CASE STUDY

THE FUTURE OF US FOREIGN ASSISTANCE HEALTH PARTNERSHIPS IN ZAMBIA:

Prospects and Recommendations for the Pivot to Government Partnership

SEPTEMBER 2026

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Acknowledgements

This report was co-authored by Deborah Kaliel, Lekani Banda Venevivi, and Sarah Rose.

This report was made possible by funding from the Leona M. and Harry B. Helmsley Charitable Trust.

The Share Trust is grateful to Alliance for Community Action, Action Institute for Policy Analysis Centre (AIPAC), Network of Zambian People Living with HIV (NZP+), Transparency International Zambia (TIZ), Alliance for Community Action, European Union(EU), Project Concern Zambia, Centre for Infectious Disease Research in Zambia (CIDRZ), Jesuit Centre for Theological Reflection (JCTR), Health GAP whose perspectives and experiences informed this work, plus a number of other stakeholders who contributed off the record. Thanks also go to Devin Hibbard and other anonymous reviewers who reviewed earlier drafts. Any errors, omissions, or inaccuracies are the sole responsibility of the co-authors.

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Executive Summary

After significant disruption in 2025, the United States has been working to solidify a new model for global health cooperation. As outlined in the "America First Global Health Strategy," the United States seeks to orient more of its health assistance around government-to-government partnerships, including expanding direct financing to partner governments. Several elements of this shift are promising: governments play a key role in managing public health, their territory-based remit gives them a unique platform for scale, and they are (at least in democracies) accountable to their citizens for delivering services. Moreover, governments are rightfully active partners in and owners of their own aid relationships; government ownership and leadership are also critical for sustaining progress in public health. An approach to global health cooperation based in government partnerships can be an important way of strengthening locally led development. But the success of these agreements will depend on how they are done. Alignment with national laws and priorities; realistic timelines and expectations for transition and sustainability; greater transparency of and inclusion of civil society in the process; clarity on US policy; attention to strengthening government systems; and attention to risk and lessons learned are all paramount.

The United States' new global health partnerships are anchored in Memoranda of Understanding (MOUs) with a partner country government that frame, at a high level, the areas that US assistance will support, the duration of the agreement, and co-financing and other requirements—sometimes extending to US priorities beyond health—for the partner country government. While implementation details are absent, the State Department has signalled its interest in structuring at least some of its investment through these MOUs as government-to-government funding, in which assistance would be channeled through partner country government systems.

By July 2026, 34 countries had signed global health MOUs with the United States for the 2026-2030 period. Together, these represent commitments worth approximately $23.6 billion: $14.3 billion in commitments from the US government and $9.3 billion in partner country co-investment. Zambia, one of the largest recipients of US health assistance in recent years, has not yet signed an agreement. Talks that opened in December 2025 stalled amid public pushback over reported requirements on mineral access, patient data sharing, specimen sharing, and steep co-financing expectations. In addition, because national elections were coming in August 2026, the government was less eager to sign anything committal during election season. Throughout, however, the stakes were clear: failure to reach agreement could potentially trigger a rapid closeout of US health assistance to Zambia, placing two decades of health gains—and 1.3 million people on HIV treatment—at risk. Now, with the elections over, and a second term beginning for incumbent president Hichilema, there is an opportunity to revisit a potential health partnership between the United States and Zambian governments.

Drawing on extensive interviews and document review, this paper recounts the stalled negotiation and provides recommendations on steps to move it forward. It also examines six direct financing models currently or previously operating in Zambia: the Global Fund, the World Bank, the European

Union, the Millennium Challenge Corporation (MCC), the US Centers for Disease Control and Prevention (CDC), and the US Agency for International Development (USAID), which carry lessons on how to implement a potential future agreement. The track records of these models demonstrate that government-led implementation can deliver strong results and real savings, including reduction in overhead spending, when financing is phased in, aligned to national systems, and independently verified with feedback and partnership with civil society and private sector.

The paper offers twelve recommendations under four pillars: (1) build sustainability and alignment, (2) strengthen government systems, (3) improve governance, accountability, and engagement, and (4) forge a durable bilateral relationship. For Washington, success will hinge upon separating health financing from transactional demands, rewarding rather than punishing co-investment, building on experiences and structures of other donors, building and/or restoring trusted in-country teams, and working as true partners. For Lusaka, success will require sharing a legal review, ensuring US support is anchored in national strategies and systems, and giving Zambian civil society and the private sector formal roles in shaping the new approach and implementing when appropriate to improve access and reach. A transparent, phased, and genuinely negotiated transition can protect Zambia's health gains while advancing self-reliance.

While these lessons and recommendations are rooted in the specific case of Zambia, many have broader applicability—across countries and other sectors where the United States might pursue government partnerships—and can help inform a new era of US foreign assistance that strengthens local systems of delivery and accountability.

1. Introduction

With the dismantling of USAID in early 2025 and absorption of foreign assistance into the State Department, the US Government's (USG) approach to foreign assistance is at a pivotal moment. The health sector has experienced the disruption of this moment most acutely, as the sector that has received the most US funding outside of humanitarian assistance. This aid also supported significant results, with estimates of 92 million lives saved by USAID health programs over the last two decades.[1] In this transition period for US foreign assistance, however, that progress—and the value of previous US support for global health—is at risk. Much rides on the path that State charts ahead.

In September 2025, the US State Department issued its new "America First Global Health Strategy."[2] This strategy articulated a new model of US foreign assistance for the global health sector, one based primarily on direct financing to governments instead of working through non-governmental organizations (NGOs). The strategy also seeks to tie health assistance more explicitly to US priorities, including those unrelated to health. Over the year since the strategy was announced, the State Department has tempered its vision of delivering health assistance exclusively through governments and has affirmed roles for NGO implementation. However, the push for new direct government financing remains a central piece of the strategy.

The emphasis on government partnerships in health is a promising shift. Governments play a central and unique role in managing public health and delivering health services. Supporting governments in these roles can reinforce the citizen-state social compact, at least in democracies, by helping to reinforce government accountability to its citizens. In addition, with its territory-based remit, the government provides a natural platform for scale. Moreover—and importantly—governments want and have a right to be active partners and negotiators in aid relationships. Government leadership and ownership over the goals and processes of health assistance are critical for sustained progress. But the success of these agreements will depend on how they are done.

The use of direct government financing is not new to the USG, but the scale of funding proposed, the speed with which agreements are expected to be developed, the lack of staff and systems in place at the State Department to manage the new mechanisms, and the potential transactional nature of the engagements, make it a monumental shift in approach that is testing the limits of both the US government's and partner governments' institutional capacity to design, negotiate, and implement this new model of partnership.

The foundation of bilateral health agreements under the American First Global Health Strategy are MOUs that outline the focus and duration of the partnership, the expected US funding envelope to

[1] Cavalcanti D, de Oliveira Ferreira de Sales L, da Silva A et al. 2025. Evaluating the impact of two decades of USAID interventions and projecting the effects of defunding on mortality up to 2030: a retrospective impact evaluation and forecasting analysis. The Lancet; 406, 283-294.
[2] US Department of State. 2025. America First Global Health Strategy.

support it and co-financing expectations for the host country government. By July 2026, 34 countries had signed bilateral global health agreements with the United States, together totaling approximately $23.6 billion for 2026–2030, of which $14.3 billion is US funding and $9.3 billion is partner country co-financing.[3] However, a handful of countries that were large recipients of US global health aid in the past have either rejected the proposed approach or have not been able to finalize negotiations on a partnership.

