



Annual Report
2025

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Pictured on front cover: Stelia Facki, a beneficiary of HPV community-based self-sampling in Chidundu Village, Machinga District, Malawi. Photo: CHAI.

Message from the CEO



2025 was one of the hardest years global health has faced in a generation. Foreign aid fell by 23 percent, the largest annual decline ever recorded. The U.S. government dismantled USAID, and the Global Fund cut more than US\$1 billion. The consequences were immediate. In HIV alone, services fell sharply, with kids hit hardest: 26,000 children living with HIV lost access to care within months (*see page 8*), and, over a year later, we’ve seen little recovery. Governments were suddenly being asked to do more with much less and to make incredibly difficult choices about which services to protect.

CHAI responded with Technical Support Units, advisors supporting ministries of health in 19 countries, helping governments identify and address inefficiencies, redirect existing funding toward the highest-priority needs, and build the case for new domestic investment. In five countries alone, this work saw nearly US\$70 million in funding raised or reallocated in less than year (*see page 8 for more on our TSU work*).

But 2025 was not only a year of retrenchment. It was a year two extraordinary opportunities came fully into view.

The first is the chance to finally end the HIV epidemic.

CHAI was founded in 2002 because the world had accepted that treating HIV in low- and middle-income countries was too expensive to do at scale. We rejected that premise, working with governments and partners to help bring the cost of treatment from thousands of dollars per person per year to less than US\$35.

In 2025, we applied that same instinct to prevention. Lenacapavir, a twice-yearly injection that is nearly 100 percent effective at preventing HIV, could be transformative for

people who struggle with the routine or stigma of taking a daily PrEP pill. But at US\$28,000 per person per year, it was never going to reach people at risk of HIV in low- and middle-income countries.

Working with a handful of partners, CHAI helped negotiate a generic version down to US\$40 per person per year, on track to reach 120 low- and middle-income countries (*page 18*). We now have a tool that could fundamentally change the trajectory of the HIV epidemic. The question is whether the world can move fast enough to take advantage of it.

The second opportunity is AI.

For decades, one of the hardest constraints in global health has been a shortage of skilled health workers. In many of the countries CHAI works, there simply aren’t enough doctors, nurses, and specialists to meet people’s needs. Training and hiring enough specialists to close that gap would take decades and billions of dollars.

AI could address that constraint in a fundamentally different way: not simply adding technology to existing health systems but rethinking how those systems are designed and what health workers are able to do.

That is the premise behind CHAI’s new AI for Health program, launched in November 2025. The program brings together work already underway across CHAI, from AI-enabled chest X-rays (*page 27*) and cervical cancer screening (*page 34*), while creating a broader platform to explore how AI could help us reimagine health systems; from clinical decision support that can help health workers operate at the top of their licenses to national health intelligence centers that can help governments make better decisions. And we’re working on the foundations needed to make all of this possible: reliable power and connectivity, representative data, and strong protections for privacy and data sovereignty (*page 52*).



A nurse from Kapiri Urban Clinic administers her first lenacapavir injection to a fellow trainee, a laboratory technician, following PrEP training in Zambia. Photo: Madaliso Silondwa / CHAI.

Both opportunities reflect the instinct CHAI was founded on: challenging the constraints that define what is possible in global health. Twenty years ago, that meant making HIV treatment affordable at scale. Today, it means asking whether we can end HIV altogether, and whether AI can help countries deliver dramatically better care, even when doctors and specialists are scarce.

Making progress on both will require extraordinary partnership. I am deeply grateful to the governments, donors, partners, and communities who make our work possible. Most of all, I am grateful to the hundreds of CHAI colleagues who spent 2025 protecting essential services and helping governments make difficult decisions, while continuing to push for what could come next.

This report offers many other reasons for hope. Among them, Rwanda, on track to become one of the first countries in Africa to reach a WHO hepatitis C elimination (*page 15*) and a WHO interim target for cervical cancer elimination (*page 34*); a turnaround in Lao PDR, where treatment coverage for severely malnourished children rose from 10 to 97 percent in a single province (*page 43*); and Guatemala, where nineteen CHAI-supported districts cut malaria cases by 51 percent even as cases rose in non-supported districts (*page 21*).

2025 took a real toll in services lost and lives put at risk. But it was also a year when two opportunities with the potential to reshape what is possible in global health came much more clearly into view.

Dr. Neil Buddy Shah
CHAI CEO



About CHAI

The Clinton Health Access Initiative (CHAI) is a global health organization that operates at the nexus of government, business, and health. Our approach hinges on our trusted relationships with governments to drive change across entire health systems.

Pictured: CHAI Latin America and the Caribbean team.

Our vision is a world in which everyone is able to live a healthy and fulfilling life.

Our mission: To save lives and improve health outcomes in low- and middle-income countries by enabling the government and private sector to strengthen and sustain quality health systems.

Our values: We are a mission-driven organization. We work in cooperation with and at the service of government partners. We have an entrepreneurial and action-oriented culture, which fosters diversity, equity, and inclusion. We operate with urgency, trust, transparency, frugality, and humility. We recognize our staff is our greatest asset.

Where we work

CHAI works with governments and partners to prevent and treat deadly infectious and non-communicable diseases, accelerate the rollout of lifesaving vaccines, reduce maternal, infant, and child mortality, make assistive technology available to those who need it, and strengthen health systems.

Our strategy is rooted in sustainability, which means governments lead the solutions and programs are designed to scale nationally with tactics that can be replicated in other countries. CHAI is deeply grounded in the countries we work, with 83 percent of employees based in program countries.

37

Countries where CHAI had programmatic engagement; 35 where CHAI operated out of an office location.

125+

Countries have access to CHAI-negotiated deals on medications, diagnostics, vaccines, and other health tools.

83%

CHAI staff based in program countries.



Our history

CHAI was founded in 2002 to help save the lives of millions of people living with HIV/AIDS in low- and middle-income countries. None of the milestones achieved over the past 20+ years would have been possible without the leadership of governments, communities with lived experience, support from our donors, and the partnership of global and local civil society organizations and multilaterals.

- **2002:** CHAI is founded.
- **2002-2003:** Introduced HIV drugs in low- and middle-income countries with CHAI's 60% price reduction. +60 countries in Africa and the Caribbean access treatment for the first time as a result of the deal.
- **2004:** Achieved up to 80% price reduction for CD4 and HIV VL.
- **2006:** Negotiated a 50% price reduction in HIV rapid tests.
- **2009:** Delivered US\$1B savings for South African government with HIV and TB price cuts. Partnership dramatically scaled up clients accessing care and treatment as CHAI began expanding into new health areas beyond HIV.
- **2010:** Supported development of innovative subsidy mechanism to get almost 300M anti-malarials to patients. Increased access to best-in-class artemisinin combination therapy in eight countries.
- **2011:** Averted childhood deaths and saved US\$950M with price deals for routine vaccines. Lowered price of rotavirus vaccine by 67% and pentavalent vaccine by 50%.
- **2012:** Created market for long-acting reversible contraceptive implants in low- and middle-income countries with 50% price cut.
- **2013:** Prevented 75K+ deaths with expansion of life-saving childhood diarrhea treatment of zinc and oral rehydration salts (ORS) in 5 high-burden partner countries.
- **2014:** Supported Liberia's Ebola rapid response to contain the epidemic. Led case management and health worker training, serving as critical link between international emergency response and Liberian government.
- **2014:** Landmark diagnostic access program accelerates scale-up of HIV viral load testing to help achieve new global goals.
- **2015:** Attained a 35% price reduction for HIV early infant diagnosis and launches a solutions-driven business model to rationalize existing CD4 networks with the most efficient instrumentation, tests, and terms to meet WHO testing targets.
- **2016:** Reduced maternal and newborn deaths by >35% in three Nigerian states with program focused on the 48 hours around delivery.
- **2016:** Created market for hepatitis C treatment in seven countries with 71-95% cost reduction for originator treatments. Significantly expanded access in 2023 for WHO-prequalified products with >90% reduction for HCV treatment from two generic suppliers and reduced price for hepatitis B treatment to under US\$3/month.
- **2017:** Increased access to cancer medications, including chemotherapies, in six high-burden countries in Africa. Expanded program in 2019 across Africa and Asia with 20+ additional medications.
- **2017:** Introduced affordable single-pill DTG-based HIV regimen with landmark TLD deal, making best-in-class optimal medication available in low- and middle-income countries.
- **2017:** Paved way for millions in savings with launch of MedAccess credit facility for healthcare access deals. Leverages US\$200M

- paid-in capital to negotiate agreements for medical innovations in low- and middle-income countries.
- **2018:** Brokered all-inclusive pricing for point-of-care molecular virology testing, representing a 30-40% price reduction
- **2018:** Reached US\$12 transformative all-inclusive pricing agreement for HIV, hepatitis, and HPV while introducing the most advanced integrated diagnostic platform available
- **2019:** Negotiated expanded access agreements to include TB, Hepatitis, and HPV tests
- **2019:** Secured a >45% price reduction for thermal ablation devices for cervical cancer
- **2019:** More than doubled number of doctors per population with close of Rwanda's flagship health workforce program. More broadly, CHAI has significantly expanded trained health workforces in 16 countries and provided strategic and operational support to governments to mobilize over US\$170M in resources to train and deploy health workers.
- **2020:** Achieved fastest-ever generic pediatric HIV drug approval and launch.
- **2020-2022:** Rapidly scaled COVID-19 pandemic response in partner countries with strategic and operational support. CHAI quickly secured and deployed donations of antigen test kits to 15+ high-burden countries, supported national oxygen strategies in 17 countries, and more.
- **2021:** CHAI achieves >30% price reduction for HIV/syphilis combination rapid tests
- **2022:** Partnered with governments to screen over 1M women in 10 countries for cervical cancer. More than 80% of women receive appropriate treatment across the program, with half of partner countries exceeding 90% treatment coverage among women who screened positive for pre-cancerous lesions.
- **2022:** Significantly expanded health insurance in Ethiopia. Scaled community-based health insurance coverage from 10M to 45M+ beneficiaries, including the most vulnerable who now receive fully subsidized coverage.
- **2023:** Over a decade of partnership, helped reduce malaria incidence by 98% across Cambodia, Lao PDR, and Vietnam, and set them on track to eliminate malaria in the next few years
- **2023:** Dramatically reduced cost of HIV treatment over 20 years. CHAI's pioneering work negotiating price reductions and generic licenses, together with critical efforts from partners like the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, reduced cost of HIV treatment from US\$10,000 per person per year in the early 2000s to under US\$45 in 2023
- **2024:** In partnership with PATH and the governments of Kenya and Tanzania, CHAI supported the launch and establishment of the Unitaids-funded regional oxygen manufacturing initiative in East Africa, which is expected to triple oxygen production in the region and reduce oxygen prices by up to 27%.
- **2025:** Together with Unitaids, Wits RHI, and Dr. Reddy's Laboratories to bring affordably priced generic lenacapavir to market at just US\$40 per person per year.

Our response to foreign aid cuts: Technical Support Units

A challenging year

In 2025, global development aid fell by 23 percent, the largest annual drop ever recorded.¹ The U.S. dismantled the United States Agency for International Development (USAID), froze contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria—the world’s largest financier of prevention, treatment, and care programs for these diseases—and threatened more than two decades of bipartisan support to Gavi, the Vaccine Alliance. U.S. development assistance fell by 57 percent in 2025.² Combined with significant cuts from Germany, France, the United Kingdom, and Japan, the world’s poorest countries lost billions of dollars in health financing virtually overnight. The Global Fund alone was forced to cut more than \$US1 billion³ in promised resources.

The scale of the cuts left no room for business as usual: governments and funders had to agree on a prioritized package of services, the investments needed to deliver them, and how to pool remaining funds behind those choices.

At the request of several governments, CHAI launched Technical Support Units, small teams to help national ministries of health optimize health budgets in this new era of shrinking aid, building on CHAI’s long-standing technical support to governments. Within weeks, CHAI was working in nine countries; by year-end, Technical Support Units were operating in 19 countries with support from 11 donors. Working alongside ministries, these teams helped redirect resources to higher-priority services, addressed inefficiencies, and built the evidence base for governments to mobilize new

financing. In five of the initial nine countries—**Burkina Faso, Eswatini, Malawi, Uganda, and Zambia**—that work has already seen nearly US\$70 million in funding raised or reallocated within a year.

The work has continued into 2026. Helping governments and funders prioritize limited resources, design more efficient systems and service delivery models, and sustain them over time will remain a core part of CHAI’s strategy.

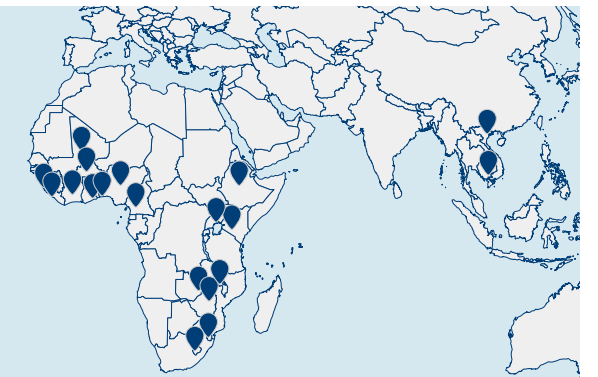
Learn more about CHAI’s response within specific programs:

- [Health Systems, page 52](#)
- [HIV/AIDS, page 18](#)
- [Malaria & Neglected Tropical Diseases, page 21](#)
- [Reproductive, Maternal, & Newborn Health, page 45](#)

Doing the right things: Ensuring limited resources go to the highest-impact services

Following the funding freeze and subsequent Global Fund cuts, governments faced an urgent question: how to maintain critical health services with dramatically reduced budgets. A World Health Organization⁴ survey of 108 countries found funding cuts had reduced critical services, including maternal care, vaccination, and disease surveillance, by up to 70 percent in some countries. CHAI’s own research found HIV programs were already in crisis: by the end of 2025, about 26,000 fewer

We established Technical Support Units in **19 countries**, with support from **11 donors**, to rapidly respond to government planning needs in 2025.



~**US\$70 million** in funding was raised or reallocated in 2025 across five initial countries.

US\$22 million secured in new domestic and donor funding.

US\$18 million in resources redirected to higher-impact areas.

children were on HIV treatment across nine countries, new HIV diagnoses had fallen 28 percent, and oral PrEP initiations had dropped 42 percent compared with 2024.⁵

The first task was triage, informed by evidence.

In **Eswatini**, CHAI mapped how HIV funding was flowing through both donors and implementing partners, ultimately uncovering US\$1 million in budget excesses unlikely to be spent before year-end. Rather than allowing those funds to lapse, the government redirected them to protect pediatric second- and third-line HIV drugs for the country’s most clinically vulnerable children. CHAI also worked with the Ministry of Health to prepare a Cabinet memo requesting additional domestic funding for essential laboratory supplies. Cabinet approved it, committing a further US\$1.7 million. Together

this addressed half the gap in lab and HIV treatment commodities.

In **Burkina Faso**, the Ministry of Health convened a strategic workshop to reprioritize a US\$150 million World Bank loan and US\$17 million Global Financing Facility grant following U.S. funding cuts. CHAI’s analysis of funding gaps and supply chain shortfalls across that US\$167 million portfolio served as the primary input. The result: 26 deferrable activities, mainly training sessions that could be shortened, changed, or deprioritized (given recent training); and approximately US\$7 million reallocated to maintain contraceptive supply, maternal and newborn health supplies, early infant HIV diagnostic tests, and malnutrition treatment. The reprioritization approach will continue, with CHAI leveraging ongoing budget tracking, as well as domestic budget and Global

Pictured: A nurse performs HIV testing in Lilongwe, Malawi. Photo: Tewodros Emiru.

Fund planning in mid-2026, to identify further opportunities.

Finding inefficiencies for cost savings

When the Global Fund cut grants by 11 percent in **Uganda** and eight percent in **Malawi**, some of the most significant gains came not from reducing services, but from looking more carefully at how existing activities were being planned and carried out.

In **Uganda**, a detailed review of HIV and laboratory commodity budgets found US\$11.8 million in savings, not from cutting services or finding cheaper products, but from making supply projections more accurate and streamlining program planning. That was enough for **Uganda** to fully absorb its budget cut without reducing access to a single essential medicine.

In **Malawi**, the same approach produced an even more striking result. Through CHAI’s HIV program, supported by the Gates Foundation and working alongside the Ministry of Health, we found the government had been over-budgeting HIV commodities by US\$15.7 million annually. We compared budgeted figures against actual procurement costs line by line and found the budget figures simply hadn’t kept pace with current prices. The savings that emerged were immediately redirected to HIV testing kits, viral load reagents, and blood safety supplies that were facing shortfalls.

This kind of hidden inefficiency wasn’t limited to commodity budgets. A separate CHAI-led mapping exercise in **Malawi** found 67 distinct health data systems that were operating largely in parallel: duplicating efforts, fragmenting oversight, and consuming resources. Working with the Ministry of Health, CHAI is now helping to plan an integrated digital system projected to save US\$5 million annually. This type of work will be critical as we shift from immediate response to longer-term systems transition.

Building the case for domestic investment

Reprioritization and efficiency gains matter, but they cannot close every gap. In **Zambia**, dual cuts from the President’s Emergency Plan for

AIDS Relief and the Global Fund left a US\$16 million shortfall against the minimum package of HIV care—the baseline set of services needed to maintain treatment continuity.

CHAI assessed the full scale of the gap and helped the Ministry of Health build the evidence case, which the Ministry then brought to the Ministry of Finance. In August 2025, the government committed US\$9 million in new domestic financing specifically to cover what external funders had withdrawn. It was a concrete step toward **Zambia**’s goal of financing HIV services independently by 2030.

This example reflects something CHAI noticed across all the countries we partnered with in 2025. Governments stepping up, making hard decisions, and finding more in their own budgets. With the right support and evidence, countries can continue to protect their people even as external funding retreats. But the scale of what has been lost and the disruption that was caused by the cuts cannot be papered over. Billions of dollars are gone from the global health system, and domestic financing alone will not fill that gap in the short-term. CHAI’s work with governments has generated evidence that will continue to influence key decisions, including the upcoming allocation of Global Fund and Gavi resources, as well as domestic budgets.

Looking ahead, we will continue to focus on transitioning to this new reality, including: (1) uncovering budget inefficiencies and ensuring limited available resources are spent; (2) transitioning systems, including by reimagining what these systems need to be (including the role of the private sector and new technologies such as AI); and (3) mobilizing resources, including from domestic sources and development banks, as well as nontraditional sources such as philanthropies and the private sector (*See Health Systems Strengthening on page 52*).



Pictured: Healthcare workers attend a training session in Ghana. Photo: Samuel Bubuedze Agbo / CHAI.



Infectious Diseases

Infectious diseases remain among the leading causes of illness and death in low- and middle-income countries, and in 2025 the money to fight them contracted sharply. Foreign aid cuts disrupted HIV and malaria programs in particular. CHAI worked with governments to keep essential commodities flowing and redirect limited budgets to the highest-priority needs. We also continued to shape markets so that new medicines, diagnostics, and other health tools reach people faster and at lower prices. Alongside this, we strengthened the systems that underpin care for severe infections, including medical oxygen, and worked to address the growing threat of drug-resistant infections that could erode the treatments countries rely on.

Antimicrobial Resistance & Sepsis

When antibiotics stop working, common infections can become life-threatening. Antimicrobial resistance, or AMR, happens when bacteria evolve to survive the drugs designed to kill them, leaving doctors with fewer, and in some cases no, treatment options. It is one of the most urgent public health threats worldwide: by 2050, an estimated 8.2 million deaths a year could be associated with drug-resistant infections, including 1.9 million directly attributable to resistance itself.⁶ The global economic burden of AMR could reach US\$100 trillion by 2050. Much of that burden is due to sepsis—the body's life-threatening response to infection, which depends on prompt and effective antibiotic treatment. Sepsis was linked to an estimated 11 million deaths in 2017—nearly one in five deaths globally—with roughly 85 percent of cases occurring in low- and middle-income countries.⁷ A 2025 study co-authored by CHAI found that over three million children died from AMR-related infections in 2022 alone—the majority of them in low- and middle-income countries.⁸

A growing burden

In April 2025, researchers from CHAI and the Murdoch Children's Research Institute presented a landmark study⁹ at the European Society of Clinical Microbiology and Infectious Diseases annual conference in Vienna. The findings were stark: in 2022 alone, drug-resistant infections killed more than 752,000 children in Southeast Asia, 659,000 in Africa, and more than 1.5 million children elsewhere in the world.

