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Global health consequences of the 2025 US foreign aid freeze: rapid assessments in Colombia, Kenya and Nepal

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ABSTRACT

Introduction In January 2025, the Trump Administration announced a 90-day freeze on all US government (USG) foreign aid, which subsequently became a permanent shutdown of the US Agency for International Development in July 2025. The sudden withdrawal of USG financing disrupted health and humanitarian systems worldwide, with disproportionate impacts on women, girls and other marginalised populations. This study documents impacts of the funding freeze during its early months (February–March 2025) on global health programmes.

Methods This rapid mixed-methods assessment combined a global online survey with qualitative case studies in Nepal, Kenya and Colombia. The survey was distributed via email through networks and relevant listservs. Semistructured key informant interviews (KIIs) (n=53) were conducted with non-governmental organisation leaders, clinicians, community health workers, government officials and humanitarian actors, all purposively selected based on their direct or indirect involvement in USG-funded health programmes. Interview transcripts were thematically analysed and triangulated with quantitative findings.

Results Survey respondents reported initial impacts of the USG funding cuts across health sectors and functions, including humanitarian and emergency response/preparedness, gender-based violence and mental health and psychosocial support. Five key themes arose from the KIIs with stakeholders in three case study countries: disruptions to sexual and reproductive health and rights (SRHR) services, HIV service interruptions and treatment access, the collapse of referral networks and service ecosystems, a mental health crisis among clients and health workers and the rising vulnerability of marginalised populations. Both survey and interview data highlighted growing inequities and anticipated reversals in longstanding health gains.

Conclusions The 2025 US foreign aid freeze generated immediate and widespread disruptions across health and humanitarian systems, revealing systems-level vulnerabilities. These early findings point to the need for more diversified and reliable financing, stronger domestic preparedness and policy approaches that centre SRHR and marginalised populations.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ US foreign aid has historically been vital in financing essential health services in many countries, and evidence from prior policy shifts (ie, the Global Gag Rule) shows that restrictive US actions can disrupt sexual and reproductive health and rights (SRHR) services, partnerships and health system functioning.

WHAT THIS STUDY ADDS

⇒ This study offers insight into early on-the-ground impacts of the 2025 US foreign aid freeze, showing immediate disruptions across SRHR, HIV and maternal health services, alongside the collapse of referral networks and a dual mental health crisis among clients and health workers. It also documents disproportionate impacts on women, girls and marginalised groups, and reveals how the freeze exacerbated structural inequities in health and humanitarian systems.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Findings highlight the urgent need for diversified and resilient global health financing, stronger domestic preparedness and rights-based approaches to SRHR. Findings also emphasise the importance of rapid-response research mechanisms and localisation strategies to mitigate future policy shocks.

INTRODUCTION

Announced on 20 January 2025 as a 90-day pause for 'assessment of programmatic efficiencies and consistency with the United States foreign policy',[1] the Trump Administration's foreign aid freeze became a permanent shutdown of the US Agency for International Development (USAID) on 1 July 2025.[2] Up until that point, the US government (USG) was the world's largest contributor of foreign aid (40% of all humanitarian aid reported by the United Nations in 2024).[3] As the largest managing agency for foreign aid within USG, USAID disbursed US$44 billion in 2023, with 'health' and 'humanitarian assistance' as two

of the largest categories of funding (18% and 25%, respectively, in 2023).[4] A retrospective impact evaluation found that USAID-supported programmes saved 92 million lives in low- and middle-income countries from 2001 to 2021, including 30.4 million children under the age of 5.[5] This evaluation and forecasting analysis estimated that the dismantling of USAID will result in 14 million excess deaths by 2030.[5]

The Trump administration's America First Global Health Strategy, published in September 2025, reports a goal of transitioning public health programme ownership to recipient countries 'in a thoughtful and strategic way'.[6] However it is clear from many accounts that USG grants were frozen and ultimately terminated abruptly and with little to no warning, causing massive chaos and confusion.[7 8] Thus, there is a need to document real-time effects of changing US foreign aid policy on global health programmes, particularly for women and girls who are often the first to be left behind in a crisis.[9]

In February 2025, the Heilbrunn Department of Population and Family Health at Columbia University (PopFam) conducted a rapid assessment of the health impact of changes to US foreign aid globally as well as in three countries in partnership with the Center for Research on Environment Health and Population Activities in Nepal, policy/strategy group in Kenya and HIAS in Colombia. This paper presents perspectives from a pivotal moment in the policy transition: the first phase of funding termination, a time when many global health practitioners were still accessible (before widespread layoffs) and when funding freezes were still perceived as temporary (before becoming institutionalised). The findings offer early insights that have shaped recommendations for navigating drastic shifts in the funding landscape for global health, development and humanitarian response.