Zambia is one such country. The USG and the Government of the Republic of Zambia (GRZ) began discussions in December 2025 but—as of publication date—have not come to an agreement due to public outcry, potential options for partnerships with other governments like China, and pushback over specific USG requirements. While much remains unclear, discussions suggest that if the USG and the GRZ cannot sign a memorandum of understanding (MOU), Zambia risks being pushed into a rapid closeout and transition of US health assistance.[4] If this were to occur, it would present a major risk to the health of the citizens of Zambia—with global health security implications beyond Zambia's borders.

Even if the USG and GRZ bilateral agreement does move forward, any elements structured as direct government financing will face a number of challenges that will need to be addressed. Critically, for instance, the US State Department currently has no publicly available operational policies, tools, or systems in place to guide government-to-government assistance, although new guidance may be forthcoming. Many USG staff familiar with models of direct government funding have been fired, resulting in few US State Department staff at headquarters and equally few US Embassy staff in Lusaka with the technical experience and specific relationships to manage large scale funding through a new, yet-to-be-fully-defined model of government-led implementation. In addition, the GRZ's own limited health infrastructure, finance and accountability systems may pose a risk to program success.

The potential timeline of the health partnership poses another challenge. Though official details of the proposed agreement with Zambia have not been released, MOUs with other countries have been explicit about expectations of a rapid transition away from USG funding, with most countries expected to end the need for all USG assistance within five years. While building a strong model from the start and planning for a gradual transition is essential, five years is an incredibly ambitious timeline which is widely seen as unrealistic in many countries, including Zambia, where approximately 50 percent of the public health response is donor funded.[5]A sudden and significant shift in funding, if not designed well, could present risks to the health and development gains that have been made in HIV, TB, and malaria control and compromise improvements in maternal and child health.

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[3] Kaiser Family Foundation. 2026. KFF Tracker: America First MOU Bilateral Global Health Agreements.

[4] Nolen, S. 2026. No H.I.V. Aid Without More Access to Minerals: US Ponders 'Sticks' Against Zambia. The New York Times.

[5] Republic of Zambia Ministry of Health and World Health Organization. 2024. Health financing progress matrix assessment, Zambia 2024: summary of findings and recommendations.

This paper focuses on the process of negotiating the potential new health MOU between the USG and GRZ, highlighting concerns about its structure, exploring potential challenges, and identifying opportunities to promote local leadership of health assistance. This paper also offers recommendations to promote successful implementation of the MOU through government-to-government (G2G) agreements if the MOU goes forward. Zambia presents an important case study in the development of this new bilateral global health model. Finding a way forward to advance this local partnership is critical to support a responsible transition of health financing and implementation to the GRZ. Learning from the best practices of past direct financing models, including the USG's own examples of G2G agreements, and listening to local stakeholders' inputs can inform this new era of US foreign assistance.

This report was written based on a desk review of public documents and news stories, as well as extensive interviews with people in Zambia and around the world that are stakeholders in the GRZ and USG foreign assistance health programs, including civil society, government, media, donors, impacted populations, and other stakeholders. Interviewees varied in their perspectives and ability to share information given the sensitivities with the on-going negotiations between the two governments.

2. Background

2.1 Health funding landscape pre-2025

In 2024, the US obligated around $580 million across 300 projects in Zambia.[6] Spending on health objectives made up over three-quarters of total US development assistance in Zambia, with 140 projects focusing on tuberculosis, malaria, HIV, maternal and child health, nutrition, reproductive health, and global health security. The significance of this support was substantial; for example 1.3 million Zambians relied on USG-funded HIV treatment to stay alive.

Prior to 2025, the United States health and development assistance in Zambia was managed by approximately 230 USG staff primarily based in Lusaka. Most US assistance was delivered through international and a handful of local NGOs,[7] with USAID-specific systems established to ensure rapid scale-up, fiduciary control, and technical quality. While effective in achieving short- to medium-term results, this model raised persistent concerns over the years regarding sustainability, fragmentation, and long-term national ownership.

[6] ForeignAssistance.gov.

[7] In 2024, approximately 28 percent of USAID funding to Zambia went to Zambian NGO partners, mostly in the health sector. (USAID. 2024.Growing Momentum: USAID Localization Progress Report. No longer available online.)

In 2024, US funding for health ($418 million) made up around 65 percent of the total external health assistance to Zambia.[8] This external financing contributed to approximately 48 percent of total health expenditure in Zambia (2023), with some parts of the national health response even more heavily funded by external sources (e.g., 91 percent of the national HIV response).[9]

External health assistance to Zambia has contributed to major gains in HIV, tuberculosis, malaria, maternal and child health outcomes, and health systems strengthening, including significantly reduced morbidity and mortality and improved life expectancy.

2.2 Upheaval to US assistance in 2025

In early 2025, the USG initiated the dismantling of USAID globally and eliminated approximately 85 percent of all programs worldwide. The majority of USAID's health programs in Zambia were among those eliminated, save for a limited few. The remaining USAID programs were transitioned to the US State Department in mid 2025. As of current writing there are approximately ten projects managed out of the US Embassy in Lusaka. USAID health funding in 2025 reached $110 million, down from $310 million the year prior.[10] PEPFAR grants managed by the US Centers for Disease Control and Prevention (CDC) have remained largely intact in Zambia but with an uncertain future as the current administration explores shifting them to a "fee for service" model that would provide CDC staff as technical assistance to governments on an "as needed" basis.[11] So far, CDC obligations have dropped from $120 million in 2024 to $87 million in 2025 to $0 to date in 2026.[12]

The number of staff to manage reduced US funding has also declined, from approximately 85 global health staff under USAID to currently 14 at the US Embassy (as well as the still fairly intact CDC team), whose work is guided by the State Department's Global Health Security and Diplomacy (GHSD) Bureau in Washington, DC.

2.3 The effects of the upheaval

The abrupt US funding shift in January 2025 was described by many Zambians interviewed for this work as sudden, shocking, and mistrust-inducing. Civil society leader Jimmy Maliseni from the

[8] OECD DAC Creditor Reporting System.
[9] World Health Organization. Global Health Expenditure Database; United Nations Zambia. 2025. Global and national HIV Estimates Launched.
[10] ForeignAssistance.gov
[11] Cohen, J. 2026. Trump administration cuts CDC's key role in global program to stop HIV. Science.
[12] ForeignAssistance.gov

Alliance for Community Action lamented: "The manner of the stop work order and how the bilateral relationship has been handled was chaotic. There is a lot of uncertainty and anxiety." Many noted that trust is critical to bilateral partnerships—and that this trust has been lost. Solomon Ngoma the Executive Director of the Action Institute for Policy Analysis Centre (AIPAC) warned of lasting damage: "It injured trust. Patients don't know when medicines will cease."

For people living with HIV (PLHIV), the disruption was never abstract. Fred Chungu, Executive Director of the Network of Zambian People Living with HIV (NZP+), publicly warned that the sudden withdrawal of 85 percent of PEPFAR's HIV funding to Zambia risked 54,860 new infections and 32,550 additional deaths within three months.[13] NZP+ watched a health service delivery architecture built over decades come apart. Community antiretroviral therapy access points closed. Community health volunteers lost their stipends and the transport allowances that helped them carry medicines to people who needed them, contributing to increased attrition from the treatment regimes that kept people alive but which were now inaccessible. "PLHIV are terrified of returning to the days when medications were scarce and death rates were high," Chungu said. Centers and services for adolescent and young women and other youth that combined HIV prevention with economic empowerment and protection from gender-based violence were shuttered, and prevention programming supporting HIV prevention for vulnerable populations were eliminated.