Many of these deaths were linked to two categories of antibiotics that should only be used with care: Watch antibiotics, broad-spectrum drugs, which carry a higher risk of triggering resistance, and Reserve antibiotics, the last-resort treatment doctors turn to when nothing else works. Between 2019 and 2021, the use of Watch antibiotics increased by 160 percent in Southeast Asia and 126 percent in Africa, while the use of Reserve antibiotics rose by 45 percent in Southeast Asia and 125 percent in Africa. When resistance develops to these drugs, there are few alternatives left. This points to an urgent need on multiple fronts: better tools to identify infections accurately so doctors can prescribe the right antibiotic; stronger infection control in hospitals and communities to stop resistant bacteria from spreading; and new treatments in development before existing ones fail entirely.

→ Program highlights

8

Countries surveyed in CHAI's market assessment for new gonorrhea diagnostics, treatments, and vaccines.

135

Countries set to gain access to cefiderocol under the landmark Shionogi–GARDP–CHAI collaboration.

→ Partner countries

Cambodia • Côte d'Ivoire • Ghana • India • Indonesia • Kenya • Nigeria • South Africa • Vietnam • Zimbabwe

→ Key donors and partners

Combating Antibiotic-Resistant Bacteria Biopharmaceutical Accelerator (CARB-X) • Global AMR Innovation Fund (GAMRIF) • Global Antibiotic Research and Development Partnership (GARDP) • Medicines and Healthcare Products Regulatory Agency (MHRA)

Pictured: Health workers in Lusaka, Zambia, celebrate the first in-country shipment of lenacapavir. Photo: CHAI.

Filling the evidence gap for new gonorrhea products

Gonorrhea is the second most common sexually transmitted bacterial infection in the world, affecting an estimated 82 million people annually,¹⁰ with the highest burden in Africa and the Western Pacific regions. It has become resistant to every antibiotic ever used to treat it,¹¹ leaving doctors with just one remaining effective treatment option. If resistance develops to that too, gonorrhea becomes effectively untreatable.

Despite this, the pipeline of new diagnostics, treatments, and vaccines has long lacked basic market intelligence from the countries bearing the highest burden. Global treatment guidelines have relied heavily on syndromic treatment, which depends on having reliable medicines to use empirically. As those medicines lose their activity, there is little reliable diagnostic surveillance data to inform response. Developers, often small companies with limited reach, had little idea which products would be needed, affordable, or adoptable in low- and middle-income countries.

In 2025, CHAI addressed this gap through a rigorous market assessment across eight countries—**Cambodia, Côte d'Ivoire, Ghana, India, Kenya, South Africa, Vietnam,** and **Zimbabwe**—conducted in partnership with CARB-X, a global public-private partnership that funds early-stage antibacterial product development. The assessment examined seven dimensions of gonorrhea care in each country, from disease burden and clinical practice to financing, regulatory readiness, and user preferences for new products.

Product developers in the CARB-X portfolio now have access to rare, field-level intelligence on what health systems need and the barriers that stand in the way—insights that can reshape which products are built and how they reach patients.

Advancing technology transfer for a critical last-resort antibiotic

Cefiderocol is one of the few antibiotics that can still treat the most dangerous drug-resistant bacterial infections, those caused by pathogens that the World Health Organization (WHO) considers to be of the highest priority. Cefiderocol is on the WHO's list of essential medicines for this reason. Yet, none of the 135 countries bearing the highest burden of drug-resistant infections currently have access to it.

A landmark 2022 agreement¹² between Japanese pharmaceutical company Shionogi and the nonprofit Global Antibiotic Research and Development Partnership (GARDP) set out to change that by licensing GARDP to make cefiderocol available across those 135 countries. GARDP in turn sublicensed Indian manufacturer Orchid Pharma to produce a generic version. But a license alone isn't enough. Manufacturing a complex antibiotic like cefiderocol requires specialized know-how that only the original developer holds.

CHAI's role is to bridge that gap: facilitating the transfer of manufacturing expertise from Shionogi to Orchid and helping navigate the technical, regulatory, legal, and financial hurdles along the way.

Hepatitis

Viral hepatitis B and C affect more than 280 million people globally¹³ and are the leading causes of liver cancer and liver failure. Over 1.3 million people worldwide die from liver diseases every year. Despite the availability of highly effective and inexpensive interventions, including a cure for hepatitis C and a vaccine to prevent hepatitis B, many people still lack access to these lifesaving tools. By building simple, cost-effective test-and-treat models and integrating hepatitis services into existing HIV and maternal health platforms, CHAI supports governments in their efforts to eliminate hepatitis C and end mother-to-child transmission of hepatitis B.

Rwanda: a milestone for hepatitis C elimination in Africa

Since 2016, CHAI has supported ministries of health across eight countries¹⁴ to screen 54 million people for hepatitis B and C, and 3.3 million in 2025 alone.¹⁵ In **Rwanda**, more than 10 million people were screened and 60,000 treated for hepatitis C between 2016 and 2025.

Despite this progress, no country in sub-Saharan Africa has yet achieved the World Health Organization (WHO) certification for hepatitis C elimination, largely due to the challenging undertaking of building the validated data systems and epidemiological models needed to demonstrate progress. This reached a major turning point in 2025.

Over the past year, CHAI worked with **Rwanda's** Ministry of Health and the Center for Disease Analysis Foundation—a U.S.-based organization specializing in exactly this kind of epidemiological modeling—to consolidate screening and treatment data, build baseline models, and align all partners on certification requirements. The groundwork was complete by the end of 2025, and **Rwanda** had submitted for the hepatitis C elimination certification by 2026. If successful, **Rwanda** will be the first country in sub-Saharan Africa to achieve this milestone, proving that hepatitis C elimination is not just an aspiration for high-income countries, but for all.

Ending mother-to-child transmission in Rwanda and Uganda

If a baby born to a hepatitis B-positive mother doesn't receive a vaccine within 24 hours, the infant has a 90 percent chance of

→ Program highlights

54M

People have been screened for hepatitis B and C since 2016, with 3.3 million screened in 2025 alone.

99%

Of infants born to hepatitis B-positive mothers in Rwanda were vaccinated within 24 hours of birth, where previously limited systematic vaccination existed.

200K+

Pregnant women were screened for HIV, syphilis, and hepatitis B in West Bengal, India, with an 87 percent increase in women receiving treatment.

→ Partner countries

Cambodia • India • Nigeria • Rwanda • Uganda

→ Key donors and partners

Canton of Geneva • GiveWell • The Hepatitis Fund • UK Foreign, Commonwealth and Development Office (FCDO)



Pregnant women are screened for hepatitis C in Madhya Pradesh, India. Photo: Sujata Khanna.

developing lifelong infection.¹⁶ Mother-to-child transmission accounts for up to half of all chronic hepatitis B infections worldwide. In Africa, where more than 65 percent of new infections occur, birth-dose vaccination coverage sits at just 17 percent.¹⁷ The tools to break this cycle of transmission exist, but barriers, including health systems that still treat HIV, syphilis, and hepatitis B as separate programs, persist. By integrating hepatitis B prevention into existing HIV and syphilis platforms, CHAI is working to change these outcomes across **Cambodia, India, Nigeria, Rwanda, and Uganda**. In 2025, these efforts delivered their strongest results to date, with **Rwanda** and **Uganda** as the clearest proof points.

In **Rwanda**, before CHAI's intervention, there was no systematic hepatitis B screening in antenatal care, birth-dose vaccination, or antiviral prophylaxis for pregnant women with high viral loads. That changed entirely between 2023 and 2025, when as CHAI worked with the **Rwanda** Ministry of Health and The Hepatitis Fund across more than 500 facilities. A 2025 evaluation confirmed a five-fold increase in pregnant women screened, a ten-fold increase in cases identified, and a nine-fold increase

in women initiating treatment. Nationally, 91.2 percent of pregnant women were screened and 96.4 percent of eligible women started on prophylaxis. Of more than 1,000 babies born to hepatitis B-positive mothers, 99 percent received a birth-dose vaccine within 24 hours, compared to limited systematic vaccination before the program began. As a result of this work, hepatitis B screening has become routine alongside HIV and syphilis at the first antenatal visit.

In **Uganda**, CHAI identified and began dismantling a structural bottleneck holding back progress at the primary care level: national guidelines required viral load testing before treatment could begin, a test that most frontline facilities lacked the equipment to perform. An assessment across 46 facilities in northern **Uganda** found that while nearly half of women who attended antenatal care were screened (1,089 screened out of 2,246), none received prophylaxis. CHAI and the **Uganda** Ministry of Health proposed initiating treatment based on a positive screening result and collecting viral load samples for follow-up. This removed the key barrier preventing eligible women from accessing care.

Building the global conditions for triple elimination

Rwanda and **Uganda**'s results are proof that while integrated elimination of HIV, syphilis, and hepatitis B is achievable, making it the norm requires more than country-level programs. The case for integration is straightforward: all three diseases share the same transmission pathway and the same point of intervention. Screening for all three at a single antenatal visit costs less, reaches more women, and puts less strain on already-stretched health systems. With diagnostic tools capable of testing for all three diseases simultaneously now approaching WHO prequalification for the first time, the moment to build integrated systems is now. Doing that requires the right diagnostics at affordable prices, the right financing mechanisms, and the evidence base to convince governments and donors to invest. In 2025 and into 2026, CHAI worked on all three fronts.

On diagnostics, CHAI launched the Triple Elimination Series, a set of market briefs¹⁸ examining what it takes to scale integrated testing for all three diseases,¹⁹ drew on a decade of experience scaling HIV/syphilis dual rapid diagnostic tests across six countries, where syphilis testing coverage reached near-parity with HIV testing, and distilled those lessons as a blueprint for the next generation of triple tests. A second brief,²⁰ published in early 2026, examined integrated HIV, syphilis, and hepatitis B screening across 16 countries, mapping the market landscape and what it will take to get triple tests adopted at scale. A third practical toolkit for integrating hepatitis and triple elimination into HIV programs followed

in April,²¹ timed to support countries preparing Global Fund applications under the next replenishment cycle.

On financing, CHAI advocated to protect hepatitis within the Global Fund's Grant Cycle 7 and is working to ensure integrated triple elimination is recognized as a priority investment in Grant Cycle 8. In **Nigeria**, CHAI conducted the country's first systematic triple elimination readiness assessment across 55 health facilities in nine states; findings that catalyzed one of the first dedicated state-level financing commitments for hepatitis B prevention. In **India**, a West Bengal pilot run by CHAI-affiliate The William J. Clinton Foundation, screened more than 200,000 pregnant women, trained over 700 health providers who built skills across 2,000 health facilities, and achieved an 87 percent increase in women linked to syphilis treatment. The results were strong enough that the state government expanded the program to cover all 1.6 million pregnant women annually. A GiveWell-funded cost-effectiveness evaluation that launched in October 2025 will generate the transferable evidence needed to bring this model to other Indian states and high-burden countries.

With **Rwanda** on track to becoming the first country in Sub-Saharan Africa to certify hepatitis C elimination, universal hepatitis B birth-dose vaccination now launched in both **Rwanda** and **Uganda**, and **India** and **Nigeria** moving from assessment to implementation of fully integrated programs, the question is no longer whether elimination is possible in low-income countries. It is. CHAI's role is shifting from demonstrating what works to building the systems that will sustain it.

HIV/AIDS

HIV remains one of the world's most urgent health crises. In 2025, over 40 million people were living with the virus, 1.3 million newly acquired it, and 570,000 died from HIV-related illnesses.²² 2025 also brought a historic blow to the global response: the U.S. government halted most bilateral foreign assistance programs, triggering widespread HIV funding cancellations, especially within the United States Agency for International Development (USAID).²³ CHAI rapidly mobilized with government partners to meet critical procurement needs and mitigate disruptions. Amid these challenges, CHAI helped deliver a breakthrough decades in the making: lenacapavir, a highly effective preventative injection, is set to be available at US\$40 per person per year, representing a promising path toward epidemic control.

Sustaining HIV funding in a year of upheaval

When global HIV funding collapsed in 2025, CHAI moved quickly to understand the full scale of the impact. Through a series of Market Impact Memos, published in partnership with Unitaid, CHAI tracked supply chain disruptions and service delivery consequences across multiple countries in real time. CHAI's research illustrated a 28 to 65 percent drop in oral pre-exposure prophylaxis (PrEP) initiations across seven countries, and CD4 testing down by as much as 64 percent across five countries between Q4 2024 and Q1 2025.²⁴ The resources, which were widely disseminated among governments, donors, and multilateral partners, became critical sources of intelligence at a moment when visibility was scarce and decisions were consequential.

In **Malawi**, **Zambia**, and **Zimbabwe**, Global Fund cuts totaling over US\$580 million across HIV and tuberculosis grants forced difficult budget reprioritization decisions. Supported by the Gates Foundation, CHAI worked closely with governments and partners to guide that process under Grant Cycle 7, safeguarding continued access to essential HIV commodities. In **Zimbabwe**, CHAI identified US\$2.7 million in savings and redirected the funding to early infant HIV diagnosis and viral load testing cartridges. In **Malawi**, a line-by-line comparison of budgeted and actual procurement costs revealed US\$15.7 million in annual over-budgeting for HIV commodities, which was redirected to HIV testing kits, viral load reagents, and blood safety supplies facing shortfalls. In **Zambia**, CHAI's analysis supported

→ Program highlights

US\$27.4M

In reallocations and new domestic investment in Malawi, Zambia, and Zimbabwe to protect critical HIV commodities after cuts to Global Fund grants.

>99%

Price drop achieved on generic lenacapavir, from >US\$28,000 to US\$40 per person per year.

120

LMICs where generic lenacapavir will be available in 2027, pending regulatory approval.

→ Partner countries

Cambodia • Côte d'Ivoire • Democratic Republic of Congo • Eswatini • Ethiopia • Indonesia • Kenya • Lao PDR • Lesotho • Malawi • Mozambique • Myanmar • Nigeria • South Africa • Tanzania • Uganda • Vietnam • Zambia • Zimbabwe

→ Key donors and partners

ELMA Philanthropies • Elton John AIDS Foundation • Gates Foundation • MedAccess • The Global Fund to Fight AIDS, Tuberculosis and Malaria • UK Foreign, Commonwealth & Development Office (FCDO) • Unitaid • Zvandiri

the Ministry of Health's case for US\$9 million in new domestic financing. Together, these efforts unlocked US\$27.4 million in efficiency savings and new domestic investment in HIV commodities. Across these three countries and more, CHAI worked with governments to ensure they were better equipped with stronger data, sharper procurement plans, and systems built to last beyond the immediate crisis (*for more on this work, see CHAI's Response to Foreign Aid Cuts on page 8*).

Lenacapavir: unlocking access to breakthrough innovation in long-acting HIV prevention

Lenacapavir, a twice-yearly injectable developed by Gilead Sciences, could be the breakthrough the world has waited decades for—one that finally puts ending HIV as a public health threat within reach. Clinical trials have shown that these injections are nearly 100 percent effective in protecting people from HIV.²⁵ While oral PrEP, the current standard of care, is also highly effective at reducing the risk of infection, many people struggle with the demands of a daily pill. Lenacapavir presents an option to remove that barrier entirely.

There was, however, a problem: Gilead's U.S. price of US\$28,218 per person per year.²⁶ At this price, the promise of this remarkable preventative would not be realized in low- and middle-income countries, where over 90 percent of new HIV infections occur.

In partnership with Unitaid, the South African research organization Wits Reproductive Health and HIV Institute (Wits RHI), and numerous other partners, CHAI led negotiations to bring affordably priced generic lenacapavir to market quickly. In September 2025, the partnership announced a landmark deal with Dr. Reddy's Laboratories to supply generic lenacapavir injections at a starting price of just US\$40 per person per year. That is on par with the current annual cost of oral PrEP and a reduction of more than 99 percent from Gilead's U.S. price. Crucially, the medicine will be available in 120 low- and middle-income countries by 2027 pending regulatory approval—less than two years after approval in high-income countries. Making new medicines widely available in low-

and middle-income countries has historically taken a decade or more; this deal changes that model entirely. The Gates Foundation announced a parallel deal with Hetero Labs at the same price point, setting the stage for a competitive, multi-supplier market that supports secure, sustainable access over time.

At the end of 2025, the first doses of Gilead's lenacapavir launched in **Eswatini** and **Zambia** to significant initial demand, proof of the appetite for this medication. By working to introduce innovative, long-acting injectable prevention at an accessible price, CHAI aims to shape a larger, more diverse market of HIV prevention tools for users to choose from. CHAI is working with urgency to turn the promise of generic lenacapavir into dramatically fewer new infections. The question now is whether the funding crisis threatening its rollout can be overcome before the opportunity slips away.

From crisis to continuity: scaling advanced HIV disease care in Kenya

Mortality due to advanced HIV disease remains unacceptably high, with 570,000 people dying from AIDS-related causes in 2025,²⁷ not from HIV itself, but from the infections a healthy immune system would simply fight off, such as pneumonia, meningitis, and tuberculosis. Children are especially vulnerable. Around 30 percent present with severe immunosuppression at their very first HIV diagnosis, and all children under five are automatically classified as having advanced disease because their risk of dying without immediate treatment is so high.²⁸ The 2025 foreign aid cuts hit hard. With community health workers who identified and tracked the most vulnerable patients losing their jobs overnight, and clinics running short of essential medicines, more people living with HIV, who were also at the highest risk, began falling through the cracks.

CHAI had already been leading the THRIVE project, a Unitaid-supported initiative working across **Kenya**, **Mozambique**, **Nigeria**, **South Africa**, **Uganda**, and **Zimbabwe** to ensure that even the most vulnerable people living with HIV could access the screening and treatment



A patient is screened for HIV in Nairobi, Kenya. Photo: Eric Gitonga.

that keeps them alive. When the funding crisis hit, THRIVE intensified and expanded support to country programs, and **Kenya** became a standout example of what was possible amid funding disruptions.

In **Kenya**, CHAI worked with AFROCAB, a network of community HIV advocates, to conduct targeted training and supply monitoring to expand access to care even amid severe disruption. The results were significant: the share of people living with HIV screened for advanced HIV disease at THRIVE focal sites increased by 21 percentage points during 2025. Screening for cryptococcal meningitis, a leading cause of HIV-related death, more than tripled. For children between five and 14 years old, screening rose by a third.²⁹

As funding cuts disrupted many formal health services, AFROCAB's community champions became a critical link to care. Champions and facilitators went door-to-door, connecting people to care and tracking down those who had stopped coming to clinics after funding cuts interrupted services. They managed to reengage 75 percent of clients who had

previously missed appointments for ART services in 2025. Meanwhile, more champions and facilitators took over routine commodity monitoring at facilities, which was critical to flagging testing or drug shortages before they became crises.

Through THRIVE, CHAI worked with the national program to strengthen systems for the long term: we worked with the Ministry of Health to develop a national operational manual for advanced HIV disease, digitized training materials for rollout across all 47 counties, and ensured patient data flowed into **Kenya's** national health system, embedding lasting capacity within their HIV response. This work embeds and strengthens government capacity, building national program resilience in response to shocks to donor-supported systems.

Across the THRIVE countries, CHAI and AFROCAB are sustaining lifesaving care during this period of change, building government-owned systems to protect people living with advanced HIV disease long after the project ends.

Malaria & Neglected Tropical Diseases

Malaria, spread by mosquitoes, has seen a concerning case uptick of nearly 23 percent since 2015 and continues to take many lives around the world. Africa carries nearly 95 percent of the estimated 282 million cases and 610,000 deaths reported across 80 endemic countries in 2024.³⁰ Neglected tropical diseases, a group of more than 20 conditions caused by viruses, bacteria, parasites, fungi, and toxins, also bear devastating consequences, affecting more than a billion people annually.³¹ To control and eliminate malaria and neglected tropical diseases, CHAI partners with governments across Africa, the Americas, and Asia to enhance disease surveillance and data-driven program management.

