International Community of Women Living with HIV Eastern Africa

Impact of the Pause of U.S. Foreign Aid on HIV&TB services in East Africa

February 2025

ICWEA areas of operation, namely, Uganda, Kenya, Tanzania, Burundi, and Rwanda

ACRONYMS/ABBREVIATIONS

AIDS	: Acquired Immune Deficiency Syndrome
ART	: Antiretroviral Treatment/Therapy
ARV	: Antiretrovirals
CBC	: Complete Blood Count
CDC	: Center for Disease Control & Prevention
CLM	: Community Led Monitoring
DREAMS	: Determined, Resilient, Empowered, AIDS-free, mentored and Safe
DSDM	: Differentiated Service Delivery Models
DVR	: Dapivirine Virginal Ring
EID	: Early Infant Diagnosis
HC IV	: Health Centre IV
HIV	: Human Immune Deficiency Virus
ICWEA	: International Community of Women Living with HIV/AIDS Eastern Africa
IP	: Implementing Partner
KVP	: Key and Vulnerable Populations
MJAP ISS	: Makerere Joint AIDS Program Institutional Support Services
MMD	: Multi-Month Dispensing
NCD	: Non-Communicable Diseases
OPD	: Outpatient Department
OVC	: Orphans and Vulnerable Children
PEP	: Post Exposure Prophylaxis
PEPFAR	: President's Emergency Plan for AIDS Relief
PLHIV	: People Living with HIV
PMTCT	: Prevention of Mother to Child Transmission
PrEP	: Pre-Exposure Prophylaxis
TB	: Tuberculosis
TV	: Television
USAID	: United States Agency for International Development
VMMC	: Voluntary Medical Male Circumcision

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EXECUTIVE SUMMARY

ICWEA conducted a rapid assessment using a mixed methods approach employing both quantitative and qualitative methods of data collection and analysis, to assess the immediate impact of the US funding freeze on HIV/AIDS services among women and girls within ICWEA countries of operation, with an urgent need to advocate for policy interventions to restore and sustain life-saving programs. The funding freeze imposed by the U.S.A government on January 24, 2025, as part of a broader foreign aid suspension, has had severe consequences on HIV/AIDS programs globally with severe consequences felt by vulnerable girls and women in Eastern Africa[2]. The findings revealed significant disruptions in HIV treatment, economic hardships, and increased stigma and discrimination, highlighting an urgent need for policy interventions on healthcare services, employment, and the well-being of people living with HIV (PLHIV).

According to the assessment, a major impact of the funding freeze has been severe disruptions in HIV/TB services. Essential services, such HIV Prevention (i.e., pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and maternal transmission prevention; Care and Treatment (i.e., viral load testing, access to ART were either halted or significantly reduced. Many PEPFAR-funded health facilities reported staff layoffs, resulting in long waiting times and treatment interruptions. Community-led monitoring programs, which play a critical role in advocacy for quality HIV/TB service delivery, were equally affected, exacerbating stigma, misinformation, and discrimination against PLHIV.

Reportedly, the freeze further posed serious economic consequences, particularly for healthcare workers and organizations reliant on PEPFAR funding. Many of the participants reported job losses, income reduction, and financial distress, making it harder to access healthcare services. Women and young professionals were disproportionately affected, as they form a significant portion of the workforce in HIV&AIDS programs. The economic strain extended beyond healthcare workers to PLHIV, with some resorting to rationing their medication due to uncertainty about future treatment availability. In addition, the funding freeze has triggered psychological and social consequences, with many PLHIV experiencing heightened stress, anxiety, and fear. Some participants reported being publicly stigmatized, while others faced discrimination and rejection within their communities. The disruption of peer counseling and mental health support programs further worsened these psychological effects. Women reportedly faced increased rates of gender-based violence (GBV), involuntary disclosure, and intimate partner violence, deepening their vulnerability.