Other donors noted that the whole health system, particularly the supply chain system, was immediately and suddenly destabilized. While the USG funding cuts were most sudden and dramatic, other donors, including the Global Fund (a multilateral fund to which the United States contributes), also reduced their funding by approximately 10 percent during this time. A recent Global Fund audit notes, "In early 2025, Zambia faced foreign aid reduction estimated at 55 percent which particularly affected its health sector."[14] Such dependence on donor aid proved destabilizing when funding so abruptly shifted. GRZ's own systems and budgets, while not without capacity, were not sufficiently prepared to absorb the sudden donor reductions at the pace at which they were imposed. The implications of this are still being felt and calculated.[15]

[13] The Zambia Observer. 2026. US AID Freeze Bites.
[14] The Global Fund Office of the Inspector General. 2026. Implementation of the Grant Revision process of GC7 grants for Zambia.
[15] Nolen, S. 2026. AIDS Creeps Back in Parts of Zambia, a Year After US Cuts to H.I.V. Assistance. The New York Times.

3. A New Health Partnership Agreement

3.1 The New Model of US Health Assistance: Some Progress, Many Questions

To date, the USG has not shared any completed, signed country MOUs, though a handful have reached the public informally. What is known from the available documents is that the MOUs outline health goals in particular areas (which vary by country), with benchmarks, timelines, and consequences for nonperformance. They also contain co-financing requirements for each country. Specifics on implementation are not included in the MOU but will reportedly follow 90 days after signing.

The process of developing MOUs has not been uniformly smooth. In some countries, negotiations have slowed or stopped due to concerns by both government and civil society over language and requirements. For instance, Kenyan civil society questioned data sharing requirements leading to a pause in negotiations while the agreement could be reviewed in court; the Kenya MOU was ultimately signed in June 2026. In February 2026, the Government of Zimbabwe withdrew from the negotiation process, in part due to data privacy concerns related to specimen sharing requirements.

In Zambia, similar concerns about the MOU—by both government and civil society—have stalled negotiations. Initial meetings between the State Department and the Zambia's Ministry of Health on the MOU began in December 2025. Talks began constructively, with the Zambian side given time to review the draft MOU. But as the GRZ moved the document through its internal processes and added in some Zambian priorities, many interviewees said the USG team began applying mounting pressure—including threats to eliminate assistance—if the MOU was not signed quickly. Zambian officials described feeling "bullied" into signing, a dynamic that raised tensions and ultimately forced a pause in the discussions. The negotiations were not open to any stakeholders outside of the USG and GRZ and little was shared about the proposed MOU priorities and requirements during the initial negotiations.

Additionally, early in the process, local and international civil society actors and the media heard rumors of specific requirements for preferential access to Zambian mineral resources and sensitive data sharing included in the agreement. They decried the lack of transparency and expressed concern about allowing the USG this access.

This combination of GRZ and local civil society concerns led to a protracted negotiation that stretched from late 2025 to the present (August 2026) with no clear decision yet reached. The timing of Zambia's 2026 national elections (held in August) also factored in. Transparency International Zambia's Bright Chizonde observed that because Zambia was in an election year, no

government could afford to be seen signing an agreement the public already views with suspicion. With the re-election in August of incumbent president Hichilema, however, conditions to re-open discussions may be in place.

3.2 The Proposed Zambia MOU: What We Know

While the full draft MOU has not been made public, the USG and GRZ held meetings over the last seven months to share some of the content. The Zambian Ministry of Health held three meetings with government officials, technical experts, and general stakeholders and one meeting specifically for civil society and the media. The USG also hosted two meetings with local civil society to share further details. Bright Chizonde of Transparency International Zambia, who attended one briefing, described it as useful in providing context, but noted that no follow-up engagement was scheduled and that suspicions remained on points that were not fully addressed — including the mineral rights provisions.

The high-level goals of the Zambia MOU are:

- Sustaining and expanding access to HIV, tuberculosis, malaria, and maternal/child health services;
- Strengthening surveillance, laboratory, and data systems;
- Transitioning key health system functions (e.g., supply chains, workforce, data systems) to GRZ ownership by 2030;
- Enhancing domestic resource mobilization.

In a preview of potential implementation planning for these goals, one element of the MOU shared by the GRZ is the intent to establish a G2G agreement that would provide US financing directly to the government using government systems**.** The agreement would link funding to performance metrics and co-investment achievements.

If the MOU is signed, management of the new USG-GRZ partnership will be done through a Joint Health Cooperation Steering Committee (JHCSC) composed of senior representatives from both governments and other key stakeholders. The committee would be co-chaired by high-ranking USG and GRZ officials and include representation from several government entities.[16] No civil society entities, private sector actors, or impacted populations were mentioned. The JHCSC is expected to meet at least quarterly to measure progress against goals. An implementation plan is proposed to follow in 90 days from signing of the MOU and would include details on the different technical

[16] Represented on the JHCSC are likely to be Ministry of Health, Ministry of Defense, Ministry of Finance, State House, Presidential Delivery Unit, SMART Zambia, Zambia National Public Health Institute (ZNPHI), Zambia Medicine and Medical Supplies Authority (ZAMMSA), and the Public Service Management Division.

areas of focus, as well as mechanisms to receive the funding, including the proposed G2G mechanisms. (see Annex 1for more information on MOU).

3.3 Sticking Points for the MOU

Based on stakeholder interviews, six points emerged as risks or sticking points to signing the MOU for the GRZ, civil society, and Zambian citizens:

- **Data sovereignty:** Civil society has expressed concerns about a 25-year specimen sharing agreement included in the draft MOU.[17] They noted the unclear use of the specimens without end user accountability in place and worry about being bound by law for this sharing agreement for 25 years. Furthermore, there are concerns that if this requirement were to include sharing personally identifying data, it may violate Zambian law.[18] NZP+ argues that the terms of any agreement should guarantee strict privacy protections in compliance with Zambian law and should ensure that Zambia benefits from any intellectual property or medical breakthroughs derived from the data.

- **Co-financing commitments and sustainability**: One of the requirements of the proposed agreement is that GRZ is expected to provide over $1 billion by 2030 for health funding—a level over 2.5 times higher than the GRZ's current annual government health expenditures which are typically around $400 million. The agreement also specifies that GRZ should take over full financing and ownership of the USG health programming within five years. GRZ has requested that funding not be conditional on meeting the co-investment levels but on the technical performance metrics alone.[19] Civil society also raised concerns related to the steep declining levels of USG support each year of the MOU timeframe.

  Interviewees noted that the GRZ may not have sufficient time to plan for the financial transition. Yvonne Mulenga from Project Concern Zambia commented that, "government should be given an opportunity to come up with a transition plan, an exit plan with clear targets, goals, and timelines themselves." However, Ministry of Finance staff interviewed later expressed optimism that the co-investment commitments were feasible, noting that, "We have analyzed the fiscal implications and from our end we are ready to take it on. The envelope will be squeezed and other sectors may slow down but we will have to do it."

[17] GRZ discussed this clause in a presentation to civil society March 2026.
[18] The Zambian Data Protection Act (2021) treats patient information as sensitive data and the Health Professions Act (2024) requires that patient information be treated as confidential and cannot be shared without a person's consent.
[19] GRZ presentation to civil society from March 2026.