Keeping programs running despite massive funding cuts

The U.S. foreign aid freeze in early 2025 severely impacted the President's Malaria Initiative (PMI), the U.S. government's flagship malaria program that funds prevention and treatment across 26 African countries. The freeze immediately threw an estimated 293 million malaria commodities into limbo, including 131 million drug doses for prevention and treatment, 38 million bed nets, and 111 million rapid diagnostic tests. Models from the Malaria Atlas Project estimated that without the PMI's interventions planned for 2025, around 15 million malaria cases and 107,000 deaths could result in a single year.³² The crisis was compounded in April 2025, when the Global Fund, which finances over half of all international funding for malaria prevention and treatment, directed recipient countries to pause non-essential activities and later announced cuts of nearly 10 percent to grant allocations.^{33,34,35}

In the wake of funding suspensions, CHAI compiled ground-level intelligence on disrupted PMI activities, timelines, and commodity orders, and shared the analysis with partners through global working groups to inform advocacy and prioritization. CHAI mobilized resources to move stranded commodities, helped governments streamline budgets, and collaborated with its network of donors to identify pathways to procure new funds to mitigate gaps, ensuring the highest priority needs were still met in 2025.

With emergency funds from GiveWell and the Gates Foundation, CHAI ensured that previously

→ Program highlights

4.8M

Emergency tests and treatments procured by CHAI to rapidly fill commodity stockouts in Malawi, Nigeria, and Senegal.

17K+

Estimated severe malaria cases averted in Benin and Cameroon through CHAI's efforts to ensure the continuation of seasonal malaria chemoprevention campaigns for children, despite U.S. funding freezes.

→ Partner countries

Angola • Benin • Burkina Faso • Cambodia • Cameroon • Democratic Republic of Congo • Dominican Republic • Ethiopia • Guatemala • Haiti • Honduras • India • Kenya • Lao PDR • Malawi • Mozambique • Myanmar • Nigeria • Panama • Papua New Guinea • Senegal • Sierra Leone • Uganda • Vietnam • Zimbabwe

→ Key donors and partners

Children's Investment Fund Foundation • Duke University • Gates Foundation • GiveWell • Inter-American Development Bank • Open Philanthropy • Partners for Equity • Skip Foundation • The Global Fund to Fight AIDS, Tuberculosis and Malaria • UK Foreign, Commonwealth & Development Office (FCDO) • United Nations Office for Project Services • Wellcome Trust

procured commodities reached their intended destination, enabling the continuation of lifesaving malaria campaigns and routine health services. Further, CHAI helped 12 national malaria programs adapt to Global Fund grant reductions without sacrificing core program delivery, assessing budgets line by line to cut costs in items like transportation, warehousing, and non-essential trainings.

Where imminent commodity shortfalls were identified, CHAI worked directly with donors and suppliers to cover them, raising US\$1.7 million to procure 4.8 million emergency tests and treatments in **Malawi, Nigeria, and Senegal**, and managing in-kind donations of over 1.1 million treatments across **Angola and Burkina Faso**. In **Zimbabwe**, CHAI helped find drastic efficiency gains, mobilizing almost 350,000 bed nets stranded in warehouses, which reached 96 percent coverage across the seven highest burden districts and protected 533,000 people. In **Benin and Cameroon**, more than two million children risked missing seasonal malaria chemoprevention—doses of preventive drugs given across multiple rounds during peak transmission season. By consolidating campaign budgets by a combined US\$1.3 million, **Benin and Cameroon** were ultimately able to deliver nearly 10 million doses across those rounds, averting an estimated 17,500 severe malaria cases.³⁶ In **Mozambique**, CHAI not only identified a 43 percent reduction (US\$8 million) in bed net distribution costs but also integrated net delivery with a mass drug campaign against trachoma³⁷ that had lost its own funding. This approach reached over a million people in the country.

Even as funding faltered, two regions closed in on malaria elimination

For over a decade, CHAI’s embedded government partnerships have helped reduce cases by more than 99 percent in the eastern Greater Mekong Subregion (**Cambodia, Lao PDR, and Vietnam**) and achieve substantial gains across Central America (**Guatemala, Honduras, and Panama**). Both regions are close to elimination, but reaching the last cases requires targeted solutions, innovative treatment, and engagement with communities

that health systems have historically missed. In 2025, CHAI focused on two priorities: strengthening precision surveillance systems capable of tracing individual cases to their source and scaling curative treatment for Plasmodium vivax, which is implemented after patients test negative for genetic Glucose-6-Phosphate Dehydrogenase.³⁸

In **Lao PDR**, the national malaria program officially adopted case investigation and classification nationwide, a strategy that enables health facilities to trace every case back to its source and target their response accordingly, following CHAI’s pilots and years of advocacy. CHAI helped develop strategic plans and surveillance guidelines in **Cambodia and Vietnam** that will anchor their elimination programs through the next decade. In Central America, CHAI collaborated with the Pan American Health Organization and the Global Fund on an accelerated elimination plan for P. falciparum in the high-burden Moskitia border region between **Honduras and Nicaragua**. In **Honduras**, CHAI also worked directly with communities to improve early case detection, an approach the government plans to scale to two more regions in 2026. In **Guatemala**, CHAI expanded access to diagnostic testing and strengthened community health worker networks.

Across the Greater Mekong Subregion and Central America, 2025 provided clear evidence that elimination is within reach, reflecting years of sustained investment in surveillance, community engagement, and innovative treatment. **Cambodia** recorded just 52 total cases—an 84 percent decline from 2024—and after September, not a single detected case was classified as locally transmitted, a positive sign that malaria is spreading less within the country’s borders. In **Lao PDR**, a nationwide case investigation revealed only four P. falciparum infections across the entire country in 2025, down from 41 in 2024.

Notable subnational progress is also measurably apparent: in Kaukira (Gracias a Dios, **Honduras**), co-creation workshops helped increase passive testing among men by 69 percent and early case diagnosis improved by

10 percentage points.³⁹ In **Guatemala**, 19 CHAI-supported districts collectively recorded a 51 percent case reduction (compared with a 122 percent increase in non-supported districts), and Escuintla achieved another record-low year with just 67 cases.

Elimination certification is on the horizon for **Cambodia**, with preparation activities guided by the new 2026-2035 national strategic plan. In **Lao PDR**, subnational elimination verification is underway in eight provinces that have recorded no local cases for three consecutive years. Historically, 92 percent of countries that reach elimination maintain it,⁴⁰ making the final push not just worthwhile but one of the most sustainable investments in global health.

Fighting dengue with Wolbachia-infected mosquitoes

2024 marked dengue’s worst year on record, with over 100 countries collectively reporting more than 14 million cases and 11,000 deaths.⁴¹ This 12-fold increase in just a decade has been accelerated by climate change, which has pushed Aedes aegypti—the mosquito that transmits the virus—into new geographies, putting nearly half of the world’s population at risk.⁴² Unlike malaria, there is still no treatment for dengue beyond managing

symptoms, underscoring an urgent need for a sustainable, scalable prevention model for countries already operating under severely constrained resources.

Leveraging two decades of malaria experience, in 2025, CHAI began to help vector-borne disease⁴³ in Central America and Southeast Asia roll out novel approaches like releasing Ae. aegypti mosquitoes infected with Wolbachia. Wolbachia is a genus of bacteria with demonstrated potential without the need for costly, recurrent insecticidal spraying.⁴⁴

Informed by readiness scoping across 14 countries, CHAI began directly supporting **Guatemala and Cambodia**, helping their ministries of health move from early-stage exploration to concrete implementation planning: securing government buy-in, producing the first high-resolution dengue risk maps to guide optimal release site selection, and developing cost-effective, scalable delivery models. Initial mosquito releases are planned for **Guatemala** in 2026 and **Cambodia** in 2027, marking an important step toward self-sustaining dengue control and, if successful, demonstrating a replicable model of government-led Wolbachia deployment.

Oxygen Therapy

While high-income countries take access to medical oxygen for granted, health facilities in low- and middle-income countries have long struggled due to aging infrastructure, limited funding, and weak supply chains. The COVID-19 pandemic made these gaps impossible to ignore. CHAI has worked on oxygen access for over a decade with one consistent goal: to ensure that a mother in respiratory distress, a premature newborn, or a child with severe pneumonia can receive oxygen when and where they need it. In 2025, with global health funding facing dramatic cuts, CHAI focused on negotiating supplier agreements to lower the cost of oxygen, helping governments generate revenue from their own oxygen infrastructure, and securing record increases in domestic budget allocations for oxygen. The result has been a massive and vital increase in medical oxygen availability throughout Africa.

The breath of life

Low blood oxygen, or hypoxemia, is a life-threatening condition for preterm infants and surgical patients, as well as people with respiratory infections, sepsis, malaria, and more. Hypoxemia increases the risk of death from such conditions seven-fold. In low- and middle-income countries, hypoxemia affects nearly one-quarter of sick newborns and more than one in six hospitalized children.⁴⁵

Medical oxygen is the only treatment for hypoxemia, yet access remains critically limited. Globally, 374 million people require medical oxygen each year. In low- and middle-income countries, only 30 percent of those with acute conditions receive adequate oxygen therapy. The situation is most severe in sub-Saharan Africa, where just nine percent of patients with acute medical conditions have reliable access to oxygen.⁴⁶ Despite the challenges, countries facing oxygen shortages are often major industrial oxygen producers, indicating untapped opportunities to align production for medical needs.

The World Health Assembly recognized this issue in 2023, when it unanimously adopted its first resolution to improve oxygen access,⁴⁷ reflecting a growing recognition of its lifesaving importance across a range of conditions. Nowhere is that importance clearer than with pneumonia, the single largest infectious cause of death in children worldwide. A systematic review by CHAI found that improving oxygen systems can reduce in-hospital deaths from childhood pneumonia by nearly 50 percent and

→ Program highlights

10,000

Tons of medical oxygen made available to government hospitals thanks to agreements signed with suppliers in Kenya and Tanzania.

99%

Hypoxemic patients in focal facilities who received oxygen in Ethiopia when they needed it, up from 79 percent at baseline in 2024.

6%

Facility-level oxygen shortages in Ethiopia, down from 36 percent in 2024.

→ Partner countries

Burkina Faso • Cambodia • Cameroon • Democratic Republic of Congo • Eswatini • Ethiopia • Ghana • India • Kenya • Lao PDR • Lesotho • Liberia • Malawi • Mozambique • Nigeria • Rwanda • Tanzania • Uganda • Zambia

→ Key donors and partners

ELMA Philanthropies • Gates Foundation • GiveWell • The Leona M. & Harry B. Helmsley Charitable Trust • Unitaid • U.S. Government/FHI360

all-cause child deaths by 25 percent. Moreover, against childhood pneumonia, oxygen systems prove to be as cost-effective as other interventions, such as vaccines.

CHAI has worked on oxygen access for over a decade, starting with childhood pneumonia and expanding through the pandemic response, with one consistent goal: to ensure that a mother in respiratory distress, a premature newborn, or a child with severe pneumonia can receive oxygen when and where they need it. In 2025, with global health funding tightening, CHAI focused on making those gains permanent by negotiating supplier agreements to lower costs, helping governments generate revenue from their own oxygen infrastructure, and securing record increases in domestic budget allocations for oxygen.

In addition to improving oxygen supplies, CHAI tackles pneumonia by supporting countries to adopt updated treatment guidelines and ensuring access to amoxicillin dispersible tablets—the first-line antibiotic for childhood pneumonia. Together, these interventions have the potential to save 300,000 lives each year across 35 countries with some of the world's highest pneumonia mortality rates.

Hub-and-spoke model brings oxygen to tens of millions

A decade ago, **Ethiopia** had just three oxygen production facilities for a population of over 100 million. A 2016 assessment of over 100 hospitals found that only 62 percent had oxygen access in their inpatient pediatric departments, and fewer than half had pulse oximeters—devices that track oxygen levels in the blood. For smaller health centers, the situation was worse: only two percent had functional oxygen cylinders.

Starting in 2016, CHAI partnered with **Ethiopia's** Ministry of Health to develop the country's first national oxygen roadmap and facilitated the installation of 14 oxygen plants, each sized to supply not just its host hospital, but neighboring facilities as well. But more infrastructure alone didn't solve the problem. Plants were running at just 55 percent of their capacity, held back by a lack of spare parts,

daily maintenance, and trained technicians and clinicians. Even when plants produced surplus oxygen, there was no clear way to get it to the smaller, rural facilities that needed it most.

CHAI's core innovation is the hub-and-spoke distribution model, which designates production facilities as central hubs supplying surrounding health centers at regulated, affordable prices. Before the model, facilities like Dildana Primary Hospital sourced oxygen from Addis Ababa, more than 400 kilometers away. Today, it receives oxygen from Arbaminch General Hospital, just five kilometers down the road.

To make the model self-sustaining, CHAI worked with the Ministry of Health and regional health bureaus to develop a national Oxygen Sustainable Financing Directive, now adopted in 11 of 14 regions. The directive requires hub hospitals to sell surplus oxygen to spoke facilities at a ceiling price. It then requires spoke facilities to deposit the money earned from selling that oxygen into dedicated accounts for operations and maintenance within health centers. In January 2025, with US\$1.8 million from the Helmsley Charitable Trust and ELMA Philanthropies, CHAI distributed essential equipment to more than 900 health facilities and supported the training of more than 5,000 healthcare workers.

The scale of the change has been significant. **Ethiopia** now has 55 production facilities, up from just three in 2016, with 14 more in the pipeline. In hospitals within the program's scope, every inpatient pediatric department now has oxygen access, up from 62 percent. Pulse oximeters are now available in 96 percent of facilities, up from 45 percent, and approximately 500 health centers out of 3,932 have oxygen services.

Altogether, these gains have brought reliable oxygen access to approximately 58 million people—nearly half of **Ethiopia's** population. Crucially, the system is now paying for itself. Other countries with similar challenges are now looking to replicate **Ethiopia's** success.

Binding supply agreements spur new plants in East Africa

Some countries across East Africa have access to less than 10 percent of the oxygen they need.⁴⁸ A 2022 study of healthcare facilities across sub-Saharan Africa found that fewer than half have reliable access to oxygen, and nearly one in four don't have it at all.⁴⁹

CHAI recognized that the oxygen shortage in East Africa was not primarily a production problem, but a market problem. To solve this, Unitaid, working with MedAccess and CHAI negotiated binding supply agreements with three local oxygen producers—Synergy Gases and Hewatele in **Kenya**, and TOL Gases in **Tanzania**—locking in price ceilings and production targets to make oxygen more affordable.

Two new plants will be commissioned in Q4 2026, each capable of producing 13 tons of oxygen per day in Mombasa and Dar es Salaam. A third partner has already commissioned a larger 20-ton-per-day plant in July 2026 in Nairobi.

These new facilities will not only supply **Kenya** and **Tanzania** but also neighboring countries including **Malawi, Mozambique, Uganda, Ethiopia, DRC,** and **Zambia**. CHAI also invested in the infrastructure needed to move oxygen from production sites to health facilities.

By boosting supply and fostering competition, this program is expected to lower oxygen costs by up to 27 percent across the region.⁵⁰ Over the next decade, the initiative has the potential to save up to 111,575,000 lives in the region.

Building national capacity in Lao PDR

In **Lao PDR**, access to oxygen therapy has long been inconsistent and poorly tracked. As recently as 2023, fewer than half of patients

in Bokeo province were being checked for dangerously low blood oxygen, and fewer than three-quarters of those who needed oxygen were receiving it. The problems ran deeper than equipment gaps. When the program began in 2021, **Lao PDR** had no capacity to produce medical oxygen within the country, depending on imports from Thailand or **Vietnam**. This meant that a single border disruption could cut off the entire supply.

Over the past year, that picture has changed dramatically. CHAI worked with the country's Department of Healthcare and Rehabilitation to build a system designed to keep running without outside support. Today, the country has eight oxygen production plants, seven large-scale liquid oxygen storage systems, and six hospitals with oxygen piped directly to patient bedsides—together capable of serving an estimated 11,000 more patients every year. In January 2025, the Ministry of Health made blood oxygen monitoring a required part of every patient assessment across all hospitals and health centers in the country.

CHAI also helped mobilize roughly US\$3 million in additional resources from partners including the Global Fund and the World Health Organization, as well as coordinated a donation of 825 oxygen sensors for newborns. More than 500 clinical and technical staff have been trained across the full program on how to identify and treat patients, and how to manage oxygen supplies.

The results speak for themselves. In Bokeo and Khammouane provinces, the share of patients checked for low blood oxygen rose to over 99 percent. Every acute care area in both provinces now has a working device to measure blood oxygen levels. Treatment coverage is up to 98 to 99 percent, giving patients a better chance at recovery.

Tuberculosis

Tuberculosis remains the world's deadliest infectious disease, causing more than 10 million people to fall ill and over a million deaths annually.⁵¹ A disproportionate amount of this burden falls in Asia and Africa.⁵² Many people with tuberculosis remain undiagnosed: either because they don't have symptoms or are misdiagnosed, or because of limited access to screening and care.⁵³ In 2025, CHAI partnered with governments to expand tuberculosis case detection through community-based approaches that bring services closer to patients, including negotiating more affordable pricing for ultraportable, digital chest X-rays to reduce the cost of improved tuberculosis screening and triage in both primary health care facilities and in the community. CHAI also supported the planning and introduction of oral swab-based tuberculosis molecular tests that can diagnose the disease within 30 minutes; helping to forecast needs to quantify demand, guide deployment strategies, and inform investment decisions. At the same time, CHAI is working with partner countries to prepare for emerging tuberculosis vaccines.

Closing the diagnostic gap with AI-powered chest X-ray

In the countries with the highest tuberculosis burden, there can be as few as one radiologist for every million people. Without enough specialists to read chest X-rays or screening stalls, people go undiagnosed for months—quietly spreading the disease to their communities. AI-powered software solves exactly this bottleneck: computer-aided detection (CAD) software reads a chest X-ray and flags how likely it is to show tuberculosis, performing as well as a trained radiologist. The World Health Organization (WHO) recommends it as a substitute for a human reader in screening people aged 15 and older. Paired with a portable X-ray machine, that means screening can go wherever clinics can't: mobile units, rural outposts, and displacement camps.

In May 2025, CHAI and Unitaid acted on that potential. By negotiating with manufacturer Poskom to cap the price of its AirRay 20 portable X-ray system, CHAI helped make it available to eligible programs across 138 low- and middle-income countries, including some of the highest-burden countries in the world.⁵⁴ CHAI is also working to further reduce costs for the AI software that accompanies the X-ray and to ensure devices stay reliable once they're in the field.

But making the technology affordable only matters if countries can actually deploy

→ Program highlights

1M+

People in Kenya screened for tuberculosis and other respiratory conditions.

5,969

Cases of asthma, COPD, and post-tuberculosis lung disease identified in Kenya.

1st

South Africa published its first regulatory guidelines for ultra-portable digital X-ray systems.

→ Partner countries

Cambodia • Cameroon • China • Ghana • India • Kenya • Mali • Nigeria • South Africa • Tanzania • Uganda • Vietnam • Zimbabwe

→ Key donors and partners

Gates Foundation • GiveWell • Open Philanthropy • Stop TB Partnership's TB REACH Initiative • The Global Fund to Fight AIDS, Tuberculosis and Malaria • UK Foreign, Commonwealth & Development Office (FCDO) • Unitaid



A patient is given a chest X-ray to screen for tuberculosis in Ladakh, India. Photo: Sujata Khanna.

it—which is exactly the barrier **South Africa** faced. **South Africa** is among the 10 highest-burden tuberculosis countries, and access to ultra-portable digital X-rays have been limited by the absence of clear rules for approving the devices. This leaves manufacturers and buyers unable to deploy ultra-portable X-ray for human use, as no regulatory standards or approval pathways exist.

In 2025, CHAI worked with the South African Health Products Regulatory Authority (SAHPRA) to close that gap, reviewing regulatory practices from other countries and building consensus among regulators and clinicians on the evidence. Rather than building a new approval process from scratch, the resulting framework lets SAHPRA recognize trusted international approvals while still holding devices to **South Africa's** own safety standards. The guidelines, published in November 2025, are **South Africa's** first regulatory guidelines for ultra-portable X-rays—a nationally owned framework that strengthens SAPHRA's own institutional capacity while giving manufacturers, implementers, and patients a predictable path for safe, scalable adoption.

Technology is only one part of closing the tuberculosis diagnostic gap. In **Kenya** and **Nigeria**, the bigger shift has been in how screening itself is designed—built to find tuberculosis and other conditions a tuberculosis-only test would miss.