Maternal and child health services were significantly affected, with early infant diagnosis (EID), prevention of mother-to-child transmission (PMTCT), and nutritional support for HIV-positive mothers facing severe disruptions. Many women reported difficulty accessing essential medications for themselves and their children, increasing the risk of HIV-related infant mortality. Additionally, healthcare facilities struggled to maintain adequate supplies of HIV treatment and nutritional support, leaving pregnant and breastfeeding women in a highly vulnerable position.

According to the assessment, immediate restoration of HIV/TB Services is crucial to prevent further deterioration of health outcomes. Governments' local and international stakeholders must advocate for urgent policy interventions to restore funding for critical HIV programs. Strengthening community-led

[2] How the shift in US funding is threatening both the lives of people affected by HIV and the community groups supporting them

monitoring and alternative supply chain mechanisms will help track service delivery gaps and mitigate future disruptions.

To address mental health and psychosocial challenges, HIV programs should strengthen the integration of counseling, peer support, and mental health first aid into service delivery. Healthcare providers should receive training in psychological first aid, and community-based organizations should expand support groups for PLHIV to counter the psychological impact of the funding freeze.

Given the widespread economic distress, there is an urgent need for livelihood support programs targeting healthcare workers and PLHIV. Financial assistance, vocational training, and entrepreneurship support should be introduced to help young women and girls who lost jobs transition into alternative income-generating activities. Governments could also incorporate affected health workers into national payrolls to ensure continuity of HIV service delivery.

To reduce reliance on external donors, governments, local and international development partners must diversify funding sources for HIV programs. This includes strengthening public-private partnerships, increasing domestic budget allocations for HIV services by governments, and exploring regional funding mechanisms. Such measures would enhance financial sustainability and resilience in the face of future funding uncertainties.

Finally, improving communication and advocacy efforts is critical in combating misinformation and stigma surrounding HIV treatment. Governments, civil society organizations, and community groups should increase awareness campaigns to ensure that people living with and affected by HIV and affected communities receive accurate information about service availability. Advocacy efforts should also focus on securing long-term commitments from governments, private sector, anthropologists and international donors to prevent similar funding disruptions in the future.

In conclusion, the funding freeze has posed an immediate crisis for HIV treatment and prevention efforts in Eastern Africa, especially among women and girls, threatening to reverse years of progress in fighting HIV&AIDS and TB programs. Without urgent intervention, millions remain at risk of treatment interruptions, worsening health outcomes, and deepened socio-economic vulnerabilities. Governments and stakeholders must act swiftly to restore funding, integrate mental health services, support affected workers, and build sustainable funding models to protect the lives and dignity of those impacted by the crisis, and most importantly, integration should be implemented in a phased approach with a clear framework, adequate capacity building, and stakeholder consultation an engagement of communities affected.

INTRODUCTION

1.1 Background

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has been a cornerstone in global HIV&AIDS response, providing life-saving services to millions of individuals worldwide[3][4]. However, on January 24, 2025, the U.S. Department of State issued a directive to suspend all foreign assistance, following an executive order mandating a 90-day freeze on foreign aid disbursements (PEPFAR Watch, 2025). This unprecedented move resulted in the immediate issuance of stop-work orders to over 450 implementing partners, effectively halting essential HIV prevention, care, and treatment programs across multiple countries (Update-1-Deadly-Pause, 2025).[5]

The impact of this funding freeze has been severe and far-reaching[6]. Initial survey data from the first weeks of the freeze revealed widespread disruption to HIV services, with many treatment and prevention programs either significantly reduced or completely terminated[7]. A substantial number of implementing organizations reported staff layoffs, and some clinics faced closure due to lack of funding (Journal of the International AIDS Society, 2025). Despite a subsequent waiver issued by the Secretary of State on January 28, 2025, to resume certain critical services such as HIV treatment, viral load testing, and maternal transmission prevention, bureaucratic and systemic delays have hindered the effective reinstatement of these programs (PEPFAR Work Stop Orders, 2025)[8].