This point is important. The GRZ may be able to meet health financing goals, but they will do so mainly through shifts rather than new resources. It is unknown if the funds would be coming from sectors or services Zambians consider critical–or how citizens might have the chance to weigh in on what gets squeezed.

Civil society also has suggestions for financing goals and approaches to reach them. For instance, NZP+ has proposed raising the health allocation toward the Abuja Declaration target of 15 percent of the national budget and imposing levies on alcohol, sugar, and tobacco to support health programs.

- **Mineral linkages:** A significant sticking point has been a rumored requirement for preferential US access to Zambia's critical mineral resources. A leaked cable stated the MOU "would give American businesses more access to Zambia's vast mineral deposits and, by extension, end what the United States sees as China's preferential access to Zambian mines."[20] However, no substantive details about the mining requirements have been shared publicly and it remains unclear if this is indeed still part of the discussion. Civil society actors have different perspectives on the possible linkages with mineral access rights. One representative noted that while controversial, it was understandable that the USG wanted to get more access to Zambia for the US mining industry. On the other hand, some stakeholders asked for clarity on whether the MOU is still about advancing health outcomes in Zambia or whether it has become a vehicle for transactional bilateral relations. Among PLHIV, the same question is experienced as a threat rather than just a policy debate. NZP+ described fear of the "weaponization of health aid" and worry that HIV assistance could be denied on a massive scale to pressure Zambia into a critical minerals agreement, with 1.3 million people on HIV treatment as the leverage.

- **Transparency:** There has been very limited consultation with civil society or other stakeholders about the MOU, beyond the few meetings mentioned above. The handful of meetings have shared some details but also were limited in time and consultation. Local and global civil society groups expressed great concern about the lack of transparency in the process. "There has been no consultation. We want access to the MOU so that we speak from facts," noted Jimmy Maliseni from the Alliance for Community Action. Solomon Ngoma from The Acton Institute for Policy Analysis Centre (AIPAC) noted that, "engagement has been symbolic rather than meaningful."

  On the other hand, some local civil society entities interviewed noted that past USG and GRZ direct agreements were not made public and they understood the need for

[20] Nolen, S. 2026. No H.I.V. Aid Without More Access to Minerals: US Ponders 'Sticks' Against Zambia. The New York Times.

government-to-government negotiations to take place behind closed doors. Some civil society actors lauded the Zambian government for having taken time to analyze the agreement unlike other countries that rushed to sign the MOUs. “The Zambian government has done a great job by keeping the MOU a closed-door discussion and they have been firm and mature. The only problem that this brings is that people get information from other sources which will cause suspicion. It is a tricky balance to attain but they have handled it well.,’’ noted Dr. Otto Chabikuli from the non-government entity the Centre for Infectious Disease Research in Zambia (CIDRZ).

However, civil society representatives also commented that this time around—given the upheaval and massive shift in programs from the USG—both governments should communicate what is possible and be open about sharing information that they can. This current secrecy is fueling mistrust. Solomon Ngoma of AIPAC further emphasized, “Share the document and make it public. Transparency is key.” He and others noted that CSOs can help educate the country and reduce the public backlash if provided with the facts.

US civil society—and even congressional overseers—have also raised concern about the lack of transparency around State’s plans for global health funding.

- **Legal Compliance:** The MOU and various potential requirements pose legal questions about compliance with Zambia's Constitution and laws related to privacy and the dignity of patients. Time is needed for thorough legal reviews of the MOU and public discussion of what is or is not allowed by law.

- **Relationships:** Overall it was apparent to many interviewed that the communications and negotiations between governments had been difficult. “There is tension between the government of Zambia and the Embassy in Lusaka,” noted Solomon Ngoma of AIPAC. The trust and relationships between the two governments has eroded over the last year, and they may not be easy to rebuild quickly, especially with limited in-country staff to support. The elimination of almost all USAID local staff resulted in a loss of deep, sometimes decades long, relationships between the USG and GRZ at working and senior levels.

3.4 Opportunities the MOU May Bring

While many people expressed concerns about the risks associated with the MOU, there were some who noted positive aspects and opportunities of the new approach. A donor noted that the MOU opened up conversations with a broad range of government ministries and government

stakeholders, pushing negotiations with entities beyond the traditional partner of the Ministry of Health, creating fuller country ownership through broader government engagement.

Some Zambian civil society representatives also saw the shift as a spur to greater Zambian leadership. Dr. Otto Chabikuli of CIDRZ offered this perspective, "The manner and speed at which aid was stopped was shocking, but ultimately it was a good move. Africans were put in front of their own responsibilities." Some stakeholders were encouraged by their government's response, highlighting how GRZ stepped up to provide services and proved to be a strong negotiator despite the upheaval. One interviewee from the Jesuit Centre for Theological Reflection (JCTR) noted that, "The system has shown some resilience in that many health services continued to be provided, even in a strained manner.'' NZP+ credits the USG funding cuts with accelerating two changes it regards as overdue: the government has increased its own health allocations to fill part of the gap, and HIV services are being integrated into routine hospital care rather than run as a parallel program. The MOU process can further this opportunity for better integration and financial ownership of the national health program. One interviewee noted that Zambia has an opportunity to leverage its negotiating position and could push back on conditions that do not serve its interests while simultaneously pushing to extract reciprocal benefits.

4. Direct Government Funding

If signed, a key feature of the new MOU would be channeling a portion of the USG funds directly to the GRZ for implementation and management through a G2G agreement. The State Department acknowledges that some funding for the MOUs may still be reserved for NGO implementation, so the estimated proportion of funding (or amount) that might go directly to the GRZ is not clear at this time. However, given the strong interest in greater G2G financing, this report explores the risks and opportunities for this type of funding in Zambia.

The experience of past and current donor-to-government funding models in Zambia , together with stakeholder interviews, point to clear opportunities of G2G models (see Annex I for more detailed analysis of Global Fund, World Bank, European Union, US CDC and USAID). These same sources also surface important lessons on the risks that the State Department and GRZ should consider if they develop a new G2G financing model for health. These risks, however, are not insurmountable. The recommendations enumerated in the next section highlight steps that can mitigate risk and maximize opportunity.

4.1 G2G Opportunities

Respondents identified five opportunities associated with the use of G2G models in Zambia's health sector. While views differed on implementation readiness, there was broad recognition that, if well designed and managed, the model could create important strategic, institutional, programmatic, and cost benefits.

- **Increased Sovereignty and Ownership:** Almost all of those interviewed—across government, civil society and former implementing partners of the USG—emphasized that the GRZ has tended to accept direction from donors rather than set its own health priorities. Several stakeholders suggested that ownership becomes more credible when government institutions are directly responsible for delivering results rather than operating through parallel donor-managed systems.

- **Cost Savings:** Direct government financing, without layers of intermediation, is often more cost efficient. CDC's G2G program found that program management costs were considerably lower than international NGO partners within the four provinces of CDC's PEPFAR implementation: overhead spending per person living with HIV was reduced by 68 percent implementing through the government's provincial health offices vs. through international NGOs.[21] An EU interviewee noted that "in an ideal world, the G2G is the best model as it is cost effective and builds ownership. It is far cheaper than implementing partners who will charge huge amounts for program overheads."

- **Strengthened Systems**: If the G2G model uses the government's own systems (e.g., financial management, data and reporting, auditing, governance) and supports work to strengthen those systems, the benefits go well beyond the scope of the specific health activities. Donor-funded system strengthening can support the government's ability to function through those same systems more broadly.