MATERIALS AND METHODS

This assessment used a mixed-methods design in order to capture both global impacts and country-specific experiences. An online survey was created in Qualtrics to rapidly assess the immediate impacts of changing US foreign funding policy on health organisations and practitioners globally. Survey domains included the scope and function of USG funding, funding disruptions, alternative sources of funding, programmatic shifts and perspectives on potential health outcomes as a result of funding changes (online supplemental file 1). The survey, launched 3 weeks after the initial pause on funding, was distributed via email in English, Spanish and French to PopFam's network of global health practitioners and other relevant listservs. Data were collected anonymously to provide privacy for respondents. Respondents could choose to identify their organisation, but were not required to due to the political sensitivity and potential organisational risks. Although 330 participants began the survey in Qualtrics, a total of 98 complete responses were recorded. The survey was available online 10 February–7 March 2025.

Table 1 USG funding metrics for case study countries

	Nepal	Kenya	Colombia
% 'Health' funding from USG before Jan 2025[21]	17	26	40
% 'Population Policies/ Programmes & Reproductive Health' funding from USG before Jan 2025[21]	54	61	8
% of USAID programming cut (March 2025)[22]	100	46	82
No. of KIIs conducted in this study	**18**	**16**	**19**

KIIs, key informant interviews; USAID, US Agency for International Development; USG, US government.

The three case study countries were selected because they had substantial USG 'health' and/or 'reproductive health' funding prior to January 2025 (table 1) and PopFam had existing partnerships in them.

Semistructured key informant interviews (KIIs) were conducted with a purposive sample of non-governmental organisation (NGO), government, civil society and health worker actors in February (Nepal) and March (Kenya and Colombia) in 2025 by the research partner in each country (table 1). An interview guide was developed with questions about USG-funded health programming, short-term and anticipated long-term consequences of the funding freeze, impacts on referral systems, partnerships and most-affected populations, and then adapted as needed by each country team (online supplemental file 2). In Nepal, participants represented NGO directors, programme managers, clinicians managing or implementing US-funded health-related programmes and departmental heads at the ministry of health and population. In Kenya, participants were identified through existing professional networks with a focus on cadres whose roles, funding streams or client populations were directly disrupted by the USG funding freeze (eg, HIV counsellors, supply-chain staff, community health workers (CHWs) and programme managers working with key populations and adolescents). In Colombia, the research team generated a list of organisations affiliated with humanitarian coordination groups or otherwise involved in the humanitarian health response, and invited at least one representative from each organisation to participate. In all three countries, participants were approached by telephone or email.

Trained interviewers conducted the KIIs in Nepali (Nepal), English and Swahili (Kenya) and Spanish (Colombia), and audio recorded them with participant consent. Interviews took place in private locations convenient for participants or over the phone. Most interviews lasted approximately 30–60 min. Thematic saturation was assessed and reached in each

Table 2 Key characteristics of survey respondents (n=98)

Respondent characteristic	n (%)
Organisation type*	
International NGO	36 (31.3)
Local NGO	21 (18.3)
University	15 (13.0)
Government	12 (10.4)
International organisations (ie, UN agencies)	12 (10.4)
Private sector	8 (7.0)
Health facilities	6 (5.2)
Foundation	5 (4.3)
Other	2 (1.7)
Geographical location of respondent	
Africa	21 (21.4)
North America	45 (45.9)
South America	9 (9.2)
Eastern Mediterranean	2 (2)
Europe	11 (11.2)
South-East Asia	5 (5.1)
Western Pacific	5 (5.1)

*Respondents could select multiple responses.
NGO, non-governmental organisation; UN, United Nations.

country (table 1). Interview recordings were transcribed and translated into English if needed. Identifying information was removed from the transcripts so that participants remained anonymous. Research team members at PopFam and the country partners used thematic analysis to analyse the qualitative data with themes that derived from the data, and then triangulated the findings with survey data to produce results.

