 each), as well as Burkina Faso, Cameroon, Democratic Republic of the Congo, Gambia, Lesotho, Liberia, Namibia, and Senegal (n=1 each). In the Americas, partnerships included Guatemala (n=4), Brazil, Canada, Haiti, and Mexico (n=2 each), along with Bolivia, Colombia, Dominican Republic, Honduras, Peru, and Trinidad and Tobago (n=1 each). In South-East Asia, respondents worked in Bangladesh (n=9), Nepal (n=5), India, and Thailand (n=1 each). In the European region, partnerships were reported with Armenia, Norway, and Ukraine (n=1 each). From the Eastern Mediterranean, collaborations included Egypt, Pakistan, and Saudi Arabia (n=1 each). In the Western Pacific, partner countries included Cambodia, Indonesia, Papua New Guinea, Philippines, and Vietnam (n=1 each). Among partner countries, there was particularly strong representation across Sub-Saharan Africa, South Asia, and Latin America. This broad geographical representation highlights the extensive global reach and impact of the initiatives included in the survey.

Donor Agencies. The most frequently reported donor agencies were USAID (n=43, 44.3%) and the National Institutes of Health (NIH) (n=33, 34.0%), with several respondents specifying sub-agencies including the National Institute of Mental Health (NIMH) (n=4, 4.1%), Fogarty International Center (FIC) (n=3, 3.1%), and the National Cancer Institute (NCI) (n=3, 3.1%). Other U.S.-based sources included PEPFAR (n=5, 5.2%), the U.S. Centers for Disease Control and Prevention (CDC) (n=4, 4.1%), and other government donors (n=4, 4.1%).

Respondents also identified a wide array of non-U.S. and multilateral donors (n=33, 34.0%) under the “Other” category. These included the Bill and Melinda Gates Foundation, Global Fund, Australian Aid, UK Aid, Canadian Institutes for Health Research, Chinese government and NGOs, Norwegian Government, Saudi Arabia Government Aid, UNAIDS, UNICEF, World Health Organization (WHO), as well as support from universities, the private sector, military and government agencies, and several international NGOs.

Funding Disruption. When asked whether their funding had recently been disrupted, 79 respondents (81.4%) reported “Yes”, while 16 respondents (16.5%) reported “No”, and 2 respondents (2.1%) selected “Other” but clarified that funding had been disrupted.

Project Characterization. The majority of respondents characterized their projects as involving Research (n=60, 61.9%). Respondents were allowed to select multiple categories for this dimension, and several other key focus areas emerged. Health Systems Strengthening / Capacity Building was selected by 52 respondents (53.6%), while Service Delivery was reported by 29 respondents (29.9%). Policy & Governance was cited by 17 respondents (17.5%). Responses not captured by the predefined categories (grouped as “Other”) included themes such as democracy, economic growth, education and training, environmental initiatives, knowledge management, publishing, quality improvement, nutrition, public health, research capacity building, and

resilience building. These diverse survey responses indicate the varied and often interdisciplinary nature of global health work. The survey's open-ended responses describing project focus illustrate considerable diversity of initiatives. There is representation across clinical, health systems, population, and implementation domains.

Project Categorization. Many respondents categorized their projects under **Infectious Diseases & Emerging Health Threats** (n=47, 48.5%), which we defined as focusing on communicable diseases (e.g., HIV/AIDS, TB, malaria), pandemic preparedness, vaccine development, and antimicrobial resistance. Approximately 16.5% of projects addressed HIV/AIDS prevention and clinical care (several initiatives centered on pre-exposure prophylaxis [PrEP] and long-acting anti-retroviral [ARV] delivery). Other projects aimed to address tuberculosis, malaria, and vaccine development, while others focused on zoonotic spillover, avian influenza, and antimicrobial resistance via surveillance and laboratory strengthening. The projects highlight a mix of implementation science, training and leadership development, machine learning innovation, and service delivery models across diverse settings and populations, including vulnerable communities, adolescents, and women living with HIV. One respondent states, *"The Nigeria Nurse Leadership Initiative aim was to elevate HIV nursing practice by empowering nurses with leadership and technical skills essential for sustaining progress in the fight against HIV/AIDS and contribute to the United Nations goal of ending HIV by 2030."* One project was a *"Behavioral RCT* [randomized control trial] *to promote PrEP and contraception for young sexually active women"*