- **More stability for patients**: For PLHIV, a well-designed G2G approach can be more stable since the services supported are not as directly donor dependent. Reductions in donor financing can still impact government services, but governments have more scope to reallocate other funding to cover critical needs, if necessary. NZP+ identified two opportunities that would help reinforce stability: (1) a more secure, nationally managed

[21] Mweebo, K. et al. 2025. Government to government (G2G) model for HIV service delivery—n approach for program ownership and sustainability in four provinces of Zambia. medRxiv.

supply chain for antiretrovirals and other essential medicines and (2) a platform for introducing innovations such as six-month injectable HIV prevention.[22]

- **Learning from other donor examples**: There is a rich history of government financing models in Zambia, with different approaches and different donors, including the USG. The upheaval in US foreign assistance allows for a moment of reflection to learn from the lessons of these examples. A former USAID employee with G2G experience reflected, "The USAID G2G model was not given time to mature nor did we allow ourselves to learn from others such as CDC." This time around, there is an opportunity for the USG to learn and build in best practices—it is worth the time to do so.

4.2 G2G Risks

There are five clusters of risk that emerged from interviews and documentation from past donor-to-government funding.

Health Impact

- **Potential loss of health gains:** Direct government financing can cause delays in implementation and funding flow due to public financial management systems delays, GRZ under-spending, staffing limitations, government administrative processes, and other factors. Delays are consequential in the health sector and can jeopardize health services, including lifesaving services, for the citizens of Zambia. NZP+ warns that adolescent girls and young women, among whom HIV prevalence (at 4.9 percent) is nearly three times that of their male peers (1.8 percent), stand to be left furthest behind if the transition is not deliberately managed.

Governance and Accountability

- **Corruption vulnerabilities**: Civil society leaders warn that direct funding could be siphoned into private pockets rather than being used for service delivery. Many recalled the case of a 2018 corruption scandal with the head of human resources in the Ministry of Health. And the Global Fund experienced corruption scandals in its partnerships particularly with commodities, supply chain, and procurements. If any USG funding through a potential G2G agreement is stolen, this would not only compromise results, it could also provide a reason for the USG to withdraw further support. However, multiple donors have examples of ways to safeguard funds that could be incorporated into this new design.

[22] Zambia was the first country outside the United States to offer long-acting injectable pre-exposure prophylaxis (PrEP) beyond research settings.

- **Political interference:** Directly funding governments can prop up ineffective governments and allow them to stay in power longer due to perceived support from donors and the increased availability of financial resources. In addition, several interviewees stressed that channeling health financing through government risks it being used for political ends, with funds diverted to non-priority areas or manipulated for electoral advantage. Civil society leaders stressed that civil society inclusion in the process is critical for safeguarding against political interests.

Institutional Capacity and Readiness

- **Weak financial management systems and absorptive capacity:** Multiple donors' audits found public financial management systems created challenges for implementation, including under-spending by the Ministry of Health. Many respondents also worried that Zambia's Treasury and Ministry of Health lack the absorptive capacity to manage large inflows of donor funds or process large sums of money. One noted, "We have had situations where we have money, but we are failing to use the money." Indeed, underspending was a challenge for G2G agreements for both USAID and CDC's G2G agreements with the provincial health offices. In most cases, these delays and absorptive capacity issues were addressed over time through targeted approaches by these donors.

- **Supply chain and procurement:** Multiple interviewees and donors mentioned past scandals with the GRZ's procurement systems. Experience suggests that the supply chain for commodities is particularly vulnerable and high risk for loss without adequate monitoring and oversight systems.

- **Risk of rushed transition:** Local stakeholders worry that the shift to more G2G funding will be implemented without adequate preparation or sufficient capacity support rather than phased in. As Dr. Otto Chabikuli from CIDRZ advised, "Stagger it in phases by implementing areas that are not contentious first." This phasing can reduce disruptions in critical services.

- **Weak and duplicative systems:** Strong systems will be critical for success, particularly if the potential new USG G2G agreement relies on the existing national health systems. Donors and stakeholders noted concerns in the past that included insufficient reporting systems, weak accountability frameworks, and lack of readiness for compliance with donor standards. Additionally, donors often have different reporting and financial oversight systems established outside of the government's own systems that require the GRZ to produce duplicative reports. In the past, this kind of duplication caused inefficiencies for the GRZ and was time intensive for donors to set up and monitor.

Management and Engagement

- **Management structures and oversight:** Multiple past donors, including the Global Fund and World Bank, noted in audits that oversight structures at times were not as effective as they could be and that there were weaknesses in sub-granting management and compliance with

donor requirements. Engagement with civil society appeared to improve oversight if done regularly. The EU and Global Fund both established a coordination unit within government structures which improved management.

- **Insufficient civil society engagement and lack of transparency:** Similar to the MOU process, there is a substantial risk to the success of any G2G funding if there is no civil society or stakeholder engagement in its design, implementation and oversight. For example, the United States' Millennium Challenge Corporation (MCC) is working on its second five-year "compact" with the GRZ and requires the government to have an ongoing civil society engagement strategy; this process of ongoing engagement has helped ensure the programs are well designed, responsive to the needs of citizens, and that expectations are clear. The PLHIV community has been specific about what civil society's role should look like, including formalized community-led monitoring feeding data to the Ministry of Health and the JHCSC; PLHIV field workers running early-warning systems that trace patients lost to follow-up to get them back into care; a seat for PLHIV networks at the negotiating table itself; and an independent oversight committee joining USG, GRZ, and civil society leaders. As NZP+ frames it, communities of people living with HIV are "the vital watchdog and bridge between the government and patients."

Politics, Transition, and Sustainability

- **Political ownership and priorities:** G2G funding agreements work well only to the extent that the two government parties are willing to work together in a mutually respectful partnership. However, policies and politicians of both governments can and do change regularly, which creates vulnerabilities. The US midterm congressional elections in November 2026 and the US presidential elections in November 2028 all introduce potential uncertainty into the proposed five year agreement. For example, one donor stated that, "while the G2G was a good model, it was highly dependent on the government of the day and their commitment to the original priorities." Some suggested additional engagement with the US Congress and Zambian Parliament to help weather the presidential transitions on both sides.
- **Transition and financial sustainability:** Many donors and interviewees suggested the proposed expectation that the GRZ would transition away from USG funding within five years is far too ambitious, given the economic situation in Zambia. The proposed US co-financing requirements could potentially set up GRZ for failure if there is not a clear plan and financial analysis on how the government can meet the requirements. Furthermore, if unexpected economic disruptions occur, either in Zambia or globally, the requirements will become even harder to meet. In addition, multiple donors' co-financing requirements could create challenges for GRZ to comply with them all, particularly if they are not coordinated.

5. Recommendations

The following section identifies top recommendations for (1) advancing the health MOU between the USG and GRZ and (2) designing and implementing a G2G funding mechanism as part of that agreement.

There are 12 recommendations that fall under four pillars, organized by what the USG and GRZ could each do—and in many cases what they could do jointly:

1. Build sustainability and alignment,
2. Strengthen government systems,
3. Improve governance, accountability, and engagement, and
4. Forge a durable bilateral partnership.

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Other stakeholders, including civil society, media, and other donors, would also have a role in the success of a USG-GRZ global health partnership and G2G financing agreement. However, this paper focuses narrowly on key actions for the USG and GRZ.

While these recommendations are crafted specifically around the current USG global health partnership dynamics in Zambia, many of them could also serve to advance the negotiation of other bilateral MOUs and the development and implementation of other G2G agreements.