The consequences of this funding freeze are already evident in increased HIV treatment interruptions, lack of access to preventive measures, and rising stigma and discrimination aamongst people living with and affected by HIV&AIDS. Community-led HIV programs, which are integral to ensuring continuity of care, have been disproportionately affected, with key services such as pre-exposure prophylaxis (PrEP) and community-led monitoring left out of the waiver's scope (Update-1-Deadly-Pause, 2025). Additionally, the disruption threatens to reverse years of progress in reducing HIV-related mortality and new infections, especially in regions heavily reliant on PEPFAR support.

This report therefore examines the ramifications of the funding freeze on HIV&AIDS services, and the urgent need for policy interventions to restore and sustain life-saving programs among women and girls living with HIV as well as prevention interventions in Eastern Africa. Without immediate action, millions of vulnerable individuals could be left without essential prevention and health services, exacerbating the global HIV&AIDS crisis.

ICWEA[9], an implementing Partner of PEPFAR-funded Community Led Monitoring project that was equally affected conducted a rapid assessment in a few sampled health facilities and locations in Eastern African countries[10] of its implementation to understand the effects, outcome, and the immediate impact of the funding freeze and stop-work order.

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[4] Journal of the International AIDS Society. (2025). Early impacts of the PEPFAR stop-work order: A rapid assessment.
[5] PEPFAR Watch. (2025). UpdatTracking the Stop Work Order (Wave 2). Retrieved from https://pepfarwatch.org
[6] U.S. aid cuts have far-reaching affect; NGOs call for increased Canadian funding to offset shortfall
[7] PEPFAR Watch. (2025). Update: Deadly Pause - Tracking the Stop Work Order (Wave 2). Retrieved from https://pepfarwatch.org
[8] PEPFAR Work Stop Orders. (2025). PEPFAR Work Stop Orders Report
[9] ICWEA Countries of operation: Uganda, Kenya, Tanzania, Rwanda and Burundi

1.2 Purpose of the Assessment

To determine the immediate impact of the freeze of the U.S foreign aid including PEPFAR on women and girls in East Africa to inform policy interventions to restore and sustain prevention, life-saving and Community-led programs within ICWEA Countries of operation.

1.3 Assessment Assumptions

While the online surveys offered a cost-effective, scalable, and anonymous method for collecting data from communities of PLHIV and those affected by HIV in the region, some notable limitations that may impact data quality and representativeness were identified and managed. The reliability of the data, complementary method**s** (e.g., phone call, and physical discussions and interviews) with Implementing Partners, walk in and expert clients, health facility Coordinators were adapted to supplement the online based surveys, ensuring inclusive survey distribution to participants without access to digital devices and internet.

1. **Access to internet and mobile devices:** It was assumed that most communities of PLHIV and those affected by HIV in the region have access to the internet and mobile digital devices, enabling them to participate in the assessment through surveys.
2. **Literacy and digital literacy:** It was assumed that all targeted online survey participants were literate and tech savvy, meaning they are digitally literate enough to read, understand, and respond to online survey questions accurately. The participants in Burundi and Rwanda could access the tool in French, ensuring their inclusion in the assessment.
3. **Anonymity encourages honest responses:** The participants would provide truthful information since online surveys offer a degree of anonymity. Relatedly, documentation on phone calls, and physical interviews were limited to the discussions guide, and not personal details.
4. **Survey reachability:** It was assumed that the survey link would reach a representative sample of PLHIV in ICWEA's Countries of operation through appropriate distribution channels such as social media especially WhatsApp, email, or community networks.
5. **Interest and willingness to participate:** Communities of PLHIV and those affected by HIV were impacted enough to complete the survey, seeing it as relevant to their needs and concerns.