The second most common category was **Reproductive, Maternal, Newborn, Child & Adolescent Health** (n=35, 36.1%), encompassing sexual and reproductive health, family planning, maternal and neonatal care, early childhood development, and adolescent health. These projects span a broad range of maternal, child, and adolescent health initiatives, focusing on sexual and reproductive health, HIV prevention, nutrition, mental health, and perinatal care in low-resource settings. They include community-based interventions, health systems strengthening, clinical research, and innovative tools to improve outcomes in neonatal care, maternal mortality, adolescent sexual and reproductive health (ASRH), and vulnerable child populations across diverse global contexts. Examples include *"Engaging adolescents and other stakeholders to explore factors related to adolescent sexual and reproductive health and plan and implement local actions to promote good ASRH." Another project was a "Nutritional intervention to help prevent environmental enteric dysfunction and subsequent malnutrition and child developmental problems."* Another project aimed to reduce Neonatal Mortality through introducing evidence-based practices by *"Reducing perinatal mortality for small and sick newborns with NEST360 intervention package."* Finally, one *"proposal seeks to improve mental health, pregnancy, and HIV outcomes among pregnant and postpartum women living with HIV with common mental health disorders in Kenya."*

Following, **Non-Communicable Diseases (NCDs), Mental Health, & Trauma**, was chosen by 26 respondents (26.8%) and refers to programs tackling chronic conditions such as cardiovascular diseases, cancer, and diabetes, as well as mental and behavioral health challenges. NCD-focused projects covered cardiometabolic risk, epilepsy, diabetes, and hypertension, often in combination with other service delivery platforms like maternal care or emergency response. Some projects explored sleep interventions, chronic condition management, or health systems responses to rising NCD burdens. At least four projects specifically targeted cervical cancer screening, prevention, and education, with some leveraging vaccine outreach, exploring the progression from human papillomavirus (HPV) infection to cancer, through integration with human immunodeficiency virus (HIV) care. One respondent described their cervical cancer project as, "*Investigating the reasons why women some* [sic] *who have HPV get cervical cancer and others do not and how to make women more likely to prevent cervical cancer with vaccines and education.*" Regarding Mental Health and Psychosocial Support, several projects explored the intersection of mental health with HIV, displacement, and gender-based violence. Peer support and community-based care models were recurring themes, along with interventions for refugees and adolescents. One person stated the following, *"Our proposal seeks to improve*

mental health, pregnancy, and HIV outcomes among pregnant and postpartum women living with HIV with common mental health disorders in Kenya. We will tailor a collaborative care model for peripartum women with HIV experiencing mental health symptoms and evaluate its impact on their mental health, antenatal, and HIV care outcomes." These projects span a wide range of clinical, behavioral, and implementation research areas, including mental health, trauma care, chronic disease prevention, surgery, addiction, and cervical cancer. One project was described as a *"grant supported peer-to-peer counselling for person* [sic] *with opioid or amphetamine use challenges. The abrupt discontinuation of funding adversely affected both our department and statewide 'recovery coach organizations', led to firing several excellent employees, and radically reduced the availability of peer-to-peer counselling services."*

Nutrition, Food Security, & Metabolic Health (which deals with nutritional deficiencies, obesity, food systems, and metabolic health) was the focus in just under 23% of projects (n=22, 22.7%). Some projects in this category included: a "*Nutritional intervention to help prevent environmental enteric dysfunction and subsequent malnutrition and child developmental problems,"* a project that was *"Improving care and mortality rates for neonates and children with severe acute malnutrition,"* and "*Global Food Security through climate smart ag* [sic] *practices."* These projects reflect thoughtful, well-planned efforts to integrate services, apply novel technologies, support marginalized populations, and mitigate disparities across diverse global and domestic contexts.