Tuberculosis has a hiding place—and integrated screening is finding it

Services aren't always designed around how people actually seek care, which means the people who most need screening are often the least likely to get it. In **Kenya** and **Nigeria**, programs moved beyond disease-specific screening models toward care that catches more in a single visit.

In **Kenya**, the Ministry of Health, supported by CHAI and funded by the Gates Foundation and GSK, set out to fix a problem familiar to anyone who has worked in tuberculosis: patients who test negative and get sent home, even when something else is clearly wrong. CHAI began by collecting data—**Kenya's** first national readiness assessment for lung health, covering 201 facilities across seven counties. The findings shaped new national guidelines for lung health and a defined package of essential services. It

brought asthma, chronic obstructive pulmonary disease (COPD), and post-tuberculosis lung disease into the same reporting system used for tuberculosis. Building on that foundation, the Integrated Program on Asthma, COPD, and TB (iPACT) rolled out in the three proof-of-concept countries in Nairobi, Murang'a, and Nakuru, training health workers to screen, diagnose, and manage all three conditions through a single care pathway that combines AI-assisted chest X-ray with simpler lung function tests like spirometers and peak flow meters. As of December 2025, more than 1,000 health workers across 165 facilities were trained in the classroom, alongside an additional 2,000 community health workers who were reached through facility-based Continuous Medical Education sessions and sensitization activities. In addition, more than 1,000 Community Health Assistants and Community Health Promoters were equipped with the knowledge and skills needed to support early detection, referral, treatment adherence, and community-raising awareness for tuberculosis and other lung conditions. More than one million people were screened, and 14,823 persons with tuberculosis were identified—a 12 percent increase in tuberculosis notifications in Nakuru and seven percent in Murang'a. Screening also caught 4,476 cases of asthma, 1,278 cases of COPD, and 617 cases of lung fibrosis. Also, 905 tuberculosis survivors were checked for lasting lung damage after treatment.⁵⁵ **Kenya** is now expanding iPACT to all 560 tuberculosis treatment sites

in the three proof-of-concept countries, and an addition 2,057 in 15 additional counties, with a plan to fund lung health services long-term through **Kenya's** Social Health Authority national benefits package.

If **Kenya** shows what integration looks like inside a health facility, **Nigeria** shows what it looks like when there is no facility to go to. **Nigeria** is home to roughly 2.3 million internally displaced people, most in the northeast, where 31 percent of health facilities are non-operational. Mobile outreach teams bring screening directly into displacement camps—tuberculosis, alongside HIV, malaria, hepatitis, and malnutrition assessment, all in a single visit. Across four camps, teams screened 5,577 people and found 144 cases, and everyone started on treatment within a day. Nearly all were also tested for HIV, and most were assessed for malnutrition and connected to support. More than one in eight of the tuberculosis cases had no symptoms at all—people who would never have sought care on their own and would have unknowingly kept spreading the disease.⁵⁶

Together, **Kenya** and **Nigeria** show what's possible when tuberculosis screening is designed around people instead of a single disease: more cases found, faster treatment, and a burden of illness that standard approaches would have missed.



Non-communicable Diseases

Non-communicable diseases (NCDs) are the leading cause of death globally, and most of those deaths occur in low- and middle-income countries, where they are expected to rise significantly over the next decade. This section covers CHAI’s work on diabetes and hypertension and on cervical cancer, alongside two related areas that share many of the same challenges: sickle cell disease, a genetic blood disorder, and assistive technology, which helps people with disabilities see, hear, move, and learn. These conditions are often missed or diagnosed late, require care over a lifetime, and have long received too little attention and funding. Across all of these programs, CHAI works with governments and partners to increase access to early and affordable diagnosis and treatment, bringing care closer to where people live, and strengthening the financing and systems that sustain it.

Assistive Technology

Globally, more than one billion people⁵⁷ lack access to lifechanging assistive technologies: products and services that enhance individual functioning, including wheelchairs, hearing aids, eyeglasses, and cognitive aids. This gap leads to an impact on livelihoods, lower quality of life and poorer health outcomes. In collaboration with governments, partners, and donors, CHAI is working to deliver assistive products at scale by improving their quality and affordability.

Advancing access for children with disabilities and developmental delays

Globally, more than a billion people don’t have access to the assistive technologies they need, according to a 2025 market report released by CHAI and ATscale.⁵⁸ Millions of children with disabilities in low- and middle-income countries are denied opportunities to play, learn, and develop, simply because they don’t have the right technology. Early identification of needs and support services are critical in the early years of a child’s life. Without them, children fall behind in ways that are hard to reverse.

Today, charitable donations provide some relief, but this approach is fragmented, unsustainable, and reaches only a fraction of those in need. In most low-resource settings, assistive technology provision sits outside government systems entirely, with weak regulation on product quality and little coordination between health and education sectors. CHAI’s market report⁵⁹ found that the unmet need for these technologies is about ten times larger than the current demand, showing there is huge scope for the market to grow.

CHAI’s approach focuses on embedding assistive technology into government health and education systems, moving away from one-off donations and toward sustainable, country-owned delivery. In 2025, our work across eight countries (**Ethiopia, Indonesia, Kenya, Liberia, Nigeria, Rwanda, Sierra Leone, and South Africa**), led to 2.9 million children being screened for disabilities. As a result, 29,124 were identified and supported with assistive technology.

→ Program highlights

2.9M

Children screened for disabilities; 29,124 already identified and supported with assistive technology.

1M+

Adults with near vision loss supported with reading glasses in Nigeria.

100

Suppliers featured in a new market report, along with 25 global organizations across 12 countries.

→ Partner countries

Cambodia • Ethiopia • India • Indonesia • Kenya • Liberia • Nigeria • Rwanda • Sierra Leone • South Africa • Uganda

→ Key donors and partners

ATscale, the Global Partnership for Assistive Technology • EYelliance • GIZ • Global Disabilities Innovation Hub • LEGO Foundation • Lever for Change • Livelihood Impact Fund • RestoringVision • Vision Catalyst Fund

Pictured opposite: Cervical precancer treatment demonstration in Kachin State, Myanmar. Photo: Studio AT.

Across these eight countries, CHAI developed or expanded curricula while supporting the training of more than 25,000 health workers, early childhood educators, and community workers to support the early identification of needs and the provision of assistive products. For example, in **Nigeria**, health workers are now fitting and distributing locally sourced devices including guide canes, standing frames, ankle boots, and neck braces to children identified through CHAI’s program.

CHAI also helped governments with their national supply chains and procurement. In 2025, CHAI procured more than 26,000 devices to help with vision, mobility, and hearing. For example, CHAI struck a deal with OneSight Essilor Luxottica Foundation, the charitable organization affiliated with the world’s leading eyewear company, enabling CHAI and governments to get more for less. In **Kenya**, CHAI partnered with local artisans and experts to design and develop adaptive play items such as braille puzzles. These were prototyped and tested in schools and are now being used in classrooms and during routine screening campaigns.

CHAI established more than 200 partnerships across the eight countries, bringing together education, health, and social sector partners to work toward our shared goal of improving the lives of children with disabilities. We also partnered with governments to influence over 60 policy interventions to guide the delivery of inclusive health and education services for children. These include national strategies, action plans, as well as screening and technology provision guidelines. Children in health facilities, schools, and communities are now routinely screened, identified, and provided with the right aid—and their needs are increasingly tracked in government data systems.

The growing involvement of government ministries, domestic financing schemes, and other local organizations signal that CHAI-proven models have become integral to how these countries routinely support people with disabilities. In **Rwanda**, assistive products now fall under government social health insurance,

which covers more than 80 percent of the population. In **Nigeria**, the Universal Basic Education Commission is integrating CHAI’s screening tool into the national health system, enabling disability tracking across facilities and schools. In **Kenya**, CHAI partnered with the **Kenya** Institute of Special Education to revise school intake screening tools that now assess about 2,000 children a month and direct families to the right services. And in **South Africa**, eyeglasses are now distributed through school health programs.

Across program countries, 29,124 children have received assistive technology through CHAI’s program so far. This includes 9,391 children provided with eyeglasses; 3,945 provided with mobility aids such as wheelchairs; 6,876 provided with cognitive aids, such as flashcards, for children with learning or communication difficulties; 5,874 children reached with adaptive play items such as sensory toys; and additional children reached with devices such as hearing aids, low vision aids, braille kits, and supportive seating devices. All this enables these children to move, play, and participate independently in daily life, in turn granting greater independence for the whole family.

A million eyeglasses in Nigeria

In 2024, approximately 25 million Nigerians⁶⁰ had age-related near vision loss (or ‘presbyopia’) that wasn’t being addressed. Adults with presbyopia struggle to complete near vision tasks such as sending a text message, counting change, threading a needle, or repairing small machinery.

Presbyopia is easily tackled with a pair of reading glasses, which are cheap to manufacture and simple to dispense. Yet, **Nigeria’s** public health system lacked the capacity to screen and reach older adults, and awareness of the condition remains low. The result: a cycle of low demand, limited supply, and high prices.

CHAI worked hand-in-hand with the Nigerian National Eye, Ear, and Sensory Health Program to launch eye care services, including screening for presbyopia and dispensing reading glasses at 770 primary health facilities across 10 states.



Health workers learn to conduct near-vision screening at a training in Plateau State, Nigeria. Photo: CHAI.

Together, we revamped the training curriculum and trained more than 2,000 health workers to provide screening and glasses; integrated reading glasses into the national supply chain; conducted clinical mentorship visits to more than 100 facilities to ensure adherence to protocols; and built tools and dashboards to monitor dispensing and correct issues as they arose. CHAI also partnered with the OneSight Essilor Luxottica Foundation to access product donations and technical assistance for building optical labs and vision centers, which provide vision services including eye exams, prescriptions, and the treatment of eye issues.

The program screened 1.2 million people over the age of 40, of whom more than a million

were found to have presbyopia and were given reading glasses. These people could finally see clearly, read their religious texts, and conduct near-vision work critical to their livelihoods—all for less than US\$2 per pair of glasses.

Given the program’s success, CHAI plans to expand to six new states in **Nigeria** in 2026. Three state governments have begun dedicating domestic funding to eye health because of the program. And, by increasing awareness of presbyopia, we have kickstarted demand for reading glasses and increased retailer interest. In 2026, CHAI will partner with private pharmacy chains to sell glasses at a price of less than US\$2.

Cervical Cancer

Cervical cancer claims more than 280,000 lives annually, 94 percent of them in low- and middle-income countries, where it remains the leading cause of cancer death for women.⁶¹ CHAI has made steady progress toward preventing cervical cancer by expanding screening, integrating services into routine health systems, mobilizing sustainable financing, and advancing innovative low-cost AI-assisted screening solutions.

The World Health Organization has set "90-70-90" targets for cervical cancer: 90 percent of girls vaccinated against HPV by age 15; 70 percent of women screened using a high-performance test by age 35 (and again by age 45); 90 percent of women with pre-cancer treated; and 90 percent of women with invasive cancer managed. Along with CHAI's work on HPV vaccines (*see Vaccines, page 48*), we are working hard with country governments to meet these goals.

CHAI's cancer program is also working on breast cancer and radiotherapy access to strengthen health systems and improve survival rates across low- and middle-income countries. Together, they represent a more integrated approach to women's cancers, where shared health system investments and coordinated service delivery can drive greater impact than any single program alone.

Better screening with at-home sample collection and AI

In recent years, the cervical cancer screening landscape—both the tools available and how they're delivered—has improved dramatically.

In the past, women needed to visit a medical clinic to be screened for cervical cancer, either through visual inspection with acetic acid, or provider-assisted human papillomavirus (HPV) sample collection. Both are invasive procedures that require a speculum and are uncomfortable or painful for many women. This can now be replaced with a self-sampling kit that women can do themselves: a simple swab does not need to touch the cervix and can be analyzed for certain high-risk strains of HPV. Self-collection empowers women, while reducing key barriers of vulnerability, distance,

→ Program highlights

US\$700K

In catalytic financing secured from Nigeria's First Lady.

90%+

Kenyan women reached through a door-to-door community screening study that had never previously been screened for cervical cancer.

→ Partner countries

India • Kenya • Malawi • Myanmar • Nigeria • Rwanda • South Africa • Zambia • Zimbabwe

→ Key donors and partners

Judith Neilson Foundation • Patrick J. McGovern Foundation • Unitaid • World Health Organization

stigma, and provider availability. It can also substantially improve screening access: evidence shows that self-sampling increases HPV testing uptake and is preferred by women over provider-collected approaches. CHAI has worked with nine countries to help extend the use of such systems, thus equitably expanding access to screening. Recent evidence generated in a subset of these countries demonstrated that community-based delivery of HPV self-sampling increases screening coverage while achieving similar rates of linkage-to-care as health-facility-based models.⁶²

However, lack of infrastructure, weak health systems, and financing constraints continue to limit the scale-up of HPV testing models, particularly in low- and middle-income country settings that suffer from variable rates of linkage-to-care. Building on its development and validation of Automated Visual Evaluation (AVE),⁶³ an AI-assisted cervix visualization tool (AI-ACVT) that provides decision support to health workers, CHAI is shaping the emerging market for this new class of products. AVE has shown superior sensitivity to the naked eye (the standard of care in many countries) and is highly cost-effective. These low-cost, accurate, and scalable solutions can serve as a primary screening approach where HPV testing cannot achieve sufficient population coverage. In 2025, CHAI engaged more than 40 commercial partners to advance AI-ACVT solutions toward regulatory approval and market entry at affordable prices in low- and middle-income countries.

Kenya: from pilot to national policy

Cervical cancer screening coverage in **Kenya** is low, especially among rural and marginalized women. Screening in these communities stands at just 53 percent,⁶⁴ compared to 65 percent nationally. And, until recently, the country had no costed elimination roadmap to systematically reach these last-mile populations.

To address this, CHAI led a study to evaluate community-based delivery of HPV self-sampling to reach underserved populations across six of **Kenya's** 47 counties (Kisii, Machakos,

Marsabit, Meru, Mombasa, and Nakuru). The study compared the standard of care (women being screened in a health facility) to two new community models: door-to-door delivery, and community outreach. The door-to-door model was found to be effective in improving access to screening. For example, more than 90 percent of the women reached through this model had never been screened for cervical cancer before. The community outreach model demonstrated stronger linkage-to-care compared with health facility-based models, however, improving facility-level coordination was identified as a key priority to further strengthen referral pathways and improve outcomes.

With these results in hand, CHAI supported the Kenyan Ministry of Health and Health Systems Insight to develop and launch the National Cervical Cancer Elimination Action Plan 2026-2030 in January 2026⁶⁵—**Kenya's** first costed national roadmap—which included a commitment to expanding community-based screening to all 47 counties.

Nigeria: unlocking domestic financing for elimination

Historically, cervical cancer elimination in **Nigeria** has depended heavily on funding from outside donors, with little committed domestic funding against its national elimination plan launched in early 2025.

Through the year, CHAI continued to serve as partner to **Nigeria's** National Task Force on Cervical Cancer Elimination after the launch of its National Costed Cervical Cancer Elimination Plan, and co-led the launch of the Partnership for Cervical Cancer Elimination in **Nigeria**, a platform specifically designed to drum up private sector and government co-financing.

As a result, a US\$700,000 donation by First Lady Oluremi Tinubu was secured for the initial rollout of 60,000 HPV tests intended to serve as catalytic financing to support six states in the scale-up of HPV testing in line with **Nigeria's** elimination plan. This is the first major domestic financing commitment for cervical cancer elimination in **Nigeria**, setting a precedent that will help strengthen the program's financial future.

Diabetes & Hypertension

Non-communicable diseases are the leading cause of death and disability globally, accounting for about three-quarters of all deaths worldwide.⁶⁶ CHAI focuses on two major conditions: diabetes, (type one and type two) and hypertension. Roughly one in nine people have diabetes; an estimated 589 million people today, a figure projected to rise to 853 million by 2050.⁶⁷ Hypertension affects about 1.4 billion adults, two-thirds of whom live in low- and middle-income countries.⁶⁸ CHAI works to expand access to affordable medicines and commodities, strengthen primary health systems, and improve policies that enable earlier diagnosis and lifelong treatment of these conditions.

Policy shifts that bring care closer to home

Governments are increasingly prioritizing bringing non-communicable disease care closer to home. Getting there starts with national policy: ensuring that local clinics and health workers have the skills and supplies to diagnose and treat diabetes and hypertension and ensuring that insurance covers the cost when they do.

In 2025, CHAI worked with ministries of health and government-led non-communicable disease working groups in **Ghana, India, Nigeria,** and **Uganda** to advance these priorities, each addressing a different bottleneck. In **Ghana**, a new sub-district clinical management protocol for diabetes and hypertension, along with revised prescribing authorities, enabled the dispensing of first-line non-communicable disease medicines at the health center level, moving care decisions closer to patients. In **Nigeria**, Kano State finalized its Task Shifting and Task Sharing Policy, which has enabled frontline health workers—not just doctors—to manage both conditions directly. In **India**, CHAI affiliate, the William J. Clinton Foundation (WJCF), helped state governments create standard guidelines for treating type one diabetes. In **Uganda**, the government launched its National Operational Strategy for Priority Non-Communicable Diseases (2025-2030), a plan to bring non-communicable disease care closer to people in need nationwide. In **Cambodia**, CHAI supported a new community participation policy that enables communes to fund village-level screening and follow-up through their own investment plans. Meanwhile, in **Vietnam** and **Papua New Guinea**, CHAI, in conjunction with partners, generated

→ Program highlights

2,667

People living with type one diabetes were diagnosed and enrolled in care across Ethiopia, Ghana, India, and Nigeria.

1,900+

Workers were trained and mentored to detect and manage type 1 diabetes.

7

Countries are advancing policy reforms that bring NCD care closer to home.

→ Partner countries

Cambodia • Cameroon • Eswatini • Ethiopia • Ghana • India • Lesotho • Liberia • Nigeria • Papua New Guinea • Uganda • Vietnam • Zimbabwe

→ Key donors and partners

Australian Government (Partnerships for a Healthy Region) • Bajaj Finserv • Breakthrough T1D • Center for Integration Science in Global Health Equity • Gavi, the Vaccine Alliance • The George Institute for Global Health • The Leona M. and Harry B. Helmsley Charitable Trust • Vision Catalyst Fund • World Diabetes Foundation

evidence to inform government policy aimed at improving service and commodity availability at the last mile. These are the policy foundations that make sustainable local diabetes and hypertension care a reality.

Type 1 diabetes: detecting early to save lives

Over nine million people live with type 1 diabetes, a chronic autoimmune condition that requires lifelong insulin therapy to manage blood sugar levels. A 10-year-old diagnosed with type 1 diabetes in a high- income country can expect to live to 71 years of age; but in a low-income country, that same child would likely live to just 23.⁶⁹ The difference comes down to whether the condition is caught at all: in many low- and middle-income countries, type 1 diabetes is often missed or misdiagnosed, and one in three people with the condition will die without ever knowing they had it“.

In 2025, CHAI partnered with governments in **Ethiopia, Ghana, India,** and **Nigeria** to support better access to type 1 diabetes diagnosis and care. Each program promoted community awareness and education, embedded routine blood glucose testing into frontline services, and strengthened referral pathways to ensure diagnosed patients can quickly access treatment. In **India**, WJCF supported improved access to ongoing care for people living with type 1 diabetes across four states through almost 100 weekly clinics. In **Ethiopia, Ghana,** and **Nigeria**, CHAI supported around 300 primary health clinics to increase type one diabetes diagnosis.

Clinics and referral pathways only help if the people staffing them can recognize type one diabetes in the first place. In 2025, CHAI trained over 1,200 clinical health workers and more than 700 other professionals across all four

countries to better detect and manage type 1 diabetes. After the initial training, CHAI helped conduct 600 follow-up sessions to embed the lessons into real clinical settings. Critically, governments have formally endorsed the training materials themselves. This has turned a one-time effort into a training resource that governments can continue to use long after CHAI’s program ends.

As a result of this work, 2,667 additional people living with type 1 diabetes were enrolled in treatment in 2025. For many, it was the first time anyone had been able to tell them what was wrong, and what to do about it.