RESULTS

Global practitioner survey

Survey respondents represented a range of organisation types and all regions, with the largest percentage based in North America (45.9%), Africa (21.4%) and Europe (11.2%) (table 2). When asked to list the countries in which the respondent's organisation works, 136 countries were mentioned.

A substantial majority (78%) of respondents reported that their organisation was receiving USG funds at the time that the Trump administration put a freeze on USG foreign aid (January 2025). Within this group, the function of this funding ranged from supporting capacity-building (74.0%), service delivery (63.0%), health systems strengthening (60.3%), social and behaviour change communication (53.4%), disease prevention and control (45.2%) and providing health commodities (34.2%) (figure 1).

Respondents reported initial impacts of the USG funding cuts across health sectors and functions, including many that serve women and girls (figure 2). Among a wide range of disrupted health services reported by respondents whose organisations had been receiving USG funds at the time of the freeze (n=76), humanitarian and emergency response/preparedness (52.3%), gender-based violence (GBV) (49.2%), mental health and psychosocial support (MHPSS) (47.7%), training/health workforce development (46.2%), social and behaviour change communication (44.6%) and control/prevention of communicable diseases (43.1%) were the most common. As of the time of the survey (February–March 2025), a majority of respondents (62%) whose organisations were receiving USG funds reported that none of their disrupted services or activities had resumed.

Respondents were asked to anticipate the three biggest global health risks resulting from the freeze. The top responses were a lack of access to services and/

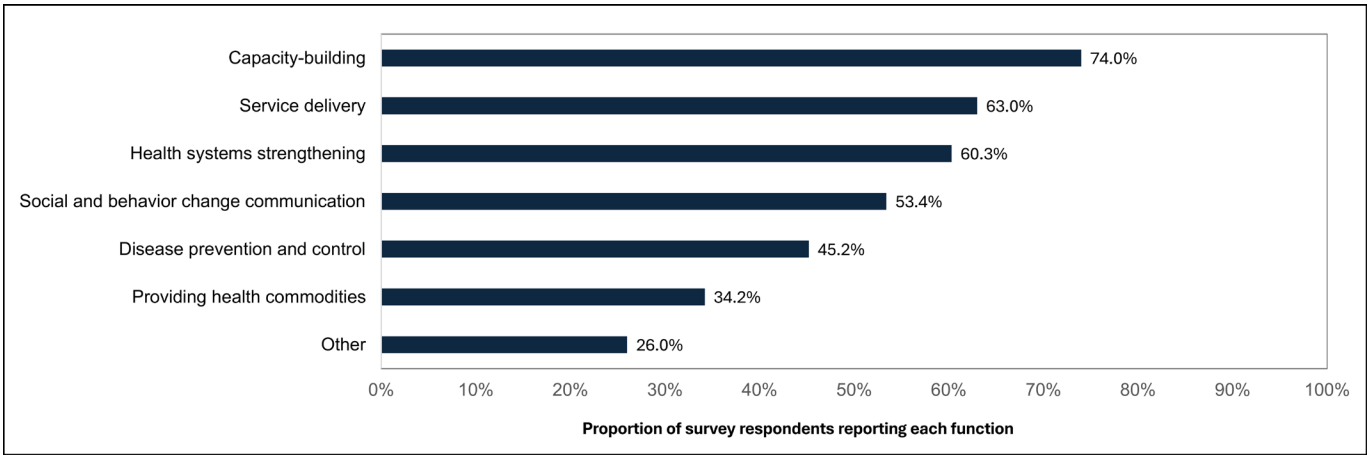

Figure 1 Function of USG funding received by survey respondents' organisations, (n=76) (*participants could select multiple responses). USG, US government.