Significantly, **Health Systems** was selected by 34 respondents (35.1%) and covers efforts aimed at strengthening health infrastructure, health informatics and data reporting, and human resources. Projects in this category emphasized capacity building, health governance, monitoring systems, and community-based accountability mechanisms. Many described technical assistance to ministries, leadership training for nurses, and expansion of workforce readiness, including pre-service and in-service training across multiple domains. One project describes that it *"would work with the government's public health system to improve quality of services - through human resource capacity development, and governance through improving the monitoring system and strengthening community accountability mechanism."* Another project was focused on *"Health systems strengthening technical assistance to bolster effectiveness of public health systems in Bangladesh."*

In particular, over 8% of all projects were focused on primary care access and community engagement. Projects in this domain emphasize community-rooted service delivery, equitable access, and locally informed strategies to improve population health. One example was a project that focused on *"Primary Care for all individuals in a Mountain Valley region of Honduras."* Another stated that *"The main focus of the project was to strengthen Community Health Management Committees (CHMCs) on their roles, responsibilities on COmmunity-based* [sic] *Health Planning and Services (CHPS) to demand quality services from providers in deprived settings."* Another described a *"Family health strategy that will be led by the family and community doctor in order to have a realistic diagnosis of the health of a given area and what strategies should be implemented to address [a] problem."*

Over 5% of the projects were focused on workforce development and retention. These initiatives focus on training, mentorship, capacity-building, and sustainable workforce expansion across levels of the health system. The *"Focus was treatment to patients, capacity building of health workers and health services,"* stated one project. Another indicated a focus on *"In service training for health professionals in disease surveilance* [sic] *and emergency response"* while another was focused on *"Training pre hospital personnel."*

As well, over 4% of projects focused on health policy, regulation and reform as well as accountability & transparency. Projects under this theme explore how data systems, monitoring, and public governance reforms influence service quality and accountability. One project described a focus on *"capacity strengthening and data dissemination to inform health policy and financing decisions at the country level and to inform global investments."*

Meanwhile, **Social Determinants** (n=28, 28.9%) included projects addressing health disparities and incorporating social determinants such as education, gender, and economic factors. Some programs here target social determinants, chronic disease inequities, and access gaps affecting migrants, refugees, and underserved communities. Projects were described as addressing *"Social determinants of migrant mental health"* and *"mental health in refugees."* Several projects also specifically address the needs of key populations—such as adolescents, low-income women, and marginalized communities—while integrating services like mental health care and gender-based violence (GBV) prevention. One respondent stated, *"The project was an implementation science study of the delivery and sustainability of an intervention to prevent intimate partner violence in Nepal."* Another respondent was *"Applying machine learning to identify factors associated with PrEP non-adherence for key populations (MSM and Transgender) in Thailand."* This thematic cluster includes both direct service delivery and policy or implementation research to strengthen long-term access and equity in SRH systems. In addition, there was a focus on Global Health Education & Partnerships reflecting collaborative learning, knowledge transfer, and institutional strengthening across borders and sectors, such as *"Capacity building in Egypt and involving the academic and private sectors into collaboration"* and projects that focus on ideals such as "*Long-term commitment"* and *"Transparent partnership."*

Some **Other Projects** focused on climate adaptation & resilience. This theme focuses on efforts to strengthen the ability of communities—particularly vulnerable or marginalized groups—to adapt to climate-related challenges. Projects emphasized long-term resilience, environmental health, sustainable livelihoods, and locally driven solutions to climate vulnerability such as severe flooding and drought. One project was focused on *"Resilience building for pastoralist community".*

Other projects focused on Information Technology & Biomedical Engineering Technologies. These themes highlight the growing role of technological innovation in improving health outcomes, service delivery, and public health research. Projects span from artificial intelligence and machine learning applications to the development of low-cost biomedical devices tailored for resource-limited settings. One project described the *"Development of a low cost obstetric bleeding device and mechanical infusion device"* while another stated that they were *"Developing a computer vision model to detect built environment features and predict pedestrian road traffic collisions in Bogota"*