Pillar A. Build Sustainability and Alignment

Theme	High-level MOU	G2G funding mechanism
1. Align with national laws and priorities	**GRZ should:** • Conduct legal review of all MOU provisions before signature and publicly disclose analysis of compatibility with the Data Protection Act, Health Professions Act, Constitution, and privacy protections. **GRZ and USG should jointly:** • Align all technical priorities with the National Health Strategic Plan. • Enable civil society review of data governance provisions.	**GRZ and USG should jointly:** • Align all G2G indicators with existing national disease strategies. • Use existing national indicators wherever possible. • Avoid creating parallel reporting frameworks.
2. Plan for sustainability	**GRZ should:** • Share the financing analysis with the public, with time for review and comment, before committing to co-financing. **USG should:** • Publish high-level financing assumptions. **GRZ and USG should jointly:** • Develop a long-term transition strategy.	**GRZ and USG should jointly:** • Include a transition timeline for every investment. • Set GRZ absorption targets. • Adjust transition plans if fiscal capacity changes. **USG should:** • Require sustainability milestones.
3. Reward co-investment	**GRZ and USG should jointly:** • Undertake fiscal analysis on possibilities for co-financing and share it publicly **USG should:** • Base commitments on realistic fiscal analysis • Replace punitive co-financing requirements with incentive-based financing. .	**USG should:** • Structure milestones to unlock additional funding rather than trigger funding losses.

Pillar B. Strengthen Government Systems

Theme	High-level MOU	G2G funding mechanism
4. Strengthen and use government systems	**USG should:** • Commit to using national systems from the outset and ensure sufficient funding is available for needed improvements and capacity. **GRZ and USG should jointly:** • Include finance, audit, procurement, and subnational actors that will support the key systems components during negotiations.	**USG should:** • Require use of GRZ systems for implementation so that funding is transparent and on budget and to help strengthen GRZ systems. • Invest and focus technical assistance in areas of vulnerability including: 1) procurement, 2) public financial management, 3) data quality and validation, and 4) accountability and audit systems. • Set aside designated funds for technical assistance in these areas and other risk areas that arise. **GRZ should:** • Clarify its priorities for systems strengthening..
5. Phase in results-based financing	—	**GRZ and USG should jointly:** • Introduce results-based financing gradually. • Pilot before scaling and transition NGO-implemented programming to government in phases. • Combine milestone and cost-reimbursement approaches initially to support continuity of certain components (e.g., salaries, medications) while incentivizing other outcomes. • Use sliding-scale disbursements, paying for partial progress commensurately above a minimum threshold. • Learn from World Bank, EU, and previous USG experience on designing results-based indicators and managing performance shortfalls constructively.

6. Invest in technical assistance		**GRZ and USG should jointly:** • Develop phased capacity strengthening technical assistance and transition plans. **USG should:** • Fund embedded technical assistance both before and during G2G implementation. • Base technical assistance exit on demonstrated capacity, not timelines.

Pillar C. Improve Governance, Accountability, and Engagement

Theme	High-level MOU	G2G funding mechanism
7. Clarify governance & management	**GRZ and USG should jointly:** • Clarify governance, decision-making, and dispute resolution. • Define stakeholder engagement mechanisms and ensure civil society and impacted populations are included. **USG should:** • Establish clear and transparent guidance, tools, systems for the MOU and its implementation so all stakeholders are aware of the expectations.	**GRZ and USG should jointly:** • Develop a common donor results framework, reported through the national health management information system . • Harmonize data reporting across donors to reduce overlap and duplication. • Harmonize co-financing requirements across donors into a single GRZ co-investment framework rather than requiring separate bilateral obligations. **GRZ should:** • Strengthen JHCSC reporting to existing GRZ coordination structures, including the National Authorization Office and the Permanent Secretary for Donor Coordination within the Ministry of Health. **USG should:** • Establish a clear and transparent G2G policy and operational guidance along with tools and systems to

		support GRZ's participation and compliance.
8. Prioritize transparency	**GRZ and USG should jointly:** • Increase public communication. • Hold joint press briefings to support factual media reporting on the MOU. • Publish (coordinated) factsheets and updates about the MOU.	**GRZ and USG should jointly:** • Publish G2G agreements, audits, and results. **GRZ should:** • Share de-identified national data.
9. Engage civil society & the private sector	**GRZ and USG should jointly:** • Include civil society organizations and the private sector as key stakeholders (and to identify opportunities for private sector co-investment) during negotiations.	**GRZ should:** • Formalize—and resource—civil society monitoring roles. • Support community-led monitoring. • Expand social contracting. • Engage private sector co-financing and logistics partners. **USG should:** • Develop guidance on expectations for civil society and private sector engagement.

Pillar D. Forge a Durable Bilateral Partnership

Theme	High-level MOU	G2G funding mechanism
10. Be equal negotiators	**USG should:** • Separate health and non-health negotiations, proceeding with elements of the MOU that are health specific and generally agreed upon, like areas of key global health support and global health security components. • Ensure health financing remains linked to health performance. • Pursue broader bilateral cooperation through parallel diplomatic channels.	**USG should:** • Ensure co-creation and co-design of the G2G objectives, milestones, risk identification and mitigation plans, and other components.
11. Rebuild trust & relationships	**USG should:** • Ensure it has sufficient staff with strong, trusted relationships with government counterparts at technical levels.	**USG should:** • Allocate sufficient staff to work on G2G management across different technical areas and with a focus on

	• View partnership building as a long-term investment.	management and close engagement with government counterparts. • Support USG staff and contractors to work alongside government management and technical teams to address identified risks and capacity needs. **GRZ should:** • Act on findings from previous G2G assessments to demonstrate commitment to improving transparency and accountability.
12. Build political support across administrations	**USG should:** • Engage government leaders and members of the legislature to socialize the MOU and G2G plans.	**GRZ and USG should both:** • Expand congressional, parliamentary, civil society, and private sector engagement during planning and implementation. • Share performance results regularly with the Zambian Parliament and US Congress. **GRZ should:** • Broaden political ownership of the potential G2G agreement across the State House and finance, defense, and health ministries, and make reversal of commitments politically costly through public debate, parliamentary scrutiny, and civil society monitoring

6. Conclusion

The government of Zambia stands at a genuinely consequential inflection point in its relationship with the United States government—and in its approach to financing its own health system. As an era of donor control and dependence closes, the real test is whether its successor will be designed to safeguard hard-won health gains while building resilient, locally led domestic systems that can sustain them into the future. Across stakeholders, the United States–Zambia MOU negotiations and proposed G2G health partnership have revealed a mixture of optimism and anxiety. While the model promises increased sovereignty, cost efficiency, and strengthened government systems, stakeholders consistently highlight profound risks that could undermine its success if not addressed.

The dismantling of USAID and subsequent transition period have also illuminated how easily trust—a prerequisite to any bilateral government partnership—can fracture. Negotiations that should have inspired confidence instead fueled anxiety, legal disputes, and diplomatic strain. Yet Zambia's fiscal authorities, policy leadership, and provincial health managers have shown readiness to partner and absorb direct funding if the right conditions are created. Civil society leaders and local organizations think the time is right for enhanced sovereignty for Zambia and are ready to support a new implementation model. Other donors have demonstrated that directly financing government—including through results-based financing—can deliver results and feel that Zambia is ready for this new approach to foreign assistance.