METHODOLOGY

2.1 Assessment design and approach

This study employed a mixed method approach utilising both quantitative and qualitative data collection and analysis, to assess the impact of the funding freeze on HIV&AIDS services in ICWEA countries of operation. A rapid assessment was conducted across selected health facilities, targeting people living with HIV (PLHIV) who are expert and walk in clients, healthcare workers, and IPs affected by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funding freeze. The assessment triangulated quantitative online surveys with qualitative insights ensuring a comprehensive understanding of the crisis's immediate effects. The data collection methods used were all primary in nature, specifically, online surveys, key informant discussions, and discussions. Commcare mobile application was used to collect semi structured survey data, whereas a key informant guide was used to gather qualitative data from the interviews, and discussions. Qualitative interviews reached out to 39 service recipients from 6 health facilities randomly visited in the regions of Kampala, Jinja, Masaka in Uganda; including two (2) staff from the regions mentioned coordinating PEPFAR funded projects. The health facilities visited in Uganda included, Kasangati HC IV, MJAP ISS Clinic, Kawaala HC IV, Wakiso HC IV, Alive Medical Services, and Kawempe NRHA. Purposive sampling techniques were applied to access information about targeted participants; because they have rich information about the scope of the assignment, including HIV services and PEPFAR funding. The assessment also adopted a convenience sampling technique because of geographical proximity, availability at a given time and willingness to participate in the assessment.

2.2 Data Analysis

Both qualitative and quantitative analyses were applied to inform the assessment as described below.

a. **Quantitative Analysis:** Responses from the online survey were analyzed using descriptive statistics, using Ms. excel. Results were visualized using tables, charts and interpreted as narratives.
b. **Qualitative Analysis:** A thematic analysis was applied to interview transcripts and open-ended survey responses, identifying major themes.

2.3 Ethical Considerations

To ensure confidentiality and ethical compliance, the study adhered to the following:

- **Informed consent:** Participants were verbally informed about the assessment's purpose, risks, and benefits before participation in physical and phone call interactions. However, for online surveys, participants had liberty to choose not to participate at any moment of data collection.
- **Anonymity:** No personally identifiable information was collected, and all responses were stored securely.
- **Data protection:** Survey platforms and interview recordings were encrypted, with access limited to the data collection team.

2.4 Assessment Limitations

Despite efforts to ensure inclusivity, sample size representativeness and data reliability, the assessment faced several limitations as documented below:

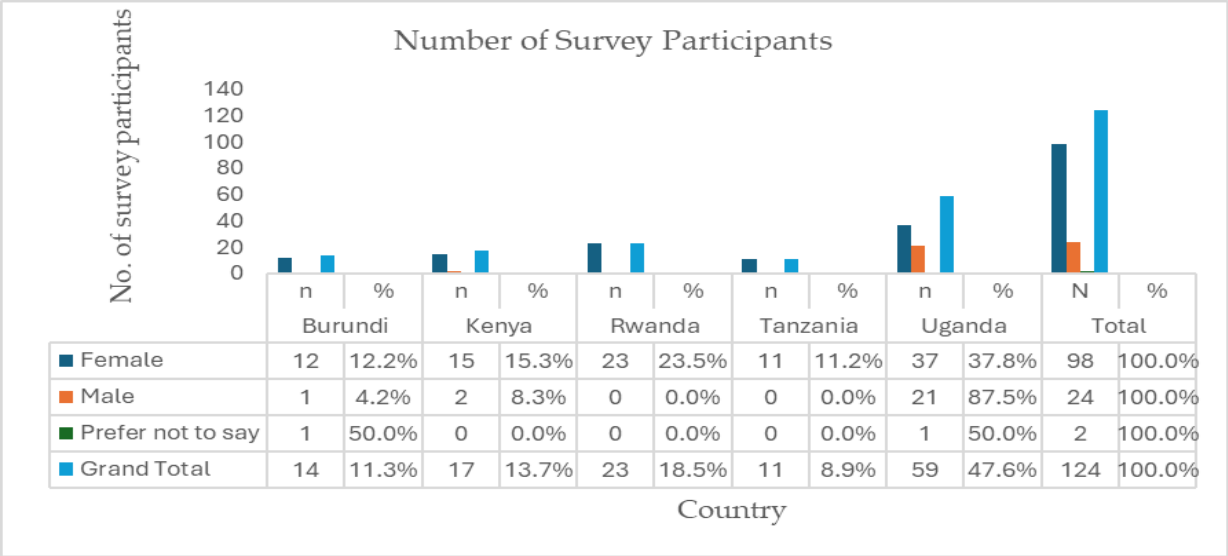
- **Limited access to the internet and devices:** Some participants, particularly in rural areas, may have been excluded due to lack of internet access and mobile devices. This prompted the need to conduct physical and phone call interviews by the data collection team.
- **Response bias:** The online nature of the survey may have led to self-selection bias, with responses skewed toward those more digitally literate. The attempt to address this was to extend the actual data collection timeline to two (2) weeks.
- **Language barriers:** While efforts were made to translate survey materials into French, some participants who do not speak either French and English may have been left out, while others may have faced challenges understanding complex terminologies. Relatedly, some could have faced difficulty in clarifying questions: Unlike face-to-face surveys, where participants could seek clarification, online surveys lacked real-time interaction, which may have led to misinterpretation of complex questions. However, was addressed through having physical interviews, and phone call interviews in Uganda Chapter, meaning other ICWEA East African chapters lacked support due to financial limitations.
- **Low response rates:** There was limited participation through the online surveys which limited the representativeness of the findings. This was addressed through physical and phone call interviews, although only in Uganda due to financial limitations to support other ICWEA country chapters.
- **Limited privacy cconcerns:** Some IPs interviewed hesitated to disclose sensitive information due to fear of data breaches or lack of trust due to the sensitive nature of the current ongoing funding freeze and review by the US government.
- **Limited ccontrol over rparticipants:** Since the survey did not document the personal details of the participants, some of the responses could have been generated from individuals outside the target group, affecting data accuracy.