Nearly 15% of project descriptions explicitly detailed core activities pertaining to **Research Training,** including capacity building in implementation science. This thematic area includes programs focused on research training, mentorship, institutional capacity strengthening, and the development of early-stage investigators, particularly in global health and under-resourced settings. Many initiatives are grounded in implementation science, aiming to bridge the gap between evidence and practice while equipping professionals with the tools to conduct context-relevant, policy-informing research. These efforts often combine technical assistance, career development, and hands-on support for dissemination and system-level improvement. Highlighted projects include *"Nigerian HIV nursing leadership and scholarship development"* as well as "*Global health research training for university student* [sic]*"* and *"Training of emerging leaders in global health research"*

The responses reflect a rich focus of global health programming, ranging from infectious disease control and maternal health to systems reform, research training, and technological innovation. Projects often intersected across multiple domains, illustrating how global health efforts are integrated across clinical care, implementation science, workforce development, and policy transformation. This breadth underscores both the diversity of global health priorities and the far-reaching consequences of funding disruptions.

Thematic Analysis

Goodwill

Respondents were asked to indicate all the ways in which the funding opportunity fostered goodwill between the recipient country and the donor agency or country. The most commonly reported benefits included Local Empowerment (n=62, 63.9%), Mutual Innovation and Collaboration (n=57, 58.8%), Transparent Partnership (n=49, 50.5%), Visible Community Impact (n=49, 50.5%), and a sense of Long-Term Commitment (n=47, 48.5%). Other frequently cited benefits included Cultural Exchange (n=30, 30.9%) and Enhanced Diplomatic Engagement (n=29, 29.9%). A small number of respondents selected “Not Applicable” or “Prefer not to answer” (n=5, 5.2%), and two respondents (2.1%) wrote in “Strengthening Global Health Security” as an additional source of goodwill. These open-ended responses emphasized the value of collaborative international research on diseases with geographic spread potential, South-to-South engagement, and improved global health and safety communication and responsiveness.

Benefits to Donor Country

Respondents also identified ways in which the funded project directly benefited the donor country. The most commonly cited benefit was Scientific and Research Advancements (n=63, 64.9%), followed by the creation of Job Opportunities (n=45, 46.4%). Other frequently noted benefits included Enhanced Global Health Security (n=41, 42.3%), Talent Exchange and Capacity Building (n=41, 42.3%), and Strengthened Diplomatic Relations (n=25, 25.8%). Additional benefits included National Security Enhancements (n=18, 18.6%) and Economic and Trade Benefits (n=14, 14.4%). A small number of respondents selected “Not Applicable” or “Prefer not to answer” (n=6, 6.2%), while two respondents (2.1%) offered additional responses under “Employment Opportunities”, suggesting an emphasis on job-related benefits. Previously reported “Other” benefits—such as improved health policies and capacity building, global food security, reduced need for migration, enhanced healthcare outreach, improved population health and welfare, person-to-person development, and resource sharing—further underscore the broader and often reciprocal impacts of global health funding on donor countries themselves.

Negative Downstream Effects

Respondents identified numerous potential negative downstream effects of donor funding disruptions. The most frequently cited consequences were diminished local workforce training and disrupted health services resulting in increased morbidity and mortality (n=58 each, 59.8%), followed closely by the loss of local expertise (n=56, 57.7%). Nearly half of respondents also noted strained international partnerships (n=45, 46.4%) and the erosion of donor credibility (n=44, 45.4%) as major concerns. Additional commonly reported effects included an increased global epidemic risk (n=36, 37.1%), economic downturn in communities (n=32, 33.0%), lowered crisis response capacity (n=30, 30.9%), and increased vulnerability to extremist narratives and heightened risk of extremist recruitment (n=22, 22.7%). A smaller number cited heightened security threats (n=16, 16.5%). A few respondents (n=3, 3.1%) selected “Not Applicable” or “Prefer not to answer”, while others contributed additional write-in concerns such as the disruption of health services leading to morbidity and mortality (noted separately by 3 respondents), along with qualitative mentions of lost access to natural resources, knowledge silos, inequitable publishing structures favoring well-funded institutions, strained domestic community partnerships, reduced scientific advancement due to stalled early-career training, and large-scale health data being left unused. These findings highlight not only the immediate programmatic and health-related harms of disrupted funding but also the broader geopolitical, scientific, and social ripple effects that can undermine trust, partnerships, and global stability.