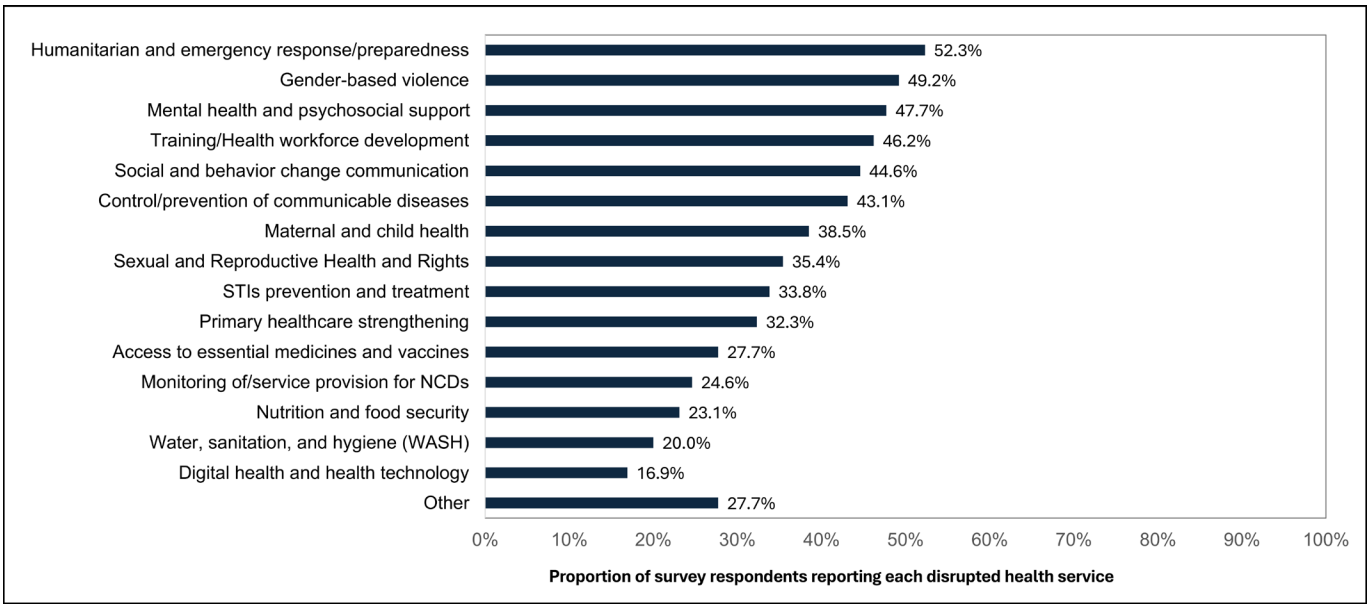

Figure 2 Disrupted health services, (n=76) (*participants could select multiple responses). STIs, sexually transmitted infections; NCDs, non-communicable diseases.

or treatment (66%), increased mortality and morbidity (41%) and health inequality/widening health disparities (35%).

Country case studies: Nepal, Kenya and Colombia

Five key themes arose from the KIIs with stakeholders in three case study countries: disruptions to sexual and reproductive health (SRH) services, HIV service interruptions and treatment access, the collapse of referral networks and service ecosystems, a perceived mental health crisis among clients and health workers and the rising vulnerability of marginalised populations.

Disruptions to sexual and reproductive health services

Across all three countries, key informants reported immediate and consequential interruptions in the availability of SRH services, particularly contraception and maternal healthcare. Stock-outs of essential commodities, closure of service delivery points and the withdrawal of key implementing partners were all described as results from a loss in USG funding.

In Colombia, the departure of an NGO providing comprehensive maternal healthcare left pregnant women without antenatal care, ultrasound scans or clear birth plans. This withdrawal of NGO services disproportionately affected vulnerable populations, such as migrants without legal documentation, who already relied on a health system that was largely limited to urgent or emergency obstetric and newborn care. With long-term perinatal care largely inaccessible to them and a public health system that is overstretched, the outlook for managing ongoing or complex maternal health needs is increasingly uncertain.

> The pregnant women were being cared for by [Anonymous]. They had an active project for pregnant women, which covered everything for them—initial care, antenatal checkups, and the whole process so that they could know where they were going to give birth. Now they have left. We have had cases of pregnant women who arrive… 'I have no idea where I'm going to have my baby, I haven't had any kind of ultrasound'… unfortunately, all the consequences are being absorbed by this population of pregnant women. (Colombia)

In Kenya, respondents described sharp reductions in access to contraception for adolescents, alongside the disappearance of critical post-rape care services.