The path forward is visible. The US government must resolve the asymmetries in the MOU, establish a clear policy and operational framework for G2G financing, and strengthen its own capacity to manage the relational and technical aspects of the agreement. The Zambian government must align internally, publicly share legal reviews, and build coordination systems capable of absorbing resources. Both entities must increase transparency and include civil society, the private sector and other stakeholders in negotiations, and during potential planning, implementation, and monitoring. Zambia has a constitutionally empowered civil society, an active media, and a population that has legitimate questions about what it is being asked to accept. Both governments must speak honestly to their people about the commitments, costs, and risks of the potential MOU and G2G funding mechanism. The opacity surrounding the negotiations to date has cost both governments social capital and political confidence. Moving forward will require openness as the foundation for partnership.

The stakes are real. They are embodied in the 1.3 million Zambians on HIV treatment, the rural communities where supply chains are still fragile, and the 40,000 health workers whose deployment is relying on funding that hangs in the balance. Asked how ordinary Zambians would know the new partnership is working, the NZP+ gave the plainest of yardsticks: steady medicine supplies in local clinics, falling disease rates in communities, and Zambian workers running the programs on their own.

Annex 1: Known details of proposed USG-GRZ Global Health MOU

While the MOU is not public, the following details were made available via presentations from the Ministry of Health to Zambian civil society on March 25, 2026.

MOU Key commitments:

- Surveillance and outbreak response: specimen-sharing, epidemiologist training.
- Laboratories: laboratory network that can support identification of outbreaks and epidemics with phased US funding decline, GRZ scale-up.
- Commodities: support for integrated supply chain via the Zambian commodity procurement entity, ZAMMSA.
- Workforce: support for frontline health care workers across multiple cadres while gradually transitioning the cost to GRZ
- Data systems: integrated and interoperable robust health data systems,
- Strategic assistance: joint implementation plan focused on long-term capacity transfer, strategic systems strengthening, and sustainable service delivery
- Sectors and interventions: HIV, tuberculosis, malaria, global health security, system strengthening and specific policy shifts to de-medicalize PrEP and formalize community healthcare workers as government cadre.
- Audits and oversight: health technical audits, supply chain audits, co-investment audits, compliance audits, specimen sharing audit monitored by the joint steering committee, quarterly reviews

An Implementation Plan is proposed to follow in 90 days from signing and would include the selected following technical areas.:

- HIV prevention, care and treatment (including Lencapavir scale-up, elimination of mother-to-child transmission, cervical cancer, and noncommunicable disease integration)
- Malaria vector control and case management
- Tuberculosis prevention, case finding, and treatment
- Global health security
- Cross-cutting systems strengthening
- Joint planning

Annex 2: Discussion and Lessons Learned from Other G2G (or Donor-to-Government) Financing in Zambia

Global Fund for HIV, Tuberculosis, Malaria has disbursed US$2 billion to Zambia, most through the government, since 2003. Current funding is $334 million for the latest three year grant cycle, although this was reduced by $31 million in 2025.[23]

Recipients	The Ministry of Health (receives 70 percent) and the Churches Health Association of Zambia (CHAZ), a local NGO (receives 30 percent of total Global Fund financing).
Funding Structure	Funds flow through a separate dedicated bank account but use the national public financial systems. Global Fund requires **co-financing requirements** to unlock 15 percent of the grant ($52.5 million for the current grant cycle). GRZ met its co-financing commitment in the last cycle with ease.
Management	Managed operationally through a Program Management Unit (PMU) that was restructured in 2022 and embedded within the Ministry of Health.
Oversight	Multiple oversight entities exist including: 1) The Country Coordinating Mechanism (CCM) — chaired by an NGO (faith based) representative with vice chair from the Ministry of Finance. 2) Independent Local Fund Agent (LFA) — PwC — conducts periodic audit/accounting oversight and reviews the Risk Profile. 3) Global Fund Secretariat oversight from Geneva: a 5-person team led by a Fund Portfolio Manager for Zambia. 4) Within Zambia, a Permanent Secretary for Donor Coordination supports Global Fund and broader donor coordination and oversight in health.
Key Risks and Results	OIG audits from 2010–2026 flagged fraud, procurement irregularities, commodity theft, weak sub-recipient and PMU oversight, limited government grant-management capacity, and poor data quality.[24] A 2024 commodities

[23] The Global Fund Data Explorer - Zambia.

[24] The Global Fund Office of the Inspector General. 2026. Implementation of the grant revision process of GC7 grants for Zambia. GF-OIG-26-005; The Global Fund. 2023. Global Fund Grants in Zambia: Collusion in a 2020 COVID-19 procurement. GF-OIG-23-022; The Global Fund Office of the Inspector General. 2022. Audit report: Global Fund grant to the Republic of Zambia. GF-OIG-22-017.

	scandal resulted in significant losses.[25] Yet progress was noted that included improved HIV/TB treatment cascade outcomes, strong ART coverage, better compliance in fund use, and Global Fund officials highlighted more timely, higher-quality audit reporting under recent GRZ management.[26]

The World Bank provides loans and grants to the GRZ made up of 24 national projects, one trust fund and five regional projects with a total commitment of $3.2 billion (as of September 2025) across many sectors[27]. Mechanisms have included results-based financing program (which disburses on the basis of milestones met or outcomes achieved) for a ~$17 million nationwide malaria pilot (2010–2014), following a single-district pre-pilot and a results-based financing approach for primary/community maternal-child health and nutrition (ended 2020). The World Bank's current portfolio includes a ~$33 million results-based financing approach (called a "program for results" or PforR) for Water and Sanitation, described below.

Recipients	Ministry of Finance as signatory with various government agencies as implementers
Funding Structure	Funds flow to the Ministry of Finance and become part of the national budget. They are then distributed to the Ministry of Water Development and Sanitation (MWDS), the National Water Supply and Sanitation Council (NWASCO), and Commercial Utilities (CUs) for implementation. Disbursements are tied to either costed Disbursement Linked Indicators (DLIs) covering sector governance reforms (legal compliance, timely fund disbursement) and service performance (people served with basic water access, performance improvement plan implementation).[28]
Management	The National Authorization Office (NAO) supports management through its unit for donor coordination.

[25] Lusaka Times Editor. 2024. Zambia : Global Fund audit exposes $6.8 million scandal amid denials by health PS. Lusaka Times.
[26] The Global Fund Office of the Inspector General. 2026. Implementation of the grant revision process of GC7 grants for Zambia. GF-OIG-26-005.
[27] The World Bank Group. Zambia profile.
[28] Republic of Zambia. 2024. Water supply and sanitation services in growth centers: Program for results (PforR).

Oversight / Monitoring	An independent verification agent is contracted to verify Disbursement Linked Results. Technical assistance also supports institutional capacity building, on-demand studies, training, and equipment.
Key Risks and Results	Past risks, specifically from the 2010–2014 results-based financing pilot, noted that the program faced corruption and staffing disputes, revealing weak MOH controls and slowing implementation.[29] Strengthened controls later supported better outcomes. A key lesson was to phase in a results-based financing approach (from pre-pilot to pilot to evaluation to scale) and to use it as a complementary mechanism within larger programs, not as a stand-alone mechanism.