Reflective comments include the following:

Downstream Impact \ Impact on Staff

"More than 100 project staff have suddenly been terminated and face a situation where immediate finding of a new job is quite bleak in the face of many similar projects being terminated at the same time. Some of these staff had left other jobs to join the project, some declined the opportunity to move into new jobs considering this project as a long term and substantial one. Some of the staff are at the beginning of their professional career, and an experience like this is frustrating. Most of the staff are mid-career, and have families - especially young children in education, to support. In absence of a state provided Social Security system, many families are likely to struggle to meet their needs and may even be forced to stop their children's education or shift them to lesser quality institutions."

"The project staff, who thought they had jobs for several more years, will be terminated. This will reduce capacity building efforts, training, and economic stability for the staff on the project."

"Our local staff is now a group of highly trained researchers and nurses whose expertise we rely on to carry out all sorts of studies at the site on infectious disease and vaccine safety. Ongoing study funding supports our staff with continued employment, improving life in the community for the families of our staff and helping to retain talent locally. Grants also help us provide ongoing healthcare services in the community, including safe births."

Downstream Impact \ Health Service - Disruptions

"The participants will lose access to HIV and other SRH services through the intervention which may lead to HIV infections, STIs, and unplanned pregnancies."

"Millions of TB patients treatment is* [sic] *disrupted. Child feeding programs suspended. Women cannot access clinics for childbirth."

"All Family Planning, HIV testing and treatment supplies were provided by the Haitian Ministry of Health and Population (MSPP). When USAID funds were cut, so were the Family Planning, HIV testing and treatment supplies. New patients cannot be tested for HIV, and there are no ARVs for treatment of HIV+ patients. Patients are already suffering from secondary illnesses and some have died. Other patients no longer have access to Family Planning products, and the birth rate will increase for mothers who do not wish to have more babies."

"The project had the potential to guide policy on anti-corruption in the procurement of health services. The disruption of funding resulted in no guidance for local decision-makers on how to accomplish the reforms. Corruption will continue to mar the contracting process, resulting in higher costs, slower contracting process, and fewer services available to treat TB in the population."

Downstream Impact \ Local Workforce - Decreased Training

"The improvement in services has been well appreciated by community members during management visits. However, the planned training, which would have contributed to further and more holistic capacity

building, had not been fully completed due to termination of the project. During our follow up visits - after the notification of termination, the communities expressed their frustration that the process had not been completed and fear that even the improvement experienced would be lost without a total system capacity building - which was undergoing in the project."

"Students no longer have a program that provides global health training and out of state mentored research experiences. The goal of such activities was to encourage students to continue their academic studies. Our track record of 66% of students continuing on to graduate studies will reduce students who continue on to graduate research and global health studies."

"...the planned training, which would have contributed to further and more holistic capacity building, had not been fully completed due to termination of the project.

"The study has not continued the staff contracts, and the clinical staff trainings in infant surface exam and congenital abnormality detection and management have ceased."

Harm

Respondents emphasized that the funding disruptions caused tangible harm—not only to individual study participants who lost access to essential services like HIV and sexual and reproductive health care, but also to the broader communities that relied on these interventions. The sudden withdrawal of support fractured trust, derailed research dissemination, and left communities vulnerable to negative health outcomes such as increased HIV transmission and unplanned pregnancies. Beyond the immediate local impact, respondents warned of lasting damage to international relationships, credibility, and even U.S. national interests, with some stating the harm may endure for decades.

Reflective comments include the following:

"The funding disruption will hurt both the active participants in the study, as well as the community who would benefit from the research."

"Nothing can help the damage. Foreign governments and collaborators lost trust in the U.S. and the damage will be felt for decades to come.

"Making such sudden and dramatic cuts is hurting the US's national interests and security."

"The repercussions of these cuts will without a doubt cause increased morbidity and mortality. The implications for how America is viewed are huge. There will be widespread resentment for failed promises and cruel funding disruptions. Anti-American sentiment is almost certain because of these funding cuts. People's live [sic] *are in jeopardy and should not be destroyed due to the whims of our current administration."*

Loss of Trust

Respondents underscored a profound loss of trust stemming from the funding disruptions, affecting relationships at multiple levels—from local communities and health workers to global partnerships.