> [Adolescents] will lose access to family planning and SRH services. We've tried for years to reduce unplanned pregnancies, keep girls in school, but now contraceptive supplies are limited or nonexistent. That will affect their livelihoods and education. (Kenya)

> On the GBV side, services like forensic exams or emergency contraception (within 120 hours) and PEP (within 72 hours) may be unavailable. Unwanted pregnancies and new HIV infections can rise. (Kenya)

Fear of losing future US funding also prompted organisations to self-censor, scaling back or eliminating services related to abortion, LGBTQ+ health and other stigmatised areas. This chilling effect led to the disruption of partnerships and the curtailment of community outreach:

> Organizations that once did holistic sexual and reproductive health work are now forced to drop anything that might jeopardize future funding. (Kenya)

> Several private clinics that collaborated with us—especially on sensitive SRHR areas—have pulled out…This is a big gap; we invested in training and capacity-building for those clinics, and many youth relied on them. Now they're unwilling to offer certain services (like comprehensive sex education) due to fear of losing U.S. funding. Our workload

for referrals is high, but we have fewer willing providers. (Kenya)

Our sexual and reproductive health program has to be rethought because issues such as abortion, such as [family] planning, such as sexual and reproductive rights awareness are issues that they [US government] are not interested in. (Colombia)

These country-level findings align with survey results showing that GBV services, SRH and rights (SRHR) programmes and maternal healthcare were among the most frequently-reported service areas disrupted by the aid freeze. Together, they highlight both the direct impact of funding withdrawal on service provision and the indirect chilling effect on the policy environment for SRH.

HIV service interruptions and treatment access

Loss of funding led to abrupt suspension of HIV services across the three countries, particularly in Nepal and Kenya. Disruptions to antiretroviral treatment (ART) distribution, community-based outreach and follow-up care left people living with HIV (PLHIV) without consistent access to lifesaving treatment.

Since our clinics are shut, we have lost contacts with several of our clients…Our community volunteers have also stopped home delivery of ART to those who are unable to visit the clinic. The ART centers run by the government cannot reach them since they do not have outreach workers for such activities. The situation will be worse now on. (Nepal)

CHW programmes, which had previously bridged the gap between government health services and communities by connecting PLHIV, were described by some respondents as the first services to be defunded. Without them, respondents feared delayed diagnoses, loss to follow-up and increases in preventable deaths:

A problem may arise soon because the government does not operate at the community level and does not provide awareness to community members. In the past, the lack of awareness led to delayed diagnoses, and such cases may increase after the funding freeze. (Nepal)

Respondents described how treatment disruptions were leaving patients without care, with potentially life-threatening consequences:

If we cannot give service, the number of the HIV cases will soar. In our district, only 50% of the HIV survivors seek care regularly by themselves. Those who fail to seek treatment, they fall vulnerable to TB, and other life-threatening diseases which contribute to high mortality rate. (Nepal)

It's serious. Patients on ARVs—where are they now? We can't reach them. Previously, we'd helped reduce the number of deaths and chronic patients, but we don't know what's happening to them anymore. We can't contact them or provide care. As staff, we no longer have a job, but what about the clients? Many may end up hospitalized or worse because they lost access to medication (Kenya)

In Kenya, women and girls were said to be disproportionately affected by the disruption of services such as prevention of mother-to-child transmission of HIV:

Kenya had made good strides in reducing mother-to-child HIV transmission, for example. Without support, I don't think we can maintain those gains; we might lose all that progress and go backward. (Kenya)

I was closely following one pregnant woman in my household visits—she'd always been able to get her medicine, but for the last three weeks she couldn't. When she delivered, her baby tested positive for HIV. If she'd continued her medication, that might've been prevented. But the abrupt disruption left her without consistent treatment, and that led to this heartbreaking outcome. It wasn't her fault—she was diligent, but suddenly the services stopped. (Kenya)

Respondents in all three countries expressed concern that these disruptions could reverse decades of progress in HIV control:

With HIV, we risk living in situations like those of 30 years ago in the '80s when the virus appeared and there was no control over it. (Colombia)

Collapse of referral networks and service ecosystems

Respondents in all three countries described how the closure of partner clinics, NGO offices and layoffs of frontline staff was dismantling established service ecosystems. The loss of partnerships was anticipated to indirectly affect even organisations not directly funded by USG, as referral systems for some services such as GBV, SRH and HIV were already severely weakened.