3.1 Demographics Characteristics

This section of demographic characteristics involved participation in data collection, distribution of age bracket, and employment levels of the participants involved in the assessment.

3.1.1 Survey Participation

The chart below highlights the participation of community members in the assessment.



	Burundi		Kenya		Rwanda		Tanzania		Uganda		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
Female	12	12.2%	15	15.3%	23	23.5%	11	11.2%	37	37.8%	98	100.0%
Male	1	4.2%	2	8.3%	0	0.0%	0	0.0%	21	87.5%	24	100.0%
Prefer not to say	1	50.0%	0	0.0%	0	0.0%	0	0.0%	1	50.0%	2	100.0%
Grand Total	14	11.3%	17	13.7%	23	18.5%	11	8.9%	59	47.6%	124	100.0%

FIGURE 1: SURVEY PARTICIPATION[11]

The figure 1 above presents data on participation across five countries—Burundi, Kenya, Rwanda, Tanzania, and Uganda—categorized by sex. In total, 124 individuals participated in the study. Uganda had the highest overall representation, contributing 59 participants (47.6%). Rwanda followed with 23 participants (18.5%), Kenya with 17 (13.7%), Burundi with 14 (11.3%), and Tanzania with 11 (8.9%).

3.2.2 Participation in Qualitative Data Collection

A total of 39 key participants in Uganda were involved in the assessment providing valuable feedback towards the impact of the funding freeze. Therefore, a total of 163 participants were involved in the rapid assessment providing critical and valuable feedback to inform the purpose of the assessment.

TABLE 1: AGE BRACKET OF SURVEY PARTICIPANTS

Age bracket	Burundi		Kenya		Rwanda		Tanzania		Uganda		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
18-24 years old	2	25.0%		0.0%	2	25.0%	0	0.0%	4	50.0%	8	100.0%
25-34 years old	1	1.6%	3	4.8%	18	28.6%	7	11.1%	34	54.0%	63	100.0%
35-44 years old	2	9.5%	3	14.3%	1	4.8%	1	4.8%	14	66.7%	21	100.0%
45-54 years old	2	14.3%	6	42.9%	0	0.0%	2	14.3%	4	28.6%	14	100.0%
55-64 years old	4	28.6%	4	28.6%	2	14.3%	1	7.1%	3	21.4%	14	100.0%
65 years old and older	3	75.0%	1	25.0%	0	0.0%	0	0.0%	0	0.0%	4	100.0%
Grand Total	14	11.3%	17	13.7%	23	18.5%	11	8.9%	59	47.6%	124	100.0%