Community-based initiatives, particularly those involving long-standing collaborations around HIV prevention, were abruptly cut off, eroding years of relationship-building. Local staff lost jobs, interventions were paused, and confidence in both U.S. institutions and healthcare systems diminished. Some respondents expressed a complete breakdown in trust toward the United States as a global health leader, calling for new models to take its place to avoid future instability.

Reflective comments include the following:

"We have been working with communities to set up innovative ways to deliver PrEP to youth. Communities are excited about the project. The funding disruption and potential need to terminate the funding breaks trust between researchers and community members and could increase barriers to HIV prevention. If we stop at this stage of the project, we would need to start all over building community relationships and developing strategies."

[Editor's Note: PrEP (pre-exposure prophylaxis) is daily dosing of antiretroviral medication for people who do not have HIV to reduce their chance of infection. When taken as prescribed it cuts the risk of sexual HIV transmission to near-zero.]

"An effective prevention intervention is stalled, local staff have lost their jobs, and trust has been lost with the community agencies and individuals which had built up over 9 years."

"The disruption will lead to increased unemployment rates in Egypt, loss of trust in the U.S., and cut of funding and jobs at the U.S. partnering U.S. universities."

"Develop a broad international global health entity that is not dependent on the United States, perhaps run from the UN (like a dramatically strengthened WHO with a strong research component the size of NIH) that can operate totally independently of the United States. Never, ever trust the US again to lead this effort."

"The United States is unreliable as a partner. The rest of the world, most importantly Europe, Japan and China must step up and in a coordinated fashion fill the gap. Even as an American, I would never again trust the United States to lead global health."

"The United States should never, ever be allowed to lead a major global health effort. Trust lost. Move on."

"Decreased community confidence in healthcare staff (due to stock-outs of anti-tuberculosis drugs) and non-payment of performance bonuses to mid-level staff."

"We have worked extremely hard to establish trust with the participants and the community. The disruption has caused major distrust in the community and resentment towards the American government, who had committed to providing funding for the work and now are (unjustly) reversing those commitments."

"It is unconscionable that we have a system in place one day and not the next. No program of research works efficiently and effectively under those conditions. We need to make commitments and stick by them and keep the pipeline moving as research with global partners takes years to build but only hours to destroy."

Chaos

Respondents described a sense of chaos resulting from the funding disruptions, with confusion and disorder affecting both ongoing and planned research activities. Projects addressing critical health concerns—such as HIV, mental health, and maternal care—were thrown into uncertainty, jeopardizing collaborative international efforts. The loss of funding not only disrupted scientific progress but also contributed to broader disorientation within affected communities and research teams. This atmosphere of instability undermined trust, halted momentum, and left stakeholders unsure of how to proceed.

Reflective comments include the following:

> *"Created confusion, project disruptions."*

> *"Staff had made plans to receive the student and faculty, rearranged scheduling, and were planning a collaborative QI project that is now put on hold."*

> *"As a scientist that just finished their PhD and is beginning their career in this field, it is devastating to see it be eroded before my eyes. I worked/studied for 10+ years to do engineering globally and was excited to begin my career, but now funding mechanisms are disappearing & the field will suffer. I do have hope that this will allow for more local capacity building, and I am considering moving abroad (I am a US-born citizen) and being a part of that work, since I can't continue to do it here in the U.S. I feel for all of the fellow professors that are just starting out, the MPH students who just graduated, and the established professors trying to secure their labs' futures."*

"Devastating is the best way I can put it."

Funding Cuts Process Resulting in Waste

Respondents highlighted how abrupt funding cuts led to significant waste of time, resources, and human capital. Salaries were withheld, staff faced termination, and carefully established community partnerships and service delivery strategies—such as those for PrEP—were left incomplete or abandoned. The sudden nature of the cuts, implemented without advance notice, not only halted progress but also threatened to undo years of groundwork, with long-lasting negative implications for both local communities and global health outcomes.