That country-level progress is only part of the picture. For years, funding for type 1 diabetes in low- and middle-income countries has flowed in through siloed, uncoordinated efforts, leaving gaps that no single program could close on its own. In 2025, CHAI helped convene 80 stakeholders from industry, philanthropy, government, civil society, and the type 1 diabetes community around a shared goal: to strengthen resource and investment coordination for type one diabetes in low- and middle-income countries. This work contributed to the launch of ALIGN-T1D, the first pooled fund established across NCDs, that aims to diagnose 14,000 people and support one million insulin-dependent patients across three initial countries, with scale-up plans underway. ALIGN-T1D marks a new chapter of multisectoral collaboration, aligning programs with government and community priorities, reducing duplication of work, and closing critical gaps to maximize impact for people living with the disease. While CHAI’s involvement with ALIGN-T1D has now concluded, our support in launching the platform will help turn years of fragmented funding into one unified push.

Sickle Cell Disease

Sickle cell disease is one of the world’s most neglected diseases. Nearly 515,000 infants are born with the genetic condition each year, most of them in Africa—and between 50 and 90 percent of them will die before their fifth birthday simply because they lack access to care.⁷⁰ Yet, sickle cell disease receives far less funding and attention than other diseases with comparable impact. Since 2024, CHAI has partnered with philanthropic advisor Coefficient Giving to transform how sickle cell disease is diagnosed and treated across Ghana, India, and Nigeria.

Market-shaping for lower costs

Sickle cell disease is a genetic blood disorder that causes red blood cells to distort into a rigid, sickle shape that impedes blood flow and causes severe pain, organ damage, increased risk of infection, and early death.

Diagnosing and treating the disease has historically been out of reach for most health systems in low- and middle-income countries. Conventional diagnostic tests, which cost over US\$8 per test—plus transportation and lab costs—require centralized laboratory equipment available only in large hospitals. This means many families never find out if their child has the disease at all. Hydroxyurea, the primary treatment, has long been priced beyond the reach of most of sub-Saharan Africa. Where cheaper versions exist, the quality is not assured. Provider hesitancy has compounded the problem: many clinicians have been reluctant to prescribe hydroxyurea due to concerns about safety and the need for regular laboratory monitoring.

In 2025, CHAI, with support from Coefficient Giving, negotiated two landmark global agreements that addressed both barriers. In the first, U.S. company Silver Lake Research agreed to supply its HemoTypeSC rapid diagnostic test at just US\$1 per test (ex-works): the lowest price ever achieved for any sickle cell diagnostic.⁷¹ Unlike conventional tests, HemoTypeSC requires only a dried drop of blood and a small vial of water, delivers results in 10 minutes, and can be performed at any clinic without laboratory equipment. In the second deal, Chinese company Qilu Pharmaceuticals agreed to provide an FDA-approved hydroxyurea product at a dramatically reduced price for

→ Program highlights

US\$1

Negotiated cost per diagnostic test—the lowest price available globally.

200,000+

Children under five screened for sickle cell disease in Madhya Pradesh, India.

1,000+

Children under five started on hydroxyurea treatment in Madhya Pradesh, India.

→ Partner countries

Ghana • India • Nigeria

→ Key donors and partners

Coefficient Giving

low- and middle-income countries. Both deals were secured within the first year of CHAI’s involvement, ahead of schedule. Together, they represent a step-change in the economics of sickle cell disease care.

Starting treatment for children in India

In Madhya Pradesh, **India**, sickle cell disease is particularly prevalent, but has been historically underdiagnosed and undertreated in children, as programs have traditionally focused on adults. An assessment by CHAI affiliate, the William J. Clinton Foundation (WJCF), across 40 facilities in eight priority districts uncovered the gaps: hydroxyurea was often unavailable at lower-level facilities; many providers were reluctant to prescribe it due to concerns about safety and the need for laboratory monitoring; and the state’s data systems were fragmented. This has made it nearly impossible to track who had been diagnosed, treated, or lost to follow-up.

In 2025, WJCF worked with the Madhya Pradesh Ministry of Health to design and launch their first targeted screening program for children under age five. WJCF built forecasting tools to manage medicine supply, trained over 6,000 health workers, and developed a monitoring dashboard to track screening, diagnosis, and treatment coverage in real time. Data from the dashboard was used to identify bottlenecks and ensure treatment and diagnostics reached the right facilities.

By end of the program’s first year, more than 202,622 children had been screened for sickle cell disease, and over 1,067 had started hydroxyurea treatment. Building on these results, WJCF is now supporting a revision of the state’s pediatric guidelines. This includes expanding training to an additional 4,000

health workers, implementing the state’s first-ever newborn screening program through the introduction of point-of-care electrophoresis devices at six pilot facilities, and scaling services across priority tribal districts.

A roadmap for change in Ghana and Nigeria

Ghana and **Nigeria** are among the countries most affected by sickle cell disease, yet the systems meant to diagnose and treat it were badly out of date. Services were concentrated in large hospitals, leaving clinics and community facilities with little capacity to help. In **Nigeria**, guidelines only recommended hydroxyurea after a patient had already experienced five health crises. This meant that children suffered repeated, yet preventable harm before treatment began. While newborn screening had been piloted in **Ghana**, it was never sustained and collapsed each time donor funding ran out.

CHAI’s first year in both countries focused on building the foundation that previous efforts lacked. In **Ghana**, CHAI supported a comprehensive revision of national screening and treatment guidelines, which was validated by national experts in August 2025, and conducted an assessment across 79 facilities in all 16 regions. In **Nigeria**, CHAI supported revised national treatment guidelines that now recommend hydroxyurea from nine months of age, representing a significant shift in the age when children can access treatment. In both countries, CHAI worked with ministries of health and national health insurance agencies to advance discussions on sustainable financing.

With those foundations in place, CHAI is now training health workers, while delivering testing and treatment supplies to dozens of facilities across **Ghana** and **Nigeria**.



Women’s and Children’s Health

Far too few women and children worldwide have access to the essential, quality health services and nutrition they need. As a result, hundreds of thousands of women die every year from avoidable or treatable conditions. More than two million babies die within their first weeks of life. And millions more children and teens die from malnutrition, pneumonia, diarrhea, or vaccine-preventable diseases. This section covers CHAI’s work in reproductive, maternal, and newborn health, childhood diarrhea, nutrition, and vaccines. In 2025, as aid cuts strained the sector, we worked with governments to protect lifesaving commodities, lower the cost of products that were out of reach, and bring proven solutions to the families and communities least likely to receive them. Across all four programs, the goal is for these services to become a routine part of national health systems that governments plan for and finance.

Childhood Diarrhea

Diarrheal disease is the second leading cause of death among children under five globally, killing roughly 370,000 children per year.⁷² Effective treatment exists: oral rehydration salts (ORS) can avert 93 percent of diarrhea deaths by preventing dehydration,⁷³ while zinc reduces the duration and severity of illness and lowers the risk of future episodes for months. Together, ORS and zinc cost less than US\$0.50 per course. But as of 2023, only 19 percent of children globally received both treatments.⁷⁴ CHAI works to close this gap by delivering ORS and zinc treatment co-packs directly into the hands of families before illness strikes.

Treatment at home

In 2011, CHAI launched its Essential Medicines program to increase ORS/zinc use in **Kenya, Uganda, India, and Nigeria** by addressing supply and demand barriers. Through this work, CHAI encouraged local suppliers to introduce 15 new ORS/zinc products, reducing prices by 45 percent. The program broke years of stagnation, raising ORS coverage in these countries from 35 percent in 2012 to 48 percent by 2016 and ORS/zinc coverage from one percent to 24 percent, saving an estimated 76,000 lives. Coverage growth in CHAI-supported countries was more than twice as high as in non-program countries.

CHAI’s current ORS/zinc work centers on the AT-HOME (Access Through Home-Based Management and Empowerment) model: a community-based approach that delivers ORS/zinc co-packs directly to households with children under five, before sickness strikes.

Pilot project delivers results in Bauchi, Nigeria

In 2025, CHAI designed and piloted the AT-HOME strategy in Bauchi, **Nigeria**, where there are an estimated 4.7 million diarrhea cases and 9,000 deaths among children under five annually.⁷⁵

Despite this, only 40 percent of diarrhea cases in Bauchi were treated with ORS, only 12 percent received both ORS and zinc, and only six percent of households had either product stored at home. Many caregivers never sought formal care for diarrhea, put off by the distance to a healthcare facility, the cost of travel or medication, or the belief that diarrhea is not life-threatening. These same people were also the least likely to use ORS and zinc.⁷⁶

→ Program highlights

865,532

Children under five reached across Bauchi, Nigeria—exceeding the 750,000 target set for the pilot.

1.6M

ORS/zinc co-packs delivered to 362,000 households in Bauchi during the pilot.

~1,100

Diarrheal deaths averted in children under five during the Bauchi pilot.

→ Partner countries

Nigeria

→ Key donors and partners

GiveWell

Pictured opposite: Mothers in Indonesia listen to a presentation about available pediatric vaccines. Photo: Arifin Fino.



Community members distributed zinc/ors co-packs to families in Bauchi, Nigeria. Photo: Sam B Multi Media.

CHAI recruited and trained 3,000 local community members as ORS/zinc distributors. Each distributor mapped households with children under five, delivered two ORS/zinc co-packs per child, and provided one-on-one counseling on the proper administration of ORS/zinc, diarrhea prevention, and when to seek care.

With funding from GiveWell, CHAI partnered with RAND and IPA to conduct a large independent randomized controlled trial over 12 months to build the evidence needed to inform decisions on scaling this model beyond Bauchi. Different areas were randomly assigned to either receive the intervention or not, and monthly surveys tracked health outcomes.

Through this pilot, CHAI reached over 865,000 children under five across Bauchi, exceeding our initial target of 750,000. Community distributors delivered 1.6 million ORS/zinc co-

packs to more than 362,000 households across more than 6,000 settlements.

The results were significant. In households that received treatment co-packs, 46 percent of children with diarrhea were treated with both ORS and zinc—nearly four times the rate seen in households that did not receive them (12 percent). ORS use alone also rose well above what CHAI anticipated. Further, fewer children with diarrhea required antibiotics in the households that received treatment co-packs: 43 percent, compared to 51 percent in the control group. Based on these results, an estimated 1,100 children's lives were saved.

CHAI aims to expand this model within **Nigeria** and to additional high-burden countries, bringing CHAI closer to its goal of a 50 percent reduction in diarrheal deaths among children under five across three to five countries by 2028.

Nutrition

Malnutrition during pregnancy and early childhood remains a major driver of poor health outcomes and preventable deaths in low- and middle-income countries. Globally, undernutrition is considered an underlying cause of nearly half of all under-five deaths.⁷⁷ CHAI's nutrition program works with governments and global partners to expand access to lifesaving solutions: multiple micronutrient supplements (MMS) for pregnant women and ready-to-use therapeutic food (RUTF) for those with severe acute malnutrition. By strengthening policies, improving affordability of essential commodities, and supporting countries to translate evidence into action, CHAI aims to ensure proven nutrition interventions reach women and children who need them the most.

Expanding treatment for children with wasting

Severe acute malnutrition is the most life-threatening form of wasting. It occurs when children become so severely undernourished that they lose muscle and tissue, leaving them critically vulnerable to infection and death. RUTF is the proven treatment: a high-calorie, peanut-based paste that enables children to recover safely at home without hospitalization. But in most countries, RUTF sits outside the routine health system, available through donor-funded programs rather than government services. CHAI's work is not just about getting RUTF to children; it is about building the policy, financing, and supply infrastructure to make wasting treatment a standard part of what national health systems provide.

In Attapeu Province, **Lao PDR**, the results show what embedding a program in local systems can achieve. Routine monitoring and care drove RUTF use among children with acute malnutrition from just 10 percent in 2023 to 97 percent in 2024—and treatment rates held after external support ended in early 2025.

In **Ghana**, the work is earlier in its journey, but the foundations are being laid. In 2025, CHAI worked with the **Ghana** Ministry of Health to strengthen the national program that treats child wasting through community health workers, rather than hospitals. As a result, RUTF was formally added to **Ghana's** Essential Medicines List and standard treatment guidelines, and its cost-effectiveness is being analyzed for potential inclusion in the national health insurance package—which would lock in domestic financing for the

→ Program highlights

5,000+

Severely malnourished children in Ghana reached with lower-priced RUTF.

97%

Children with acute malnutrition in Attapeu Province, Lao PDR, reached with RUTF, up from 10 percent.

20%+

Price reduction on multiple micronutrient supplements in Burkina Faso.

→ Partner countries

Burkina Faso • Ethiopia • Ghana • Kenya • Lao PDR • Malawi • Nigeria • Rwanda • Senegal • Uganda • Zambia

→ Key donors and partners

Gates Foundation • The Eleanor Crook Foundation • UK Foreign, Commonwealth & Development Office (FCDO) • UNICEF

long term. CHAI trained 85 national master trainers on revised community protocols, who in turn trained 610 health workers across 14 districts—enabling more than 12,300 children to receive treatment for acute malnutrition in 2025, a 31 percent increase from the previous year. Of these, more than 5,000 children were reached with RUTF that CHAI procured using Eleanor Crook Foundation funding and donated to the government to support the national Community-based Management of Acute Malnutrition program. It was secured at a price of US\$29.50 per carton through an open competitive tendering process run by CHAI—37 percent lower than the UNICEF weighted average price of US\$46.70.⁷⁸

Affordable micronutrients for pregnant women

Using MMS during pregnancy is one of the best investments in maternal and newborn healthcare.⁷⁹ The United Nations International Multiple Micronutrient Antenatal Preparation is a daily oral supplement containing 15 essential vitamins and minerals.⁸⁰ It has been shown to reduce low birth weight by 12 percent and infant mortality among vulnerable groups by 15 to 29 percent, compared with simpler iron-folic acid supplements.^{81,82} Yet only five

percent of pregnant women in low- and middle-income countries receive it—largely due to its prohibitive cost.⁸³

Reaching the remaining 95 percent requires more than one-off procurement. It requires building the policy and financing scaffolding for MMS to flow through routine antenatal care.

In 2025, CHAI procured enough MMS to reach 100,000 pregnant women in **Burkina Faso** at a price more than 20 percent below the standard rate. In parallel, CHAI is supporting 10 governments to strengthen coordination, planning, and policy so MMS can be scaled through national health systems. Thanks to this work, MMS is now included in national standard treatment guidelines in five countries (**Ethiopia, Ghana, Malawi, Nigeria, and Rwanda**) and the Essential Medicines Lists of six countries (**Ghana, Malawi, Nigeria, Rwanda, Senegal, and Uganda**). These policy changes are what will turn an MMS procurement for 100,000 women in **Burkina Faso** into a credible path toward reaching millions: moving MMS from pilots run on donor timelines to a standard part of antenatal care that governments deliver and finance themselves.

Reproductive, Maternal, & Newborn Health

Every two minutes, a woman dies in childbirth.⁸⁴ Almost all deaths occur in low- and middle-income countries, and the vast majority are preventable. An estimated 218 million women and girls still need modern contraception,⁸⁵ 2.3 million newborns die in their first month of life, and approximately 1.9 million babies are stillborn each year.⁸⁶ By accelerating access to lifesaving commodities and devices, strengthening health system capacity, and shaping global markets, CHAI works with governments across reproductive, maternal, and newborn health programs to close the gap between evidence-backed tools and medicines and the women and babies that need them. In 2025, CHAI made important gains in postpartum hemorrhage prevention and management, newborn care, and contraceptive access, even as the withdrawal of major donor funding tested the resilience of health systems.

Holding the line: contraceptive access in a year of disruption

Together with partners, CHAI continued to scale access to the hormonal IUD—one of the most cost-effective long-acting contraceptive methods available, offering up to eight years of protection. Since 2021, through the Hormonal IUD Access Group co-led by CHAI and FHI 360, CHAI has stewarded global market coordination and worked with governments to integrate the hormonal IUD into national supply chains and service delivery systems. In 2025, CHAI supported governments to develop or implement national costing introduction plans for hormonal IUD scale-up in 11 countries (**Cameroon, DRC, Eswatini, Kenya, Malawi, Nigeria, Rwanda, Senegal, Sierra Leone, Uganda, and Zambia**). Between 2021 and 2025, over 579,000 women have been reached with hormonal IUDs in seven of these countries.

CHAI also continued to drive scale-up by connecting donor resources to government priorities. Since 2021, the CHAI-administered Catalytic Opportunity Fund has committed over US\$13.4 million to hormonal IUD introduction across 57 grants in 17 low- and middle-income countries.

However, 2025 tested whether governments could sustain this progress. The United States, which previously provided approximately 41 percent of all donor government family planning funding, terminated its family planning grants worldwide. This triggered disruptions for an estimated 47.6 million

→ Program highlights

~18.7M

Dual HIV/syphilis test kits procured across Ethiopia, Mozambique, Nigeria, and South Africa.

480

NICUs equipped with caffeine citrate across 7 countries.

91%

Reduction in postpartum hemorrhage cases needing surgical management in Ethiopia.

US\$3.86M

Contracted in 2025 to support 16 hormonal IUD scale-up grants in 11 countries through the CHAI-administered Catalytic Opportunity Fund.

→ Partner countries

Burkina Faso • Cambodia • Cameroon • Côte d'Ivoire • Democratic Republic of Congo • Eswatini • Ethiopia • Ghana • India • Kenya • Lesotho • Malawi • Mozambique • Myanmar • Nigeria • Rwanda • Senegal • Sierra Leone • South Africa • Tanzania • Uganda • Zambia • Zimbabwe

→ Key donors and partners

Beginnings Fund • ELMA Philanthropies • Embassy of Ireland • Family Health International • Gates Foundation • Global Impact • Government of Flanders • Guttmacher Institute • MedAccess • PATH • Pivotal • Solina Centre for International Development and Research • Sun Community Health • Surgo Foundation • Technical Advice Connect LTD/GTE • The Children's Investment Fund Foundation • The Global Fund to Fight AIDS, Tuberculosis and Malaria • The Waterloo Foundation (TWF) • UK Foreign, Commonwealth & Development Office (FCDO) • Vital Strategies, Inc. • World Health Organization (WHO)

women and couples who had relied on U.S. government-supported programs for contraceptive care annually across more than 40 countries.⁸⁷

CHAI responded to the contraceptive funding crisis by working with governments and partners to rapidly quantify risks and close gaps in national supply plans and stock inventory.

When the United States withdrew its support, **Malawi** lost US\$1.8 million in expected support for contraceptive supplies, increasing the country's already substantial funding gap to US\$11.4 million. The **Malawi** Ministry of Health's Reproductive Health Directorate, with support from CHAI, conducted a rapid funding gap analysis to mobilize additional support, securing US\$245,000 in government funding, US\$1.5 million from the United Nations Population Fund (UNFPA), and US\$6.7 million from the Health Services Joint Fund, a pooled funding mechanism for the government and its development partners. These resources, along with additional procurements by UNFPA, closed **Malawi's** family planning commodity gap for 2025.

Across the region, the funding shock accelerated a longer-term shift toward domestic ownership. In **Kenya**, CHAI supported the National Council for Population Development to secure a 43 percent budget increase for family planning commodities. In

Uganda, the government used CHAI-supported impact assessments to approve a US\$1.2 million supplementary budget and committed 50 percent of the US\$10 million ring-fenced reproductive health commodity budget to family planning in fiscal year 2025/2026. In **Zambia**, CHAI's technical assistance supported the government in mobilizing resources through a matching fund that closed a US\$2 million funding gap, redirecting excess funds to maternal health commodities and increasing its 2026 family planning commitment by 74 percent. **Ethiopia's** experience pointed to what long-term resilience can look like: a multi-donor compact, which CHAI helped the Ministry of Health design in 2023 to absorb the shock. The compact committed the government to growing contributions from US\$500,000 to US\$12.4 million annually, an 18-fold increase. This serves as a reminder that the most durable protection against funding shocks is built long before they arrive. (*Read more about the funding cuts on page 8*).

Saving mothers' lives: postpartum hemorrhage prevention and treatment

Postpartum hemorrhage—severe bleeding after delivery—is a preventable crisis but remains the leading cause of maternal death worldwide, responsible for an estimated 43,000 deaths every year.⁸⁸ Clinically effective interventions for prevention exist: prophylactic uterotonics like oxytocin and heat-stable carbetocin prevent heavy bleeding, while the E-MOTIVE bundled response (including objective blood loss measurement drapes and tranexamic acid to stop bleeding) helps ensure dangerous bleeding is caught and treated sooner.