In Nepal, respondents reported being unable to connect newly identified HIV-positive clients to treatment following their office closures:

After our office closed, 3 [HIV positive] cases have been referred to us, requesting us to link them to the treatment. We could not do that because we were told not to do anything now. So, in this context, if we lose them then there is a high possibility and risk of infection spreading in the community. (Nepal)

In Kenya, the closure of referral partners left major gaps in access to safe abortion and related care, particularly given the limited scope of public-sector services:

We have nowhere to refer clients for certain services—particularly abortion-related. Public facilities often don't offer these services beyond post-abortion care, and many women fear going there. So we're bracing for more complications from unsafe procedures. (Kenya)

Even if their organisations did not directly receive USG funds, respondents reported that they felt impacts of the USAID freeze.

We didn't receive direct USAID funding, but we partnered with USAID-funded organizations like [Anonymous]… once the freeze was announced, [Anonymous] told partners they'd halt all operations until the 90-day freeze ends. Although we had no direct contract with USAID, our subgrantees and partners did, and so our work is indirectly

> impacted. Within the SRHR network in Nakuru…many member organizations depended on USAID funding. Some have now ceased operations because of the freeze. (Kenya)

Community-level partnerships (such as those with community health promoters in Kenya and peer educators in Nepal) were among the first services to be defunded, leading to serious disruptions in referral pathways:

> We used to work with Community Health Promoters (CHPs), giving them a small stipend so they'd identify and refer (HIV) patients. Without funds, there's a gap. Private facilities also referred clients to us, but if we're not operating fully, they have nowhere to send them. (Kenya)

In Colombia, respondents reported that technical working groups and inter-agency humanitarian coordination bodies were losing members as partner organisations shut down. The closure of migrant shelters left remaining service providers with limited capacity and no physical spaces in which to deliver care:

> Migrant shelters were closed in Ipiales… We found ourselves alone with services to provide, but no places to provide them. (Colombia)

Perceived mental health crisis among clients and health workers

Respondents described a dual mental health crisis affecting both clients and health workers. For clients, the disruption of mental health services compounded the psychological toll of broader service reductions. In Colombia, which hosts one of the world's largest populations of refugees, migrants and internally displaced persons,[10] a key transit corridor through Latin America runs through the Darién Gap, a dangerous overland route connecting Colombia and Panama.[11] Due largely to escalating US immigration enforcement and deportation practices, increasing numbers of migrants are 'reverse transiting' through the Darién Gap back into Colombia.[12] Respondents described many returnees exhibiting signs of hopelessness, confusion and fear of detention or deportation, meanwhile resources to support mental health (traditionally provided by NGOs with operational bases near the Darién Gap) are contracting:

> Many come back very downcast, defeated…they return with very strong emotional affectation and require emotional and professional help. (Colombia)

Several respondents in Kenya reported witnessing an increase in suicidal ideation among both clients and health workers. One mentioned that a CHW was hospitalised after experiencing severe stress linked to their abrupt job loss. Respondents described clients, particularly those living with HIV or cancer, expressing deep fear about a return to conditions of decades past:

> Clients—especially those with HIV or cancer—(have come) to me terrified at the prospect of returning to the conditions we had 20 years ago, when people were bedridden and faced severe stigma. Some even mentioned suicidal thoughts. (Kenya)

For health workers, the economic and psychological strain was acute. Layoffs, as well as prolonged uncertainty about long-term employment and heavier workloads for remaining staff, contributed to widespread distress. A participant from Nepal described this as follows:

> Everyone is suffering from mental health issues. They are saying things like 'where will we get a job now?' and 'what should we do now?' (Nepal)

One health worker in Kenya described working with a 'skeleton staff' trying to maintain essential services, while another shared that a few clinic staff members volunteered their services after the funding freeze.