Reflective comments include the following:

> *"The project investigators have not been able to receive their salaries. The staff they have hired may need to be let go soon. The work they have done building community relationships and setting up strategies to deliver PrEP will be wasted."*

> *"The global damage that has been caused by this irresponsible sudden cutting of funding, without any warning, will be felt for years to come."*

Anger

Several respondents expressed deep frustration and anger over the abrupt funding disruptions, describing a sense of betrayal and broken trust, particularly toward U.S. institutions that had previously committed support. Communities and staff had invested significant time, resources, and coordination into collaborative efforts—only to have those initiatives paused or canceled. There was a strong call for accountability, with

respondents emphasizing that existing commitments should be honored and upheld, regardless of shifting donor strategies or political climates.

Reflective comments include the following:

> *"The funding disruption will hurt both the active participants in the study, as well as the community who would benefit from the research. We have worked extremely hard to establish trust with the participants and the community. The disruption has caused major distrust in the community and resentment towards the American government, who had committed to providing funding for the work and now are (unjustly) reversing those commitments. The participants will lose access to HIV and other SRH services through the intervention which may lead to HIV infections, STIs, and unplanned pregnancies. The community expected us to complete the study and disseminate research findings. This will no longer happen, which again, causes frustration and distrust towards American researchers and USA overall. There was a prior sense of appreciation for the research support and capacity building, which is now eroding. Participants and the community are confused and angry."*

> *"Commitments that have been made, must be honored. And future strategic planning can realign goals without canceling that which has been committed."*

National and International Security

Respondents raised urgent concerns that abrupt funding cuts undermine both national and international security. In regions already facing extreme instability—such as Haiti—these disruptions jeopardize the lives of millions who depend on critical health services. Respondents warned that weakened global health systems reduce the capacity to detect and respond to infectious disease threats, increasing the risk of cross-border outbreaks. Additionally, the sudden withdrawal of U.S. support was seen as damaging to America's global influence, creating openings for geopolitical rivals to fill the void and eroding trust in U.S. leadership on the world stage.

Reflective comments include the following:

> *"The decision from the US government to cut funding poses a real threat to US security, leaving a gap to be filled by others who do not share US values and interests. This will lead to a diminished US influence globally, which is a negative outcome, as America is the leader of the world."*

> ***"The funding disruption put the lives of more than 12 million people at risk in a context where Haiti is facing one of the most critical security situations in its history, where people desperately need such support."***

> *"The objective was to build a global health security architecture for early detection, response and mitigation of emerging infectious disease and antimicrobial resistamce* [sic]*. Withdrawal of funding will heavily impact coutry capcity* [sic] *detect and mitigate outbreaks and trsnsboundary* [sic] *spread of disease putting millions at death and disease risk."*

> *"Making such sudden and dramatic cuts is hurting the US's national interests and security"*

Strengthening Global Health Partnerships

Respondents voiced recommendations regarding timely, appropriate, and effective next steps and future considerations. There was a desire to prioritize community needs through locally led, sustainable interventions

that build domestic capacity—not dependency—and elevate the leadership and flexibility of Global South universities and schools of public health to reduce reliance on U.S.-based actors. There was a clear consensus that building local capacities to support ongoing efforts is essential to long-term sustainability of all partnerships. In order to sustain the impact and retain the effects of prior effort, it is recommended that bridge funding be applied in order to thoughtfully transition when and if project and governmental priorities change. Respondents recognized the need for ongoing rigorous and thorough assessments of programs and advised the development of road maps toward improvements that minimize disruption while maximizing long-term impact.

> *“Be clear about community needs being priority, and build in ways that allows the community to grow to meet needs locally."*
>
> *“Increase the role for and better leverage the flexibility of southern-based universities and schools of public health to diversify the reliance on US-based groups."*
>
> *“Immediate bridge funding is needed to ensure that the projects are able to continue and finish out their objectives and promises in local communities."*
>
> *“The interventions should be locally generated and sustainable based on the level of development of the recipient nations. Greater focus needs to be on development of local capacity NOT dependency on foreign aid."*
>
> ***“Commitments that have been made, must be honored. And future strategic planning can realign goals without canceling that which has been committed."***
>
> *“I'm in favor of thorough assessment of the programs, but impactful programs should be maintained, and those that are not should have a clear roadmap to improvements."*
>
> *“Transition our if [sic] funding should be taken strategically and not disruptive, consider respectful and mutual understanding of partnerships"*