Across 10 countries—**Ethiopia, Ghana, Kenya, Lesotho, Malawi, Nigeria, Rwanda, Senegal, Uganda**, and **Zambia**—CHAI and partners provided technical assistance to ministries of health to introduce heat-stable carbetocin and scale the E-MOTIVE bundle. All 10 have integrated E-MOTIVE into their national service delivery guidelines and standardized in-service training curricula. As of the end of 2025, over 2,800 facilities across these countries were trained on the E-MOTIVE bundle—meaning thousands more women give birth in facilities

equipped to stop a deadly hemorrhage. In parallel, CHAI partnered with governments to integrate tools and products into country procurement systems: seven countries have added calibrated drapes to national essential supplies lists (or similar), with two more in progress. All 10 countries have added tranexamic acid to national forecasting and quantification processes.

Countries are already seeing results. In **Malawi**, postpartum hemorrhage cases detected in focal facilities rose 26 percent from 996 (July–December 2024) to 1,253 (July–December 2025) following E-MOTIVE trainings and the distribution of calibrated drapes, reflecting improved detection rather than a rise in incidence. In **Ethiopia**, cases needing surgical management in focal facilities decreased by 91 percent from approximately 30 to approximately two cases each month, likely due to quicker intervention, as response times improved from 45 minutes on average to just 15 minutes.

Helping babies breathe: caffeine citrate for apnea of prematurity

Around 14.3 million babies are born preterm each year. About 65 percent of them are in sub-Saharan Africa and South Asia, where 90 percent of extremely preterm babies die (compared to less than 10 percent in high-income countries). Apnea of prematurity—pauses in breathing that can cause hypoxia—affects about 85 percent of babies born before 30 weeks. Caffeine citrate, a safe treatment that stimulates breathing and is standard in wealthy countries, is unavailable across much of sub-Saharan Africa. In 2023, CHAI negotiated a special-access price with drug manufacturer Ethypharm and the Kenyan Ministry of Health, dropping the cost of caffeine citrate from US\$9.80 to US\$2.60 per ampoule—a 73 percent reduction. Continued CHAI engagement extended that price across the region, facilitating government procurement in

additional markets. Seven countries—**Ethiopia, Ghana, Kenya, Nigeria, Rwanda, Uganda**, and **Zambia**, have introduced caffeine citrate and are scaling access, while **Lesotho, Malawi**, and **Senegal** are beginning to procure the medicine. Within two years, **Kenya** equipped all 129 of its public-sector newborn intensive care units (NICUs) with caffeine citrate. **Uganda** and **Zambia** have since followed with independent government procurement. As of 2025, 480 public-sector NICUs across these countries were equipped to help premature babies breathe, with more in progress.

Eliminating congenital syphilis

Syphilis in pregnancy is a leading but preventable cause of stillbirth and newborn death. Testing has historically lagged—not for lack of tools, but due to market failures and weak procurement systems. In 2021, CHAI partnered with MedAccess and SD Biosensor to reshape the market for dual HIV/syphilis rapid diagnostic tests, reducing the price per test to US\$0.84 and enabling routine testing at scale.

Since then, CHAI has supported implementation across 14 priority countries, reaching more than 31 million pregnant women, averting an estimated 90,000 stillbirths through timely treatment, and saving procurers US\$11.3 million.

In 2025, CHAI worked with governments in four countries (**Ethiopia, Mozambique, Nigeria**, and **South Africa**) to close gaps in testing availability—procuring 18.7 million dual HIV/syphilis test kits in total: 9.3 million in **Nigeria**, 4.1 million in **Ethiopia**, 2.9 million in **Mozambique**, and 2.4 million in **South Africa**. Coverage rose substantially between 2021 and 2025: **Ethiopia** from 69 percent to 80 percent, **Mozambique** from 84 to 100 percent in target provinces, **South Africa** from 73 to 95 percent, and **Nigeria** from just 24 percent to 70 percent, reaching millions of pregnant women who would previously have gone undiagnosed and untreated.

Vaccines

Vaccines are one of the most cost-effective public health tools, preventing over four million deaths annually.⁸⁹ In 2025, that progress faced its biggest test in years: a historic drop in global health funding. CHAI helped governments plan around tighter immunization budgets while continuing to close coverage gaps for unvaccinated and under-immunized children, expand human papillomavirus (HPV) vaccination to adolescent girls for the first time in Liberia, strengthen vaccine supply systems that governments are now funding themselves, and prepare global stakeholders—including the World Health Organization (WHO)—for the arrival of new tuberculosis vaccines.

Building sustainable immunization financing

2025 was one of the steepest single year drops in global aid on record.⁹⁰ Immunization programs were somewhat buffered from the immediate shock, given that Gavi, the Vaccine Alliance—the global alliance that finances vaccine access for the world’s lowest-income countries—operates on five-year funding cycles. However, Gavi’s June 2025 pledge summit for the 2026-2030 period made clear that the immunization sector would face its own reckoning. As Gavi enters its next five-year period, governments will face mounting pressure to do more with less.

CHAI's Technical Support Units (TSUs)—small teams embedded within national ministries of health—were launched in 2025 in response to the foreign aid funding crisis (*read more about TSUs on page 8*). Through these units, CHAI secured US\$900,000 to establish our TSU immunization effort across four countries: **Nigeria, Uganda, Ethiopia, and Burkina Faso**. Our work focuses on helping these governments plan, budget, and manage immunization resources more efficiently. Full implementation begins in 2026, as countries enter the next Gavi funding period.

Reducing zero-dose children

Improving immunization coverage and equity remains one of the most consequential and persistent challenges in global health. As of 2024, 14 million children globally were zero-dose—meaning they had never received even a single dose of any routine childhood vaccine.⁹¹ The World Health Organization's (WHO) Immunization Agenda for 2030 aims to halve

→ Program highlights

666K

Girls vaccinated in Liberia’s first-ever HPV catch-up campaign, covering 100 percent of all eligible girls.

95K+

Zero-dose and under-immunized children reached in Ethiopia, surpassing the WHO’s 90 percent coverage target.

→ Partner countries

Benin • Burkina Faso • Cambodia • Cameroon • Democratic Republic of Congo • Eswatini • Ethiopia • India • Indonesia • Kenya • Lao PDR • Lesotho • Liberia • Myanmar • Nigeria • Papua New Guinea • Rwanda • Sierra Leone • Tanzania • Uganda • Vietnam • Zimbabwe

→ Key donors and partners

Abt Associates/PNG Partnership Fund • Cancer Research UK • CEPI/RVMC • ELMA Philanthropies • Gates Foundation • Gavi, the Vaccine Alliance • GIZ • IMA World Health/CDC • Insight to Impact LLC • Jacaranda Health • Nigeria Centre for Disease Control and Prevention (NCDC) • Rockefeller Foundation • UNICEF • United States Agency for International Development (USAID)

this number. Most of these children live in low- and middle-income countries, and within those countries, the children least likely to be vaccinated are often the same children living in remote, conflict-affected, or otherwise hard-to-reach communities. This includes displaced families, nomadic populations, and others that health systems struggle to consistently reach.

Closing these gaps requires multiple actions: reaching more zero-dose children with vaccines already in routine use, introducing new vaccines—like human papillomavirus (HPV)—that protect against more diseases, and strengthening the national systems that deliver them.

In **Ethiopia, India, and Nigeria**, CHAI conducted in-depth studies to identify the specific barriers keeping certain groups of children unvaccinated; with barriers differing sharply by setting. For example, in urban Addis Ababa, **Ethiopia**, vaccination sessions were combined with nutrition and deworming visits so working caregivers didn’t lose income to a separate trip. In nomadic communities in Afar, CHAI worked with trusted local leaders to identify and reach mobile families. In Oromia’s farming communities, dialogue with traditional healers addressed cultural resistance to vaccination. That work helped CHAI reach more than 90 percent of the estimated zero-dose and under-immunized children—over 95,500 children across 14 districts in 2025—meeting the target set under the WHO’s Immunization Agenda 2030.⁹² In Kano, **Nigeria**, locally led interventions across three local government areas strengthened routine immunization by targeting the specific barrier in each setting. In Nassarawa, on-the-job peer mentoring (rather than one-off training) lifted health worker competency from 14 percent to 82 percent, a gain that held steady over three quarters. In Gabasawa, handing microplanning to community stakeholders rather than health staff alone surfaced an entire settlement missing from official service maps. This opened access for roughly 640 previously unreachable children, including zero-dose children. In Gaya, matching messengers to audience closed a trust gap: female volunteers addressed mothers' concerns about side effects, while

male volunteers reached fathers through mosques and home visits where men were more likely to listen to other men. Together, these approaches converted over 68 percent of zero-dose and hesitant households to vaccination in these settlements.

In **Indonesia**, the core problem was different: inaccurate data, not lack of access. Reporting gaps from private clinics meant some children who had already been vaccinated were still counted as zero-dose in the national system. CHAI worked with subnational governments to link private-facility vaccination records into the national registry and map facility catchment areas, giving health authorities an accurate picture of which children were truly unreachable. More than 220,000 false zero-dose records were corrected, and coverage among truly unreachable children increased by up to six percent.⁹³ Separately, advocacy and coordination with subnational governments secured a seven percent increase in zero-dose budgets and diversified the sources of immunization funding.

Eliminating vaccine stock gaps

In several countries, vaccine availability is sufficient at the national level, but stock levels at the last mile remain unstable. This instability is driven by inefficiencies in last-mile distribution, limited visibility of supply chain data, and delayed identification and resolution of stock management gaps.

In 2025, CHAI supported ministries of health in nine countries: **Ethiopia, Cameroon, Kenya, Lao PDR, Indonesia, Nigeria, Rwanda, Tanzania, and Uganda** in establishing routine data review mechanisms to strengthen vaccine stock management. This was achieved through the implementation of review meetings during which national and subnational stakeholders systematically reviewed vaccine stock data and jointly identified and coordinated redistribution of supplies to address imbalances across the supply chain. **Cameroon, Kenya, and Uganda** are in the process of incorporating these meetings into their various budget platforms (at national and subnational

levels) and workflows to ensure sustainability and continuity.

In **Kenya**, the meetings reduced facility stock gaps by 25 percent. In **Uganda**, more than 90 percent of stock reporting requirements are now being met, which has helped the government mitigate stock gaps and ensure timely response. In **Cameroon**, the meetings improved last-mile delivery by increasing the proportion of facilities with adequate vaccines stocks from 41 percent at baseline to 58 percent at endline, while reducing stockouts from 38 percent to 23 percent.

Improving coverage against cervical cancer

HPV vaccination is one of the newer additions to many countries’ routine immunization schedules. First introduced in the early 2000s, global coverage nearly doubled between 2019 and 2025.⁹⁴ But girls who age out of the routine window before a country introduces the vaccine need a different kind of campaign to reach them.

In November 2025, CHAI partnered with the government of **Liberia** to support the country’s first-ever HPV multi-age catch-up vaccination campaign for girls aged nine to 18—aimed at girls who had not been captured in either routine infant or early-adolescent immunization programs. The campaign delivered end-to-end technical support by coordinating stakeholders across multiple sectors, training health workers, and managing the vaccine supply chain. The campaign vaccinated over 666,000 girls—100 percent of the eligible population, surpassing the 90 percent benchmark the WHO uses globally to track progress toward eliminating cervical cancer.⁹⁵

Forecasting demand for novel tuberculosis vaccines

Tuberculosis remains the world’s leading infectious killer, with more than 10 million cases and a million deaths annually. More than 90 percent of the burden is concentrated in low- and middle-income countries.⁹⁶ Existing tuberculosis prevention tools help, such as Bacille Calmette-Guérin vaccines for infants and preventive treatment for high-risk groups, but these aren’t enough to eliminate the disease. Several candidates for vaccines that target adolescents and adults are in advanced clinical trials and show a lot of promise, with expected commercial availability from the early 2030s.^{97,98}

In 2025, CHAI developed a global demand forecast for novel vaccines in partnership with Gavi and MMGH Consulting, funded by the Gates Foundation. The global forecast modeled four scenarios and was informed by in-depth interviews across nine high-burden countries (Brazil, **China**, **DRC**, **India**, **Indonesia**, **Nigeria**, Pakistan, **South Africa**, and **Vietnam**). The model is designed to help policymakers, vaccine developers, and manufacturers plan years before the vaccines will reach the market, with the ultimate goal of removing access barriers and ensuring that people can benefit from these vaccines as early as possible.⁹⁹ The forecast was significant enough that the WHO adopted it through its Tuberculosis Vaccine Accelerator Council’s Finance and Access Working Group, which now uses CHAI’s analysis to guide global market-shaping efforts for these vaccines.

Together with the WHO, Gavi, and other ecosystem stakeholders, CHAI is informing global efforts to ensure timely, equitable access to vaccines that modeling suggests could avert millions of deaths in low- and middle-income countries over the coming decades.



Pictured: Healthcare worker accompanies a mother and child to a clinic in rural Ethiopia. Credit: Melinda Stanley.



Health Systems

In 2025, sudden, large-scale cuts to foreign aid threatened health systems that millions of people depend on. CHAI worked with governments in more than 20 countries to protect and redirect existing funding to highest priority gaps, identify new sources of financing, and transition toward systems that are less dependent on external support—all while maintaining gains made in the health sector. Alongside standing up Technical Support Units in direct response to the aid cuts (*see page 8*) which largely focused on improving budget efficiency in 2025; CHAI continued work on upgrading and harmonizing systems that governments are taking over (e.g., digitizing health campaigns); ensuring funds that are allocated are executed against and translate to improved service delivery (e.g., strengthening community health workers payment systems); and mobilizing resources while removing or reducing financial barriers to access including through free care and insurance programs.

Pictured: A family living in a remote community in Cambodia's Kampong Chhnang province, several hours from the nearest health center. Photo: Corina Milic / CHAI.

The majority of CHAI's health systems work in 2025 focused on Technical Support Units (*see page 8*). The following describes work that was underway and continued during this period. The selection of projects demonstrates health systems work as an enabler to all of CHAI's program goals from malaria through child health.

Digitizing health campaigns and putting the data in governments' hands

Governments across Africa and Asia routinely run large-scale health campaigns, mobilizing thousands of health workers to reach millions of people in a matter of weeks: distributing bed nets, vaccinating children, providing prophylaxis for diseases like malaria. These campaigns can be enormously effective in deploying evidence-based interventions, but they have a persistent weakness: the data on the populations they are designed to reach and, in turn, transition to country systems.

Workers are deployed based on campaign-specific population estimates. Visits and treatments are recorded on paper, but the reporting is often incomplete, and data can take weeks to reach decision-makers. Coverage gaps may only emerge after the fact and can make costly second rounds of the campaigns unavoidable. Because these campaigns are often run by external organizations, governments often do not have the data and systems they would need to run the next one independently.

In the **Democratic Republic of Congo (DRC)**, there was limited real-time data. CHAI worked with the government to adopt DHIS2, a free, open-source, web-based data platform, as a single national platform. It is now operational across mosquito net distribution, polio, and yellow fever campaigns, reaching over five and a half million people. Its impact can be best illustrated through a polio campaign, which reached more than 3,000 children who had never received a vaccination, in 2025.

In **Benin**, public health campaigns had been run on platforms managed by outside organizations since 2020. CHAI worked with the government to transition to a government-owned platform,

→ Program highlights

US\$70M

In funding raised or reallocated via technical support units across five initial countries in the wake of significant foreign aid cuts (*see page 8*).

3,000+

Children who had never received a single vaccine were reached for the first time through a digitized polio campaign in the DRC.

2,381

Health facilities across Ethiopia, Malawi, Nigeria, and Rwanda are receiving reliable funding through insurance and payment reforms.

→ Partner countries

Benin • Burkina Faso • Cambodia • Cameroon • Côte d'Ivoire • Democratic Republic of Congo • Eswatini • Ethiopia • Ghana • India • Indonesia • Kenya • Lao PDR • Lesotho • Liberia • Malawi • Mali • Mozambique • Myanmar • Niger • Nigeria • Rwanda • Sierra Leone • South Africa • Tanzania • Uganda • Vietnam • Zambia • Zimbabwe

→ Key donors and partners

Australian Government Department of Foreign Affairs and Trade (DFAT) • Beginnings Fund • Bushnell Kessel Charitable Fund • Coefficient Giving • Effektiv Spenden • ELMA Philanthropies • Founders Pledge • Gates Foundation • Gavi, the Vaccine Alliance • GiveWell • Global Affairs Canada • Global Financing Facility • Global Fund & Africa Frontline First • Horace W. Goldsmith Foundation • Irish Aid • Livelihood Impact Fund • Ministries of Health • Sida • Silicon Valley Community Foundation • Skip Foundation • Temasek Foundation • Tropical Health and Education Trust • UK Foreign, Commonwealth & Development Office (FCDO) • UNICEF • United Nations Office for Project Services • World Bank

training 22 government staff who now run and maintain the system without external consultants. The impact? Better targeting through digital tracking. By helping teams identify who had received treatment, the technology contributed to seasonal malaria chemoprevention coverage jumping from 52 to 73 percent over two years.

Moving health workers onto government payrolls

In many countries, community health workers are the only healthcare providers in a remote village. They may be the person who checks on a pregnant mother, spots a child with signs of malnutrition, or ensures a family has bed nets before malaria season. In most places, they are paid by international donors and operate parallel to government systems. This leaves governments without a full picture of who is providing care, what skills they have, where they are located, and what they’re paid. This means when funding disappears suddenly, as it did in 2025, workers stop getting paid overnight and the communities they serve lose access to basic care.¹⁰⁰ Through our Technical Support Units and other efforts, CHAI has worked with countries to map donor-funded health workers and develop government staffing structures based on a prioritized package of services that dictate what roles will be absorbed onto government payroll.

In **Zimbabwe**, for example, more than 22,000 village health workers are being shifted from Global Fund financing to government payroll. But because they did not have a reliable worker record, due to a heavily manual and decentralized process, nearly one in four payment attempts was rejected. In 2025, CHAI worked with the Ministry of Health to verify and correct the entire worker list, bringing the rejection rate down to under five percent. Similarly, in **Nigeria**, no single registry existed to track community health worker identities or locations. In 2025, CHAI worked with the government to verify over 80,000 community health workers and assess every state’s readiness to move to a government-run payroll system.

Infrastructure financing

Donor investments in infrastructure and equipment often cover capital costs but not maintenance, so when something breaks, health systems can't always afford the fix. Electricity is an example of this gap: a quarter of primary health facilities in sub-Saharan Africa lack reliable power, often because funding was never allocated to keep things running, leaving facilities without refrigeration for vaccines, lighting for night deliveries, or power for essential equipment. In 2025, CHAI, with support from Sweden’s Regional Team for Africa, began to solve this through a blended finance model: private energy companies are contracted to install, operate, and maintain solar power infrastructure in exchange for long-term service fees paid by governments. Plans are now in place to electrify 1,100 health facilities and schools across **Eswatini**, **Kenya**, **Malawi**, and **South Africa**.¹⁰¹ This model offers a broader approach to infrastructure financing: one that considers not just how to fund investments in the short-term, but how governments can sustainability finance them and contract the private sector in the face of the changing foreign aid funding landscape.

Improving financial protection and making sure funding reaches frontline providers

With increasingly limited external and domestic financing, more people are likely to pay more than they can afford on health or not seek care in the first place due to the costs of care.¹⁰² CHAI works with governments to design, implement, and improve tax- or insurance-based systems to ensure even the most vulnerable have access to essential services. In the wake of 2025’s foreign aid cuts, our work extended to help governments determine which previously donor-funded services should be integrated into publicly-financed systems.

In **Ethiopia**, CHAI has helped build a community-based health insurance scheme since 2019; a national program that covers informal workers and rural households, where premiums are pooled to share the cost of care. However, the poorest were still priced out of the system, as all households paid the

same premium regardless of income. In 2025, premiums were restructured on a sliding scale, with the program now covering 63 million people and 84 percent of the eligible population, up from only 66 percent in 2022.