The European Union has provided GRZ €140 million annually in grants under its multi-sectoral "Global Gateway" strategy. In 2026, the EU initiated a results-based financing mechanism for €40 million to be provided on budget for education and health programming.[30]

Recipients	Zambian National Treasury
Funding Structure	Funds are transferred directly to the National Treasury and become part of Zambia's national budget and executed through the GRZ's systems.
Management	Managed through the National Authorization Office (NAO), established per an EU requirement. The NAO sits within the Ministry of Finance and is chaired by the Secretary to the Treasury. NAO is also responsible for designing national strategic plans and for program design/implementation oversight.
Oversight / Monitoring	Managed through a project management team at the EU delegation in Zambia.
Key Risks and Results	Reported risks include slow execution due to government administrative processes, diffusion of donor focus, and the possibility that EU priorities could crowd out core social-sector needs. Identified need for stronger project-monitoring capacity and greater consistency of staff assigned to activities. The

[29] Sederlof, H. 2014. Implementation completion report review: Zambia-health RBF project. World Bank Independent Evaluation Group.
[30] Sichula, A. 2026. EU set to launch €40 million education-focused budget support for Zambia. Zambia Monitor.

	EU has noted increased confidence in Zambia based on 2021 PFM reforms and improved governance.[31]

Millennium Challenge Corporation (MCC) does not provide funding directly to the GRZ but enters into five-year compacts with the GRZ, with both design and implementation led by the government. Below describes the details of the first compact (2012- 2018). A second compact was signed in 2024 and amended in 2026 to expand its focus from agriculture to include mining-related reforms.[32]

Recipients	The compact was signed by the Ministry of Finance but all aspects of the compact are managed by a PMU created by the GRZ called an Millennium Challenge Account (MCA).
Funding Structure	MCC does not fund governments directly. Instead, the US Treasury pays the implementing entities selected as part of the MCA-managed procurement process. This approach reduces USG fiduciary risk and supports partner - government procurement management functions, though it does not typically engage or strengthen core government systems such as public financial management systems directly.
Management	Managed through MCA Zambia and overseen by a board chaired by the GRZ Treasury secretary that includes civil society and private sector participation. Civil Society plays a key role to provide feedback and monitoring.
Oversight / Monitoring	A small MCC in-country team (3-5 people) based in Lusaka provides local liaison. A small headquarters team in Washington, DC provides high-level oversight. Third party Fiscal and Procurement Agents support oversight of the MCA's procurement and implementation duties. All eligibility reviews, compacts, and audits are made public via the MCC website.

[31] Delegation of the European Union to Zambia and COMESA. 2024. European Union resumes budget support to Zambia.
[32] Millennium Challenge Corporation. Zambia Compact II.

Key Risks and Results	Compact I was assessed as largely successful, with the MCA managing the completion of almost all infrastructure deliverables, and the GRZ meeting fund-release conditions and passing program-related sustainability legislation. Lessons identified included the need for greater implementing-entity capacity strengthening and incentives for asset maintenance and policy-reform sustainability; the importance of flexibility given shifting implementation needs; and a need for deeper stakeholder and civil-society engagement, including more realistic expectation-setting.[33]

The US Centers for Disease Control and Prevention (CDC) has implemented approximately half of USG PEPFAR programming in Zambia since the early 2000s. In 2019 it began transitioning HIV service delivery implementation from international NGOs to four Provincial Health Office (PHO) partners through G2G cooperative agreements (a type of grant), with substantial CDC engagement in programmatic, technical, human resource, and financial management oversight.[34]

Recipients	Provincial Health Offices (PHO) in Lusaka, Eastern, Southern, and Western
Funding Structure	Under Cooperative agreements, the four PHOs receive monthly grants that supplement central government funding and provide technical assistance and oversight to district health offices, which deliver services through health facilities. Funds flowed to separate US dollar accounts at the PHOs and are drawn down against agreed workplans and budgets. The funding is outside the national and sub-national public financial management systems and the national budget.
Management	Government management is through CDC established PMUs within the PHOs.
Oversight / Monitoring	Implementation is supported by technical assistance from CDC staff and external experts on HIV guidance, finance, data, and human resources. The mechanism is managed by a Lusaka-based CDC team with support from other local CDC staff. Two CDC staff are embedded within each PHO office, with additional oversight from CDC headquarters in Atlanta.

[33] Millennium Challenge Corporation. 2020. Star Report - Zambia Compact: Lessons from the compact.
[34] Mweebo, K. et al. 2025. Government to government (G2G) model for HIV service delivery—an approach for program ownership and sustainability in four provinces of Zambia. medRxiv.

Key Risks and Results	Noted risks included the government's ability to absorb funding, the strength of provincial and district financial management systems, and results that depended on individual PHO personnel that could vary with staffing changes (a point later improved by establishing systems to reinforce best practices). Risks and capacity were monitored through annual capacity assessments and audits. Substantial technical assistance was provided to minimize risk to each province with a clear phase out plan as capacity was strengthened. Government implementation delivered strong technical results with HIV treatment and viral load monitoring rates improved and efficiencies achieved. Overhead spending per person living with HIV was reduced by 68 percent through PHO implementation compared to international NGO implementation.[35]

USAID expanded G2G health partnerships in the late 2010s. There were two main types of G2G agreements used: G2G Fixed Amount Reimbursable Agreements (milestone based) and Cost Reimbursable (cost based) Agreements. In Zambia, USAID previously had fixed amount reimbursable agreements and cost reimbursable agreements with initially two PHOs later expanding to four, with a technical focus that expanded from HIV to include tuberculosis, maternal health, nutrition, and systems functions. All components of the agreements were co-designed with government officials to strengthen alignment and GRZ ownership. USAID's G2G awards ended in 2022 when financial and procurement risks emerged. In 2024, USAID embarked on a new G2G design with the Zambian Local Authorities and Ministry of Community Development but progress stopped when USAID was dismantled in 2025. Though USAID's G2G investments were modest relative to its larger portfolio in Zambia, they were politically and strategically significant, focused on improving alignment, government ownership, and decentralization.[36]

Recipients	Direct agreements with four Provincial Health Offices (PHOs) in Copperbelt, Central, Luapula, and Northern
Funding Structure	Under Fixed Amount Reimbursable Agreements USAID paid against costed milestones. With Cost Reimbursable agreements, USAID covered ongoing costs such as salaries and equipment, all flowing through the government's own public financial management system from the Ministry of Finance through the Ministry of Health to the PHOs. Funds flowed to separate US dollar accounts at the PHOs

[35] Mweebo, K. et al. 2025. Government to government (G2G) model for HIV service delivery—an approach for program ownership and sustainability in four provinces of Zambia. medRxiv.
[36] Anonymous former USAID staff interview. Lusaka, Zambia, March 25, 2026.

	and were drawn down against agreed workplans and budgets, in form of advances or reimbursements.
Management	Government management was composed of GRZ funded staff that were part of the PHO. The PHO director led the relationship but PHO clinical care or public health specialists managed day- to- day management, working with other PHO staff as needed. This team worked with teams at the District level and facilities for implementation.
Oversight / Monitoring	USAID Government Agreement Technical Representatives (GATRs) managed the agreement, supported by a team of technical and M&E advisors with oversight from the legal team and the USAID Mission Director. Three to five USAID staff were embedded within the PHO offices for technical and coordination support. Extensive technical assistance was provided by external NGO implementing partners to manage risks.
Key Risks and Results	One prominent risk USAID noted was underspending by the GRZ. USAID's $9 million G2G pilot spent only $4.5 million in year one due to public financial management systems delays, GRZ under-spending, weak PHO staffing, and slow liquidation. Embedded USAID staff built strong relationships with GRZ counterparts, but procurement and financial risks led to termination in 2022, straining relations. Significant results were achieved in HIV, maternal and child health and nutrition.[37]

[37] Anonymous former USAID staff interview. Lusaka, Zambia, March 25, 2026.