Table 1 above indicates that most survey participants (50.8%) were aged 25-34, with Uganda contributing the highest number (54%) in this category, followed by Rwanda (28.6%). The 35-44 age group accounted for 16.9% of responses, with Uganda again dominating (66.7%). Older age groups (45 and above) were less represented, making up about 25% of the total, with notable participation from Burundi and Kenya. The youngest participants (18-24 years) were relatively few (6.5%), primarily from Uganda. These trends suggest that the methodology used limited the meaningful participation of young people.

3.2.3 Employment Status of Participants

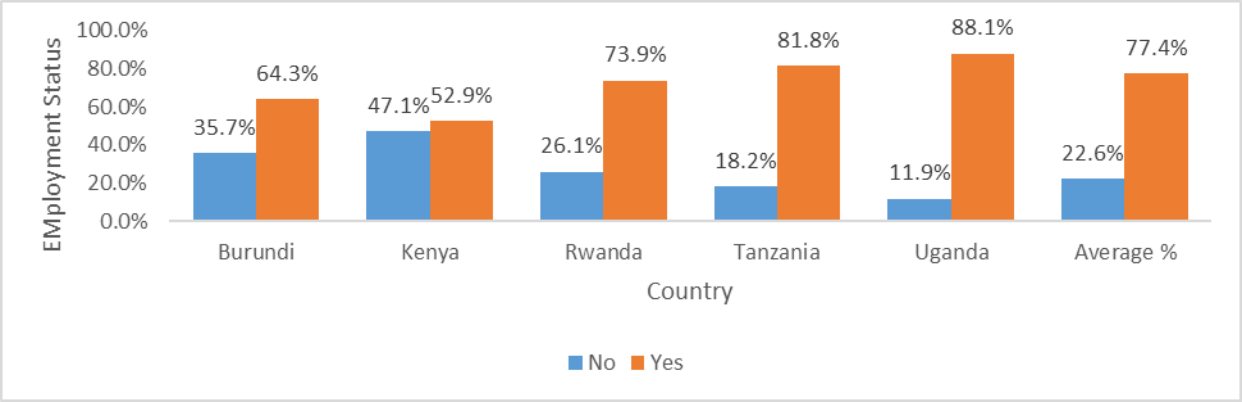


FIGURE 2: EMPLOYMENT STATUS OF PARTICIPANTS

3.2 Awareness of the US "funding freeze" by the participants

The rapid assessment explored awareness of the participants on the current funding freeze scenario in their locations of work, and access to health services.