In **Nigeria**, millions of women and children lack access to affordable healthcare. Since 2022, CHAI has worked with six states to build insurance programs specifically for these families—enrolling pregnant women and children under five in free maternal and child health services, while helping states develop the funding and systems to run these programs themselves. As a result, health insurance coverage has tripled across the six states, growing from 281,000 people to more than a million. When external funding ended in November 2025, the states took over by continuing to enroll new beneficiaries using their own budgets and the systems they had built.¹⁰³

Supporting governments to pay providers more strategically—by aligning on the benefits package and modality of payment—is key. This includes ensuring payments make it to facilities and those facilities manage their budgets well. Without this, people may be covered by insurance, but their health facilities may not be able to deliver services. In 2025, CHAI worked with governments to close the gap between what is budgeted at the national level and what reaches facilities on the ground.

Across **Ethiopia**, **Malawi**, **Nigeria**, and **Rwanda**, CHAI has helped governments build reliable

payment systems that channel funding directly to health facilities. In **Ethiopia** and **Rwanda**, this has been done through a capitation model where facilities receive a fixed amount per person in their catchment area, and in **Malawi** and **Nigeria**, through direct funding to facilities for operating and other costs. By 2025, these reforms have reached more than 2,000 facilities across the four countries, improving continuity of care.

For example, in **Nigeria**, a CHAI cost analysis of maternal and child health service delivery informed a redesign of how the Basic Health Care Provision Fund pays facilities’ directly, nearly doubling facilities’ quarterly allocations and adding performance scoring and management support alongside the funding itself. That combination of more funding and performance management is now scaling from 436 to 739 facilities in Kano and Kaduna states, helping them more consistently deliver a full package of essential services. In **Ethiopia**, initial pilot evidence under the capitation model showed fewer drug stockouts and improved prescribing, with financing-related stockouts three times more common in control facilities than in pilot ones—suggesting that capitation’s advance, predictable payments help facilities plan and manage services better.

Looking ahead, CHAI will continue to support governments in raising resources through pre-payment, and allocating funds to the highest priority services, while ensuring funds and commodities reach the frontlines.



Cross-cutting Experts

CHAI's specialized technical teams provide critical expertise that amplifies the impact of our work across all disease areas and countries. These teams collaborate with over 50 CHAI program and country teams worldwide to generate evidence, develop innovative solutions, secure affordable access to essential health products, and support governments in making data-driven decisions. These cross-cutting capabilities enable us to tackle complex global health challenges from multiple angles—whether through market-shaping interventions that reduce costs, cutting-edge diagnostics that improve care delivery, or digital tools that strengthen health systems. The collective impact can be seen in nearly every program milestone throughout this report, demonstrating how integrated expertise drives transformational change in global health.

Pictured: CHAI Guatemala's malaria program team.

Innovation

The global health funding crisis has forced a difficult question: when resources contract, what work matters most? CHAI's Innovation team identifies the most cost-effective interventions to protect health gains under shrinking budgets, while building new programs in critical but long-neglected areas, and leveraging market access and government partnerships. The Maximum Impact Incubator, CHAI's GiveWell-funded engine for identifying and scaling the most cost-effective health interventions, launched Technical Support Units (TSU) to help governments navigate funding cuts. At the same time, CHAI established two new programs in mental health and lead exposure, and a third that extends CHAI's growing work in AI for global health.

Incubating ideas for maximum impact

When U.S. government funding cuts disrupted health systems across multiple countries in 2025, teams moved to rapidly help governments respond to the funding cuts by repurposing CHAI's technical assistance programs to analyze funding gaps and identify ways to mitigate the impact. The Incubator played a pivotal role in confirming the cost-effectiveness case to build our confidence in the potential impact of the work and use this to create an investment case for GiveWell, Coefficient Giving, and later other Effective Altruism-adjacent donors.

The resulting GiveWell/Coefficient Giving grant for the TSU program provided a US\$4.7 million fund across five countries. The program embedded advisors directly within government health systems to help them manage and respond to the funding cuts.

At the same time, CHAI's Incubator continued to identify highly cost-effective programs and incubate these for scale. Of seven programs identified as highly cost-effective in 2025, two have been funded for full implementation in addition to the TSU grant.

In **Nigeria**, a US\$8.8 million private-sector malaria case management program is improving diagnosis and treatment through private pharmacies and drug shops, with an estimated 3,000 lives projected to be saved over a four-year period.

In **Burkina Faso**, a US\$500,000 oxygen program is preparing to equip 37 health facilities to treat children with severe pneumonia and malaria complications.

→ Program highlights

US\$4.7M

The size of the GiveWell/Coefficient Giving funded Technical Support Unit program launched to help governments navigate international funding cuts.

US\$66M

Total GiveWell investment in CHAI since 2022, identified through the Incubator's cost-effectiveness work, including US\$14 million in new grants in 2025 alone.

2

New programs launched in pressing and neglected areas: mental health and lead exposure.

→ Partner countries

Burkina Faso • Cameroon • China • Ethiopia • India • Indonesia • Kenya • Lao PDR • Nigeria • Rwanda • Senegal • South Africa • Uganda • Vietnam • Zimbabwe

→ Key donors and partners

Coefficient Giving • GiveWell • Grand Challenges Canada • Lead Exposure Elimination Project • Wellcome Trust

Since 2022, GiveWell has committed approximately US\$66 million across CHAI programs identified through the Incubator’s cost-effectiveness work, including US\$14 million deployed in 2025 alone. GiveWell has renewed its grant at US\$11.3 million in total through 2028.

New program: medicines for priority mental health conditions

Roughly a billion people worldwide¹⁰⁴ live with a mental health condition. Four conditions, schizophrenia, bipolar disorder, major depression, and anxiety, account for about 80 percent of the mental health burden. People with serious mental health conditions lose 10 to 20 years of life expectancy on average, and more than 70 percent of those with psychosis receive no treatment at all. Safe, effective psychotropic medicines exist to treat these conditions but rarely reach those in need in low- and middle-income countries. This gap is exacerbated by chronic underfunding: on average, less than two percent of low- and middle-income country health budgets are allocated to mental health.¹⁰⁵ Furthermore, most of that spending is directed to psychiatric institutions rather than community-based treatment.

In 2025, CHAI established its global mental health program in partnership with the Wellcome Trust, and in close collaboration with MedAccess. The program focuses on four countries, **Ethiopia, Nigeria, Rwanda, and South Africa**, where CHAI completed a systematic assessment of the barriers to accessing quality-assured psychotropic medicines and convened a Lived Experience Council to help guide program priorities. The assessment identified five barriers: regulatory constraints on product registration, financial barriers at both procurement and patient levels, weak demand forecasting, unreliable supply chains, and low community demand, driven by stigma and limited awareness. In parallel, MedAccess and the University of Oxford identified the priority antipsychotic medicines that joint CHAI-MedAccess market-shaping efforts will target—working to close the gap between access in high- and low-resource settings for newer

medicines. In 2026, supported by additional programmatic funding from the Wellcome Trust, the program will shift its focus from assessment to executing priority interventions in the program countries. CHAI will support partner governments in various activities, including estimating demand, building relationships with suppliers for priority products, and supporting updates to clinical treatment guidelines. Together these efforts can begin to close the treatment gap for people living with mental health conditions.

New program: combatting lead exposure

Lead is one of the most overlooked health threats of our time, and its harm compounds from childhood into adulthood. Around one in three children worldwide—nearly one billion, mainly in low- and middle-income countries—have elevated blood lead levels.¹⁰⁶ Lead absorbed early is stored in the bone and released into the blood over decades, and that cumulative exposure is now linked to more than 5.5 million deaths every year, primarily from cardiovascular diseases.¹⁰⁷ The economic toll is similarly staggering, with the World Bank estimating the global cost of lead exposure at US\$6 trillion, nearly seven percent of global GDP.¹⁰⁸ Exposure happens through everyday channels: lead-based paint that flakes into household dust, informal battery recycling operations that contaminate soil and air, traditional cosmetics, lead-glazed cookware and ceramics, and contaminated water from aging pipes. Yet most countries lack the basics needed to respond. Reliable blood lead data is scarce, and the systems to regulate or replace these sources are weak or absent.

In 2025, CHAI launched our lead exposure program with two initial projects. To help countries understand where exposure is happening, we kicked off a partnership with Renaissance Philanthropy to accelerate the development of next-generation lead diagnostics—faster, cheaper tests that can make routine screening feasible at scale. To address one of the largest preventable sources of exposure—lead paint—CHAI conducted supply chain research in **India, China, Nigeria, Zimbabwe, Uganda, Kenya, and South Africa**



A woman is screened for tuberculosis using an ultra-portable, AI-compatible chest X-ray device in Vietnam. Photo: Poskom.

to identify market-based interventions that could speed the shift away from lead in paint production.

New program: AI for global health

The next decade of progress in global health will be shaped in part by how quickly countries can put artificial intelligence to work in their health systems for the benefit of patients. CHAI’s bet is that low- and middle-income countries are well-positioned to “leapfrog” on many AI applications while building towards AI-powered health systems shaped by local priorities, data, and clinical realities rather than waiting for finished products to arrive from elsewhere.

In November 2025, CHAI launched a new program to deepen and coordinate this work. It builds on a foundation already in place: a pricing agreement that has brought AI-

compatible portable chest X-ray devices for tuberculosis screening within reach of remote communities (*more on page 27*), and ongoing development of AI-assisted screening tools for cervical cancer (*more on page 34*). The new program brings these and other efforts together under a unified strategy to strengthen clinical care through AI-powered clinical decision support and diagnostics, while improving health systems management through the establishment of National Health Intelligence Centers that use AI to turn health system data into better government planning, surveillance, and performance. Underpinning all three is AI foundations, reliable power, connectivity, and devices; clear data and safety rules; and a trained workforce. Across these efforts, CHAI will leverage its full suite of market-shaping and technical assistance capabilities to help governments test, evaluate, and scale successful AI solutions.

Analytics & Implementation Research

CHAI generates evidence on the introduction and scale-up of new health products, innovations, and interventions in partner countries. We then use that evidence to inform national and global policies and turn those policies into action. Through epidemiological, geospatial, economic, and qualitative analyses, we develop solutions that expand access to healthcare, enhance system efficiency, and reduce morbidity and mortality. Our approach is driven by government decision-makers and their most urgent needs and opportunities. Our research is not just rigorous—it is strategic, actionable, and timely—ensuring governments have the evidence they need when it matters most.

Clinical Sciences

CHAI develops strategies and provides access to products that improve the delivery of health services. We do this through interpreting and sharing trends in global health, training health workers on treatment guidelines and standards of care and helping develop global and national public health policies. CHAI senior clinicians have direct professional experience managing patients; using medicines and diagnostics; and training fellow physicians, including those on technical advisory groups, on the use of these products. This can be a valuable resource when emerging conditions lack evidence or normative guidance, as was the case for COVID-19 and Mpox.

Diagnostics

Access to testing is a critical part of care and prevention for nearly every disease. Accurate diagnosis requires the right mix of affordable, quality technologies, and effective health systems. However, testing remains a critical gap for many diseases—half the world does not have access to essential tests. The COVID-19 pandemic brought this into sharp focus. Providing testing rapidly became an enormous priority for countries to track and manage the spread of the disease. CHAI supports countries to improve existing testing services and to introduce and scale up new technologies so patients can be diagnosed accurately and begin treatment sooner. We work closely with governments to upgrade testing services and cost-effective supply chains, support training, and other areas. In recent years we have helped countries deliver health services for diagnosing and monitoring cervical cancer, cholera, COVID-19, diabetes, hepatitis, HIV, maternal and newborn health conditions, sickle cell disease, sexually transmitted illnesses, and tuberculosis.

Digital Health

CHAI works hand-in-hand with governments to design, develop, scale, and institutionalize digital technologies to accelerate progress toward their public health goals. We support ministries of health to adopt technologies that serve health workers, health systems managers, and those that simplify the use of and access to data. We provide strategic and operational support to governments, working closely with end-users, global and local software technology organizations, donors, and others to influence digital health initiatives, ensure strong and thoughtful planning and coordination, and drive sustainability.

Global Markets

CHAI was founded to make treatment more equitable for millions of people living with HIV in low- and middle-income countries. Sustainable access to effective and quality-assured medicines and diagnostics remains a core pillar of our approach. CHAI helps governments maximize the impact of limited funding by identifying innovative products, or enabling access to existing products, that improve patient outcomes while reducing costs. We assist pharmaceutical, vaccine, and diagnostics companies with strategies to expand patient access in low- and middle-income countries via various types of market interventions, from enabling effective product licensing and incentivizing accelerated new product development, to leveraging financial tools such as volume guarantees and buy downs and devising new product introduction strategies. As a result, since CHAI was founded in 2002, we have completed over 150+ agreements to bring the most effective drugs and diagnostics to tens of millions of people. These agreements ensure people in over 125 low- and middle-income countries can access the best products while realizing billions of dollars in savings.

Product Development, Quality, Costing, & Regulatory Affairs

CHAI accelerates affordable access to quality-assured medical products for people living in low- and middle-income countries. Working with innovator and generic suppliers and other global stakeholders across disease areas, we support product development and market introduction, while maintaining a relentless commitment to quality, safety, effectiveness, and affordability, and stringent regulatory standards.

Financials

Clinton Health Access Initiative, Inc. and subsidiaries. Years ended December 31, 2024 through 2025.

Consolidated statement of activities:

Revenues and support	2025	2024
Contributions	US\$710,772	US\$5,027,576
Grants	-	-
Contributions of nonfinancial assets	326,246	557,265
Interest and other income	1,543,401	885,039
Net assets released from restrictions	281,865,154	237,074,709
Total revenues, gains, and other support	284,445,573	243,544,589
Expenses		
Program services	259,345,003	222,341,818
Management and general	29,245,502	20,586,924
Fundraising	763,717	941,687
Total expenses	289,354,222	243,870,429

Consolidated statements of financial position:

Assets	2025	2024
Cash and cash equivalents including donor restricted amounts	US\$182,731,910	US\$137,088,371
Advances and deposits	6,388,643	10,173,278
Grants receivable	14,927,709	21,042,446
Prepaid expenses	13,357,667	7,244,413
Operating lease right-of-use asset	878,565	1,271,318
Property and equipment	380,197	418,709
Total assets	218,664,691	177,238,535
Liabilities and net assets		
Accounts payable	7,442,006	6,368,644
Accrued expenses	23,379,665	13,769,751
Operating lease liability	855,834	1,248,587
Deferred revenue	162,085,433	142,320,323
Total liabilities	193,762,938	163,707,305
Net assets		
Without donor restrictions	4,634,265	9,542,914
With donor restrictions	20,267,488	3,988,316
Total net assets	24,901,753	15,531,230
Total liabilities and net assets	218,664,691	177,238,535

Acknowledgments

CHAI’s work is possible thanks to a committed network of donors and partners.

Abt Associates Pty Ltd
African Society for Laboratory Medicine
Agence Française de Développement
AIDS Vaccine Advocacy Coalition
Alan Schwartz
APIN Public Health Initiatives
Asia Pacific Leaders Malaria Alliance
Asian Infrastructure Investment Bank
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Breakthrough T1D
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Malawi Ministry of Health
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National Agency for the Control of AIDS, Nigeria
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National Department of Health, Papua New Guinea
National Institute of Health and Care Research
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Swedish International Development Cooperation Agency
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Swiss Tropical and Public Health Institute
Technical Advice Connect LTD/GTE
The Aurum Institute NPC
The Australian Government

The Brigham and Women’s Hospital (BWH)
The Children’s Investment Fund Foundation
The Global Fund to Fight AIDS, Tuberculosis and Malaria
The Hepatitis Fund
The Leona M. and Harry B. Helmsley Charitable Trust
The MCJ Amelior Foundation
U.S. Civilian Research & Development Foundation
UBS Optimus Foundation
UK Foreign, Commonwealth and Development Office
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References

1

OECD, A Historic Decline in Foreign Aid: Preliminary 2025 ODA Data (Paris: OECD, April 2026).

2

OECD, "A Historic Decline in Foreign Aid: Preliminary 2025 ODA Data," data explainer, April 2026, <https://www.oecd.org/en/data/insights/data-explainers/2026/04/a-historic-decline-in-foreign-aid-preliminary-2025-oda-data.html>.

3

Lesley Reed, "U.S. Steps Back Up as Biggest Donor to the Global Fund," RESULTS (blog), December 12, 2025, <https://results.org/blog/u-s-steps-back-up-as-biggest-donor-to-the-global-fund>.

4

World Health Organization, "WHO Issues Guidance to Address Drastic Global Health Financing Cuts," news release, November 3, 2025, <https://www.who.int/news/item/03-11-2025-who-issues-guidance-to-address-drastic-global-health-financing-cuts>.

5

CHAI, HIV Market Impact Memo (June 2026), <https://www.clintonhealthaccess.org/wp-content/uploads/2026/06/HIV-Market-Impact-Memo-June2026.pdf>.

6

GBD 2021 Antimicrobial Resistance Collaborators. "Global Burden of Bacterial Antimicrobial Resistance 1990–2021: A Systematic Analysis with Forecasts to 2050." The Lancet 404, no. 10459 (2024): 1199–1226. [https://doi.org/10.1016/S0140-6736\(24\)01867-1](https://doi.org/10.1016/S0140-6736(24)01867-1).

7

Rudd, K. E., S. C. Johnson, K. M. Agesa, et al. "Global, Regional, and National Sepsis Incidence and Mortality, 1990–2017: Analysis for the Global Burden of Disease Study." The Lancet 395, no. 10219 (2020): 200–211. [https://doi.org/10.1016/S0140-6736\(19\)32989-7](https://doi.org/10.1016/S0140-6736(19)32989-7).

8

Hu, Y., J. Harwell, et al. "Abstract 00829." ESCMID Global 2025, Vienna, April 11–15, 2025.

9

Hu, Y., and J. Harwell. "Global Trends and Impact of Antimicrobial Resistance in Paediatric Populations: An Analysis Using WHO AWaRe Classification and Priority Pathogens." Oral presentation, ESCMID Global 2025, 2025.

10

Clinton Health Access Initiative. "CARB-X and CHAI Partner to Sharpen AMR Response, Tackle Gonorrhea in Low- and Middle-Income Countries." November 26, 2024.

11

Center for Infectious Disease Research and Policy. "CARB-X Partner, Clinton Health Access Initiative, Is Gonorrhea-Focused." CIDRAP, 2024. <https://www.cidrap.umn.edu/antimicrobial-stewardship/carb-x-partner-clinton-health-access-initiative-gonorrhea-focused>.

12

Shionogi, Global Antibiotic Research and Development Partnership (GARDP), and Clinton Health Access Initiative (CHAI). "Landmark License and Collaboration Agreements to Expand Access to Cefiderocol in 135 Countries." June 15, 2022. <https://www.clintonhealthaccess.org/news/shionogi-gardp-and-chai-announce-landmark-license-and-collaboration-agreements-to-treat-bacterial-infections-by-expanding-access-to-cefiderocol-in-135-countries/>.

13

World Health Organization, Global Hepatitis Report, 2026 (Geneva: WHO, 2026), <https://www.who.int/publications/i/item/9789240122383>.

14

Nigeria, Uganda, Rwanda, India, Cambodia, Myanmar, Indonesia and Vietnam

15

As of 2025, CHAI has successfully concluded its support to the national hepatitis programs in Indonesia, and India, with the exception of the ongoing West Bengal triple elimination project. The data presented here reflect only the programs where CHAI continues to provide active support.

16

JHEP Report, [https://www.jhep-reports.eu/article/S2589-5559\(23\)00108-8/fulltext](https://www.jhep-reports.eu/article/S2589-5559(23)00108-8/fulltext)

17

World Health Organization, "Viral Hepatitis B and C Burden of Disease, WHO Policy Adoption Status in Countries, 2025," information sheet, WHO/UCN/HHS/SIA/2025.01, Geneva: WHO, 2025, <https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/2025-whd-hep-information-sheet.pdf>.

18

Clinton Health Access Initiative, "Integrated Screening for Triple Elimination Memo,"<https://www.clintonhealthaccess.org/report/integrated-screening-for-triple-elimination-memo/>.

19

Clinton Health Access Initiative. "HIV/Syphilis Dual-RDT Market Brief." CHAI Triple Elimination Series, September 2025. <https://www.clintonhealthaccess.org/wp-content/uploads/2025/09/CHAI-HIV-Syphilis-Dual-Market-Brief-Sep2025.pdf>

20

Clinton Health Access Initiative. "Integrated Screening in Antenatal Care: Market Memo." CHAI Triple Elimination Series, March 2026 (updated May 2026). <https://www.clintonhealthaccess.org/wp-content/uploads/2026/03/CHAI-Integrated-Screening-Market-Memo-March-2026.pdf>

21

Clinton Health Access Initiative. "Delivering Integration Under GC8: A Toolkit to Strengthen HIV Outcomes through Integration with Hepatitis, Harm Reduction, and Triple Elimination." April 2026. <https://www.clintonhealthaccess.org/wp-content/uploads/2026/04/CHAI-GC8-Resource-Toolkit.pdf>

22

UNAIDS, "Fact Sheet," <https://www.unaids.org/en/resources/fact-sheet>.