> I offer my services voluntarily. When staff couldn't come, a few of us stepped in to ensure people at least got ARVs. One nurse and one clinical officer remained, so we did patient assessments and made sure no one went home without medication. (Kenya)

Rising vulnerability of marginalised populations

Respondents identified LGBTQ+ individuals, migrants, youth, pregnant women, sex workers and PLHIV as among those most at risk from the USG funding freeze. In Colombia, participants voiced concern that anti-LGBTQ and gender-related rhetoric in the USA could influence political discourse and policy abroad, further undermining protections for marginalised communities:

> Clearly in some way the speeches and decisions that are being made in the United States also affect how other countries and leaders think. In particular, I think that we as an LGBT organization, it affects us a little more because many of the speeches that are given around what is happening are against gender identity and sexual orientation. (Colombia)

In Kenya, respondents described disproportionate impacts on sex workers, who were increasingly excluded from essential health services:

> Medical staff are ignoring key populations like sex workers, and many have lost hope. *(Kenya)*

> Services became limited to HIV testing and care for pregnant and breastfeeding women only. There was no provision for PrEP [pre-exposure HIV prophylaxis], which many sex workers rely on to remain HIV negative. *(Kenya)*

As seen with SRHR programmes, organisations serving marginalised groups (such as LGBTQ+ individuals) expressed concern that they would be forced to alter their services to comply with funding restrictions. Participants reported that programme cuts were already exacerbating existing inequities, limiting access to critical health services and eroding trust among populations that already faced stigma and discrimination.

> I want policymakers in the U.S. to see that although this might be a political decision on their side, it's a matter of life and death here. A child missing immunizations because

of funding cuts can end up with a preventable disease; a pregnant woman without healthcare can lose her baby; an HIV-positive patient missing treatment faces severe complications…The impact of this freeze will be felt for years unless urgent action is taken. (Kenya)

DISCUSSION

This rapid mixed-methods assessment provides some of the earliest empirical evidence on the immediate consequences of the 2025 US foreign aid freeze, capturing perspectives from global health practitioners and country-level actors across three continents. The findings illustrate how the sudden cessation of USG funding has generated profound and multilayered disruptions, and how the disruptions have not only impacted individual health services but also the systems, partnerships and workforces that sustain global health delivery.

The results build on and extend evidence from prior policy disruptions. For example, the reinstatement and expansion of the Global Gag Rule in 2017 disrupted contraceptive and other SRH services, producing substantial impacts on NGOs and health systems including disrupted partnerships, chilling effects/self-censorship and weakened service delivery.[13] By contrast, the 2025 funding freeze represents a far broader and deeper rupture. Rather than a targeted restriction, this is a systemic withdrawal of financing that halted programmes across nearly every domain of health and humanitarian response. Other rapid assessments of these recent funding disruptions reiterate the cascading impact undermining the delivery of health services across the SRHR and humanitarian sectors.[14–16] The scope of disruption, from SRH and HIV to mental health and emergency preparedness, underscores the unprecedented nature of this shift.

Several cross-cutting themes emerged, including the collapse of referral networks and service ecosystems, the mental health toll on health workers and the disproportionate effects on women, girls and marginalised groups such as LGBTQ+ populations, sex workers, PLHIV and migrants. These findings have important implications for global health governance and financing. Heavy reliance on a single bilateral donor has created fragility across countries and sectors. The sudden cessation of USG funds revealed the risks of donor concentration and the absence of contingency mechanisms for sustaining critical health services. More resilient financing architectures, characterised by diversified funding streams, stronger multilateral coordination and greater investment in domestic systems, are urgently needed.

At the same time, the crisis offers an opportunity to reimagine global health financing and power-sharing. Localisation of funding and decision-making (long discussed but underimplemented) emerges as an urgent priority.[17] South–South collaboration where countries with shared contexts co-develop and coinvest in solutions as well as global investment directly in health systems, frontline workers and community infrastructure will be key to building resilience.