DISCUSSION AND CONCLUSION

The survey of 97 global health professionals reveals a vast and deeply interconnected network of partnerships across 47 countries and all six WHO regions. These partnerships—predominantly supported by U.S. funding—demonstrate the geographic breadth and sectoral diversity of global health initiatives. Projects spanned multiple domains, from infectious diseases and reproductive health to non-communicable diseases, climate resilience, and biomedical engineering. The majority of initiatives were categorized under research, health systems strengthening, and service delivery, with many emphasizing interdisciplinary approaches and the integration of community engagement, implementation science, and policy reform. This thematic complexity underscores the multifaceted nature of global health work and the essential role of long-term, stable funding in sustaining progress.

Beyond technical and service achievements, respondents highlighted substantial mutual benefits generated by global health funding. These included strengthened diplomatic relations, talent exchange, job creation, and scientific advancement for both recipient and donor countries. Respondents also emphasized the goodwill fostered through local empowerment, transparent partnerships, and community engagement. Notably, over 60% pointed to local empowerment as a core achievement, with many citing strengthened workforce development, capacity-building for emerging leaders, and research mentorship as critical outcomes. The

survey findings affirm that global health funding extends far beyond transactional development aid—it catalyzes long-lasting infrastructure, knowledge sharing, and mutual trust between nations.

However, these collaborative gains are now under threat. The abrupt suspension or withdrawal of funding has had wide-ranging downstream effects, including disrupted health services, stalled research, and job losses. Respondents described increases in morbidity and mortality, reduced training opportunities, and loss of local expertise as immediate consequences. The termination of HIV and reproductive health services, in particular, was noted as especially harmful, with respondents citing community-level suffering, increased vulnerability to disease, and broken commitments to program beneficiaries. These disruptions were also framed as undermining progress toward Sustainable Development Goals and destabilizing health systems in fragile settings.

The emotional and relational toll of funding disruptions was profound. Respondents described a widespread loss of trust in donor agencies—especially the U.S.—emphasizing how years of relationship-building were upended in moments. This breakdown in trust extends from local health workers and communities to national ministries and international academic partners. Respondents emphasized that such abrupt reversals not only harmed immediate program beneficiaries but also damaged the United States' credibility as a global health leader. Many called for alternative, more reliable international structures for health funding and coordination to reduce future volatility.

One of the consequences of U.S. disengagement from global health may indicate waning U.S. leadership on the global stage. Respondents emphasized that such withdrawal creates a vacuum that may be filled by other actors, whose values and strategic interests may diverge significantly from those of the U.S. This not only risks diminishing America's soft power and global influence but also poses broader implications for global stability, health security, and diplomacy. The framing of the U.S. as a global leader suggests that its sustained investment in global health is seen as both a moral and strategic imperative. Certainly the partners will be looking elsewhere to ensure that these gaps are filled.

Finally, the data reveal that these funding disruptions have implications far beyond health outcomes. Respondents warned that weakened global health systems can lead to broader geopolitical instability, increased vulnerability to extremist recruitment, and diminished global epidemic preparedness. From a national security perspective, the U.S. stands to lose strategic influence and soft power if funding instability continues. Disengagement decreases US knowledge of emerging health threats and changing disease patterns. The ability to respond timely will be diminished as the U.S. stance moves from being proactive to reactive. The findings offer a compelling case for rethinking how donor countries structure and sustain their global health commitments. Stability, transparency, and long-term investment are not only ethical imperatives—they are strategic necessities for both global well-being and international security. Weakening health systems, surveillance networks, and infrastructures that prevent the spread of infectious diseases ultimately increases threats to U.S. health security and global trade. The humanitarian gains, soft-power benefits, and protection of U.S. and global interests far outweigh the relatively small costs—especially when transitions follow documented best practices implemented at scale.

While the suddenness of cuts causes the most damage, this moment can also be a call for LMICs to assume greater local leadership and sustainability through responsible, non-disruptive transitions that restore funding in a measured, strategic way, honor commitments, provide bridge financing, and invest over the next five years in documenting evidence and scaling what works.

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