23

Clinton Health Access Initiative, "HIV Market Impact Memo, June 2026," accessed June 2026, <https://www.clintonhealthaccess.org/report/hiv-market-impact-memo-june-2026/>.

24

Clinton Health Access Initiative, "HIV Market Impact Memo." July 2025. <https://www.clintonhealthaccess.org/wp-content/uploads/2025/07/2025-Q2-CHAI-HIV-Market-Impact-Memo.pdf>

25

"Twice-Yearly Lenacapavir or Daily F/TAF for HIV Prevention in Cisgender Women," New England Journal of Medicine], <https://doi.org/10.1056/NEJMoa2407001>.

26

UNAIDS, "UNAIDS Urges Gilead to Drop Price of New HIV Prevention Shot," June 18, 2025, <https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2025/june/20250618.lenacapavir>.

27

UNAIDS, "Fact Sheet," 2024, <https://www.unaids.org/en/resources/fact-sheet>.

→ View CHAI leadership teams on our website: www.clintonhealthaccess.org/leadership

28 World Health Organization, "Advanced HIV Disease," <https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/treatment/advanced-hiv-disease>.

29 Clinton Health Access Initiative, "THRIVE Country Data," 2025.

30 World Health Organization, World Malaria Report 2025: Addressing the Threat of Antimalarial Drug Resistance (Geneva: World Health Organization, 2025), <https://www.who.int/publications/i/item/9789240117822>.

31 World Health Organization, "Neglected Tropical Diseases," WHO, accessed August 12, 2026, https://www.who.int/health-topics/neglected-tropical-diseases#tab=tab_1.

32 Symons TL, Lubinda J, McPhail M et al. "Estimating the potential malaria morbidity and mortality avertable by the US President's Malaria Initiative in 2025: a geospatial modelling analysis." *The Lancet* 405, 10496 (2025): p2231-2240, doi: [10.1016/S0140-6736\(25\)00805-0](https://doi.org/10.1016/S0140-6736(25)00805-0)

33 The Global Fund provides over half of all international financing for malaria programs and has invested more than US\$20.3 billion in malaria control programs as of June 2025.

34 The Global Fund to Fight AIDS, Tuberculosis and Malaria, "Malaria," last modified September 10, 2025, <https://www.theglobalfund.org/en/malaria/>.

35 The Global Fund to Fight AIDS, Tuberculosis and Malaria, "Global Fund Board Backs Prioritization of Lifesaving Interventions amid Crisis, Urges Strong Eighth Replenishment to Protect Progress." Press release, May 14, 2025. <https://www.theglobalfund.org/en/news/2025/2025-05-14-global-fund-board-backs-prioritization-lifesaving-interventions-strong-eighth-replenishment-protect-progress/>

36 Estimate derived from 2023 modeling conducted with the Swiss Tropical and Public Health Institute (Swiss TPH), which projected the impact of seasonal malaria chemoprevention across sub-Saharan Africa over a three-year period (2024–2026). Compared with a counterfactual scenario without seasonal malaria chemoprevention, models estimated that a business-as-usual scenario (75 percent coverage)—successfully maintained in 2025 through strategic response to funding cuts—could, on average, avert more than 4,800 severe malaria cases in Benin and more than 12,600 in Cameroon each year from 2024–2026.

37 Trachoma, a neglected tropical disease, is the world's leading infectious cause of preventable blindness.

38 Without sufficient levels of this blood enzyme, radical cure for *P. vivax* malaria can cause hemolytic anemia, a potentially life-threatening condition where red blood cells are damaged and the body cannot replace them quickly enough. While *P. falciparum* is the parasite responsible for the most severe and deadly form of malaria, *P. vivax* is responsible for most recurrent malaria, as it can lie dormant in the liver and re-emerge weeks or months later. To prevent relapse, curative treatment aims to clear the *P. vivax* parasite load from the bloodstream (usually with chloroquine or artemisinin-based combination therapies) and the liver (using primaquine or tafenoquine).

39 Malaria case detection within 48 hours is a benchmark to enable timely treatment, aiming to intervene on the Plasmodium parasite load quickly to avert severe symptoms and onward transmission.

40 Smith DL, Cohen JM, Chiyaka C et al. "A sticky situation: the unexpected stability of malaria elimination". *Philos Trans R Soc Lond B Biol Sci.* 368, 1623 (2013): 20120145, doi: <https://doi.org/10.1098/rstb.2012.0145>

41 WHO, 'Dengue: global situation, surveillance and progress – 2024 update.' Weekly epidemiologic record, December 26, 2025. <https://www.who.int/publications/i/item/who-wer10052-665-678>

42 WHO. 'Dengue.' Fact sheet, last updated August 21, 2025. <https://www.who.int/news-room/fact-sheets/detail/dengue-and-severe-dengue>

43 CHAI's Wolbachia work is funded by Skip Foundation and Wellcome Trust (conducted in partnership with the Health Finance Coalition, which was integrated into BillionScale Health in 2026).

44 Wolbachia, once established in a local population, can avert dengue transmission via one of two approaches: by suppressing the overall Ae. aegypti population or by replacing the population over time with Wolbachia-carrying individuals, which have a reproductive advantage but are not well suited for viral replication of arboviruses.

45 Ahmed Ehsanur Rahman, Anika Tasnim Hossain, Harish Nair, et al., "Prevalence of Hypoxaemia in Children with Pneumonia in Low-Income and Middle-Income Countries: A Systematic Review and Meta-Analysis," *Lancet Global Health* 10, no. 3 (2022): e348–e359, [https://doi.org/10.1016/S2214-109X\(21\)00586-6](https://doi.org/10.1016/S2214-109X(21)00586-6).

46 Hamish R. Graham, Carina King, Ahmed Ehsanur Rahman, et al., "Reducing Global Inequities in Medical Oxygen Access: The Lancet Global Health Commission on Medical Oxygen Security," *Lancet Global Health* 13, no. 3 (2025): e528–e584, published online February 17, 2025, [https://doi.org/10.1016/S2214-109X\(24\)00496-0](https://doi.org/10.1016/S2214-109X(24)00496-0).

47 World Health Organization, Increasing Access to Medical Oxygen, WHA76.3, Seventy-Sixth World Health Assembly, May 30, 2023, https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R3-en.pdf.

48 Oxygen Hub. "Closing the Medical Oxygen Gap in Sub-Saharan Africa." <https://oxygenhub.org/psaplants/>

49 V. Smith et al., "A Comprehensive Approach to Medical Oxygen Ecosystem Building: An Implementation Case Study in Kenya, Rwanda, and Ethiopia," *Global Health: Science and Practice* 10, no. 6 (2022): e2100781, <https://doi.org/10.9745/GHSP-D-21-00781>.

50 "Unitaid and Partners Launch First-of-Its-Kind Regional Manufacturing Initiative to Improve Access to Medical Oxygen in Sub-Saharan Africa," Unitaid, October 22, 2024, <https://unitaid.org/news-blog/unitaid-and-partners-launch-first-of-its-kind-regional-manufacturing-initiative-to-improve-access-to-medical-oxygen-in-sub-saharan-africa/>.

51 World Health Organization, "Global Tuberculosis Report 2025," published November 12, 2025, <https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2025>.

52 World Health Organization, "1.1 TB Incidence," in *Global Tuberculosis Report 2024* (Geneva: World Health Organization, 2024), <https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2024/tb-disease-burden/1-1-tb-incidence>.

53 World Health Organization, "Tuberculosis," fact sheet, last updated March 24, 2026, <https://www.who.int/news-room/fact-sheets/detail/tuberculosis>.

54 Clinton Health Access Initiative, "Unitaid and Partners Cut Cost of Portable AI-Compatible X-Ray Device, Bringing TB Screening Closer to Communities," May 20, 2025, <https://www.clintonhealthaccess.org/news/unitaid-and-partners-cut-cost-of-portable-ai-compatible-x-ray-device-bringing-tb-screening-closer-to-communities/>.

55 Clinton Health Access Initiative, March 23, 2026, <https://www.clintonhealthaccess.org/blog/integrated-tb-screening-kenya-nigeria/>.

56 Clinton Health Access Initiative, "TB Has a Hiding Place. Integrated TB Screening Is Finding It," Clinton Health Access Initiative, March 23, 2026, <https://www.clintonhealthaccess.org/blog/integrated-tb-screening-kenya-nigeria/>.

57 World Health Organization and UNICEF, Global Report on Assistive Technology (Geneva: WHO, 2022), <https://www.who.int/news/item/16-05-2022-almost-one-billion-children-and-adults-with-disabilities-and-older-persons-in-need-of-assistive-technology-denied-access--according-to-new-report>.

58 ATscale and Clinton Health Access Initiative, 2025 Assistive Products Market Report (Boston: Clinton Health Access Initiative, 2025), <https://www.clintonhealthaccess.org/wp-content/uploads/2025/06/Assistive-Products-Market-Report-2025.pdf>.

59 ATscale and Clinton Health Access Initiative, 2025 Assistive Products Market Report (Boston: Clinton Health Access Initiative, 2025), <https://www.clintonhealthaccess.org/wp-content/uploads/2025/06/Assistive-Products-Market-Report-2025.pdf>.

60 Livelihood Impact Fund, "Livelihood Impact Fund Launches Global Vision Impact Award, Inviting Governments to Scale the World's Most Overlooked Public Health Win," news release, May 19, 2026, <https://www.livelihoodimpactfund.org/eyeglassesnews>.

61 World Health Organization, "Cervical Cancer," WHO, <https://www.who.int/news-room/fact-sheets/detail/cervical-cancer>.

62 Clinton Health Access Initiative (CHAI). "Five-Country Prospective Community-Based Self-Sampling Study." Manuscript in preparation.

63 Phiri, Henry, Felix Uwinkindi, Mamadou Diop, et al. "Performance of an Artificial Intelligence-Based Tool for Cervical Precancer Screening in Five Countries in Africa." *The Lancet Global Health* 14 (2026): e49–e60. [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(25\)00352-3/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(25)00352-3/fulltext)

64 Kenya Health Information System 2 (KHIS-2). "HPV Coverage at 4%, VIA at 90%, and PAP Smear at 6% of Screening Coverage." Ministry of Health, Kenya. Accessed August 11, 2026.

65 World Health Organization, Regional Office for Africa, "Kenya Launches National Cervical Cancer Elimination Action Plan 2026–2030," news release, January 16, 2026, <https://www.afro.who.int/countries/kenya/news/kenya-launches-national-cervical-cancer-elimination-action-plan-2026-2030>.

66 World Health Organization. "Noncommunicable Diseases." WHO Fact Sheet, September 2025.

67 International Diabetes Federation. IDF Diabetes Atlas. 11th ed. Brussels: International Diabetes Federation, 2025.

68 World Health Organization. "Hypertension." WHO Fact Sheet, September 2025.

69 Type 1 Diabetes Index. Type 1 Diabetes Index 2026. 2026.

70 Alexandra M. Thomson et al., "Global, Regional, and National Prevalence and Mortality Burden of Sickle Cell Disease, 2000–2021: A Systematic Analysis from the Global Burden of Disease Study 2021," *The Lancet Haematology* 10 (2023): e585, [https://doi.org/10.1016/S2352-3026\(23\)00118-7](https://doi.org/10.1016/S2352-3026(23)00118-7).

71 Clinton Health Access Initiative, "CHAI Secures Price Reduction for Sickle Cell Disease Diagnosis," news release, May 30, 2025, <https://www.clintonhealthaccess.org/news/chai-secures-price-reduction-for-sickle-cell-disease-diagnosis/>.

72 Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2023 (GBD 2023) Results. Seattle: Institute for Health Metrics and Evaluation (IHME), 2024. <https://vizhub.healthdata.org/gbd-results/>.

73 World Health Organization and UNICEF. Clinical Management of Acute Diarrhoea. Joint Statement. Geneva: World Health Organization, 2004. https://www.who.int/publications/i/item/WHO_FCH_CAH_04.7

74 UNICEF. "Diarrhoeal Disease." Accessed August 20, 2026. <https://data.unicef.org/topic/child-health/diarrhoeal-disease/>.

75 Institute for Health Metrics and Evaluation (IHME), Diarrhea (Seattle: IHME, University of Washington, 2018), accessed September 11, 2026, <https://vizhub.healthdata.org/lbd/diarrhoea>.

76 CHAI, RAND, and Innovations for Poverty Action (IPA), unpublished baseline data, AT-HOME randomized controlled trial, Bauchi, Nigeria, 2025 (results forthcoming).

77 WHO Malnutrition Fact Sheet (updated March 2024): <https://www.who.int/news-room/fact-sheets/detail/malnutrition>

78 UNICEF Supply Division, RUTF Market Supply Update 2025 (UNICEF, 2025), <https://www.unicef.org/supply/media/24886/file/RUTF-Market-Supply-Update-2025.pdf>.

79 Bjorn Larsen, John Hoddinott, and Saba Razvi, "Investing in Nutrition: A Global Best Investment Case," *Journal of Benefit-Cost Analysis* 14, no. 2 (2023): 171–98.

80 WHO/UNICEF/UNU Workshop on UNIMMAP Formulation, 1999.

81 Emily C. Keats, Batoool A. Haider, Emily Tam, and Zulfiqar A. Bhutta, "Multiple-Micronutrient Supplementation for Women during Pregnancy," *Cochrane Database of Systematic Reviews*, no. 3 (2019): CD004905, <https://doi.org/10.1002/14651858.CD004905.pub6>.

82 Emily R. Smith, Anuraj H. Shankar, Lee Shu-Fune Wu, Said Aboud, Seth Adu-Afarwuah, Hasmot Ali, et al., "Modifiers of the Effect of Maternal Multiple Micronutrient Supplementation on Stillbirth, Birth Outcomes, and Infant Mortality: A Meta-Analysis of Individual Patient Data from 17 Randomised Trials in Low-Income and Middle-Income Countries," *Lancet Global Health* 5, no. 11 (2017): e1090–e1100, [https://doi.org/10.1016/S2214-109X\(17\)30371-6](https://doi.org/10.1016/S2214-109X(17)30371-6).

83 Carleigh A. Ajello, Auliya Suwantika, Olivia Santika, Sarah King, and Julia De Lange, UNIMMAP MMS for National Health Systems: Considerations for Developing a Supply Strategy, Kirk Humanitarian Resource Paper, November 2022, https://kirkhumanitarian.org/wp-content/uploads/2022/11/FINAL_Kirk_UNIMMAP_MMS_SupplyPaper_Digital.pdf.

84 World Health Organization, *Trends in Maternal Mortality Estimates 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division* (Geneva: World Health Organization, 2025).

85 Emily A. Sully et al., *Adding It Up: Investing in Sexual and Reproductive Health 2019* (New York: Guttmacher Institute, 2020).

86 United Nations Children's Fund (UNICEF), *Child Mortality Estimates*, Global Database, March 2026.

87 Elizabeth A. Sully and Amy Friedrich-Karnik, "Foreign Aid Cuts Will Lead to 34,000 More Pregnancy-Related Deaths in Just One Year," Guttmacher Institute, March 2025, <https://www.guttmacher.org/article/2025/03/foreign-aid-cuts-will-lead-34000-more-pregnancy-related-deaths-just-one-year>.

88 Clinton Health Access Initiative, *2023 Annual Report*, 2023, <https://www.clintonhealthaccess.org/annual-report/annual-report-2023/>.

89 UNICEF. (2024). Vaccination and Immunization Statistics. UNICEF Data: Monitoring the situation of children and women. Retrieved from <https://data.unicef.org/topic/child-health/immunization/>

90 OECD. (2026, April 9). A historic decline in foreign aid: Preliminary 2025 ODA data. <https://www.oecd.org/en/data/insights/data-explainers/2026/04/a-historic-decline-in-foreign-aid-preliminary-2025-oda-data.html>

91 World Health Organization. "Immunization Coverage." Fact sheet. 2025. <https://www.who.int/news-room/fact-sheets/detail/immunization-coverage>

92 World Health Organization and UNICEF. Immunization Agenda 2030: A Global Strategy to Leave No One Behind. <https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030>

93 "Millions of Children Have Never Had a Single Vaccine—Finding Them Isn't Enough." Global Health Hub. <https://www.globalhealthhub.de/en/news/detail/millions-of-children-have-never-had-a-single-vaccine-finding-them-isnt-enough>

94 WUENIC. "Global Childhood Vaccination Holds Steady, Yet over 14 Million Infants Remain Unvaccinated." 2025. <https://www.unicef.org/press-releases/global-childhood-vaccination-holds-steady-yet-over-14-million-infants-remain>

95 World Health Organization. Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem. 2020. See also "Cervical Cancer." Fact sheet.

<https://www.who.int/news-room/fact-sheets/detail/cervical-cancer>

96 World Health Organization. (2025). Global tuberculosis report 2025 (2025), <https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2025>.

97 Stop TB Partnership, Working Group on New TB Vaccines. TB vaccine clinical pipeline.

98 Portnoy A, Clark RA, Quaife M, et al. (2023). The cost and cost-effectiveness of novel tuberculosis vaccines in low- and middle-income countries: A modeling study. *PLOS Medicine*, 20(1), e1004155. <https://doi.org/10.1371/journal.pmed.1004155>.

99 CHAI, Gavi & MMGH Consulting. (2025). Global demand forecast for novel TB vaccines. <https://www.clintonhealthaccess.org/report/forecasting-global-demand-for-life-saving-tb-vaccines/>

100 KFF. "The Trump Administration's Foreign Aid Review: Proposed Reorganization of U.S. Global Health Programs." 2025. <https://www.kff.org/global-health-policy/the-trump-administrations-foreign-aid-review-proposed-reorganization-of-u-s-global-health-programs/>

101 CHAI. "New Solar Initiative to Power Thousands of African Hospitals." February 2025. <https://www.clintonhealthaccess.org/news/new-solar-initiative-to-power-thousands-of-african-hospitals-partnership-aims-to-electrify-health-facilities-across-four-countries/>

102 Human Rights Watch. "New Data Exposes Global Healthcare Funding Inequalities." April 2025. <https://www.hrw.org/news/2025/04/10/new-data-exposes-global-healthcare-funding-inequalities>

103 CHAI. "How Six Nigerian States Tripled Health Insurance Coverage for Vulnerable Families." December 2025. <https://www.clintonhealthaccess.org/blog/nigeria-tripled-health-insurance-coverage/>

104 Institute for Health Metrics and Evaluation, "Global Mental Disorders Have Nearly Doubled since 1990, Now Affecting 1.2 billion People Worldwide," news release, May 21, 2026, <https://www.healthdata.org/news-events/newsroom/news-releases/global-mental-disorders-have-nearly-doubled-1990-now-affecting>.

105 UnitedGMH, Financing of Mental Health, October 2023, <https://unitedgmh.org/app/uploads/2023/10/Financing-of-mental-health-V2.pdf>.

106 UNICEF and Pure Earth, The Toxic Truth: Children's Exposure to Lead Pollution Undermines a Generation of Future Potential (New York: UNICEF, 2020), <https://www.unicef.org/reports/toxic-truth-childrens-exposure-to-lead-pollution-2020>.

107 Bjorn Larsen and Ernesto Sánchez-Triana, "Global Health Burden and Cost of Lead Exposure in Children and Adults: A Health Impact and Economic Modelling Analysis," *The Lancet Planetary Health* 7, no. 10 (2023), [https://doi.org/10.1016/S2542-5196\(23\)00166-3](https://doi.org/10.1016/S2542-5196(23)00166-3).

108 Bjorn Larsen and Ernesto Sánchez-Triana, "Global Health Burden and Cost of Lead Exposure in Children and Adults: A Health Impact and Economic Modelling Analysis," *The Lancet Planetary Health* 7, no. 10 (2023), [https://doi.org/10.1016/S2542-5196\(23\)00166-3](https://doi.org/10.1016/S2542-5196(23)00166-3).



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