Finally, this study's findings call attention to the fact that global health is inseparable from human rights. The Trump administration's America First Global Health Strategy explicitly places cost savings and US commercial interests above ensuring health as a human right. Restrictions on SRH services, exclusion of key populations and the chilling effects of political rhetoric underscore the ways in which funding disruptions intersect with, and often reinforce, broader patterns of stigma and discrimination. New bilateral health memoranda of understanding (MoUs) exemplify how the 'America First' strategy is being operationalised by tying funding to unequal data-sharing commitments, a shift that risks undermining hard-won global health gains while eroding privacy protections and weakening human rights safeguards in partner countries.[18 19] Combined with new restrictions on who may receive USG funding through the new *Promoting Human Flourishing in Foreign Assistance* policy,[20] the long-term risks include not only reversals in health gains but also a weakening of rights protections that have taken decades to secure.

This study has several limitations. First, the online survey experienced substantial response fatigue, likely due to many other surveys launched around the same time: although 330 individuals initiated the survey, only 98 completed enough questions to be included in analysis. As the survey was distributed through PopFam's professional networks, selection bias is possible and SRHR, humanitarian and MHPSS actors may be overrepresented. Nonetheless, given the persistent neglect of women and girls in crisis contexts, such intentional focus provides critical insight often missing from other assessments. Finally, multiple respondents from the same organisation may have contributed, limiting the precision of quantitative estimates. The qualitative case studies are limited to three countries selected purposively, which may not reflect the experiences of other contexts. Furthermore, data collection occurred in February–March 2025, before the transition from a temporary 'pause' to the announcement of a permanent shutdown of USAID operations, meaning that findings reflect early-stage disruptions rather than the full scope of impact. Despite promises of anonymity, some participants declined to participate out of fear of retribution, possibly biasing the results. Finally, perspectives are drawn from providers, implementers and policymakers rather than clients themselves. Further research should directly capture the lived experiences of affected communities.

Despite these limitations, this study provides valuable insights into the immediate consequences of the USG foreign aid freeze, serving as one of the first studies to document both immediate service disruptions at the country level and the systemic vulnerabilities that threaten longer-term recovery.

CONCLUSION

The abrupt cessation of US foreign aid in 2025 triggered a global health crisis with potential far-reaching

implications for service delivery, health systems resilience and human rights. At this point few donors have stepped up to fill the void left by the USG. Documenting the lived experiences of practitioners provides critical insight into the real-time consequences of funding disruptions. These insights can inform more resilient and equitable responses in the future. Moving forward, the global health community must act on several fronts:

- Low- and middle-income country governments should:
  - Diversify funding, reducing reliance on a single donor and ensure rapid-response mechanisms to protect essential services.
  - Strengthen domestic financing and contingency planning to reduce vulnerability to external shocks.
- Implementing organisations should invest in localisation, staff support and advocacy pipelines to sustain service delivery under uncertainty.
- Academic and research institutions, together with local partners, should develop rapid-response mechanisms to document and analyse the effects of policy shocks in real time, and build infrastructure to document long-term impacts on the ground.
- Governments and donors should build accountability safeguards, such as transition or probation periods for funding changes, to ensure that political shifts do not compromise essential services, protecting health systems from abrupt funding withdrawals.

Ultimately, the collapse of referral networks, the mental health crisis among health workers and the heightened vulnerability of marginalised populations suggest that the USG funding freeze was more than a temporary disruption but rather a systems-level shock that has exposed structural weaknesses in global health financing and governance. Addressing these weaknesses will require both an urgent response as well as a long-term reimagining of how global health is funded, governed and delivered.

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Contributors Conceptualisation and study design: SEC, TDN and AT. Study tools creation: SEC, SB, SE, MCG and AT. Investigation/data collection: AT, JT, AS, JK, LM and CR. Data analysis: SEC, SB, MCG, AT and JK. SB drafted the manuscript; all authors edited, reviewed and approved the final version of the manuscript; SEC is the guarantor. All authors, except the first, second and last, are listed in alphabetical order.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants but the Columbia University Institutional Review Board (IRB-AAAV7004) determined the study to be exempt research because participants responded in their professional capacity describing their work, and no personal identifying information was collected (online supplemental file 3). Given this exemption and due to the nature of this rapid assessment and need to capture data on the immediate impacts of the funding freeze, the research team therefore decided not to seek separate ethical review in each country. Interviewers explained the study using an information sheet before obtaining verbal informed consent from all participants. A waiver of written consent was obtained because the name and signature on a consent form would be the only record linking the participant and the study. KIIs were audio recorded with consent. Only members of the research team had access to the data.

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