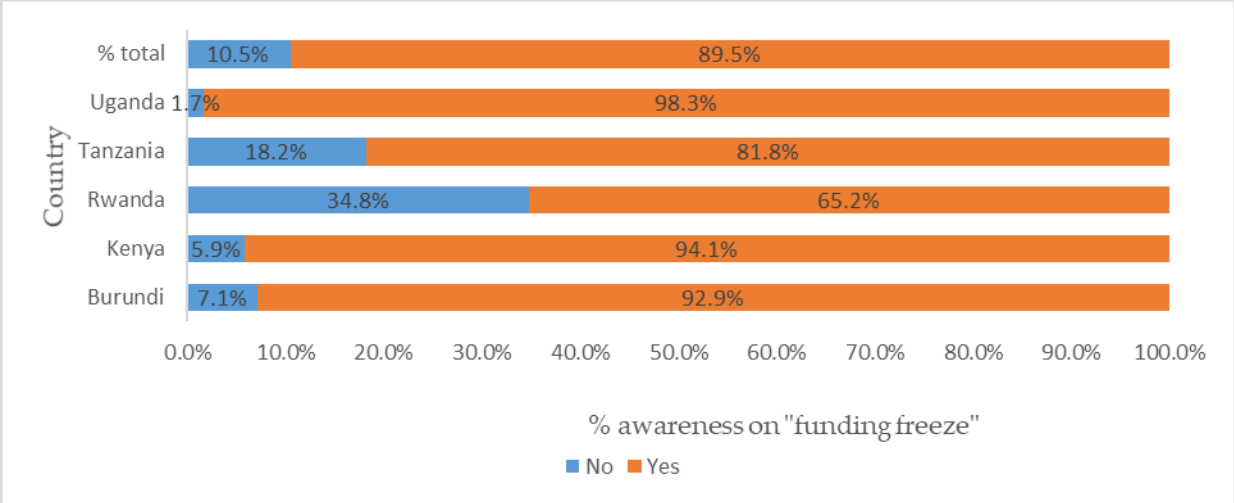


FIGURE 3: AWARENESS OF THE "FUNDING FREEZE"

An overwhelming majority (89.5%) of participants were reportedly aware of the US government's decision to freeze foreign aid, with the highest awareness reported in Uganda (98.3%), followed by Kenya (94.1%), and Burundi (92.9%). Rwanda had the lowest awareness (65.2%), indicating a significant gap in information dissemination compared to other countries. Tanzania also showed relatively low awareness level (81.8%), though still high overall. The percentage of participants unaware of the decision (10.5%) suggests that the funding freeze has been widely communicated, particularly in countries where the impact may be more pronounced, such as Uganda, where engagement appears to be the strongest.

Connectedly, the assessment underscored the importance of the different means of information in aiding access to information about the funding freeze as described in the subsequent table 2.3.

Whereas voices from the quantitative analysis implied high levels of awareness about the funding freeze and its implications, the majority of the local community members reportedly had no access to information about the freeze, while a few had partial information and needed to confirm at the health facilities at the time of refill. From the analysis, high levels of awareness could imply they were individual's affiliated to Organizations implementing PEPFAR funded programs or those that formed part of the networks. Some walk-in clients reportedly had access to the information via social media, especially TikTok and via WhatsApp groups.

"We have heard, but we did not understand what the funding freeze meant", said a walk-in client.

I heard from two members of my neighborhood, saying

"Munange edagala lya akawuka ka mukenenya ligenda kuba nga telikya gabibwa. Mbu omuzungu aligula yasazewo nti tewakyali sente" literally translated, I heard that medication for HIV won't be available anymore, that the white man who was funding it has decided that there is no more money; "for me I did not understand the in depth of what and why they were saying what they said but at least I heard them saying there will be no more medicine", says one female community member in Kampala.

3.3 Sources of Information on the "funding freeze.

TABLE 2: SOURCE OF INFORMATION ON THE "FUNDING FREEZE"

Sources of Information	Burundi	Kenya	Rwanda	Tanzania	Uganda	Average %	Key Observations
Social media	38.5%	43.8%	40.0%	33.3%	12.1%	24.5%	Most dominant in all countries, except Uganda where other sources played a bigger role.
Communication from PEPFAR IP	7.7%	18.8%	6.7%	11.1%	20.7%	6.6%	Strong source, especially in Kenya and Uganda.
News Media (Standard Houses)	0.0%	6.3%	0.0%	11.1%	13.8%	1.3%	More influential in Uganda and Tanzania.
Colleagues	15.4%	0.0%	26.7%	0.0%	2.5%	8.4%	Most notable in Rwanda and Burundi but negligible elsewhere.
Combination of Sources (social media + PEPFAR IP + News Media,	38.4%	31.1%	26.6%	44.5%	50.9%	19.2%	Many participants relied on multiple sources,

etc.)							particularly in Uganda and Tanzania.

In Burundi, social media (38.5%) and a combination of sources (38.4%) were the primary sources of information, with colleagues (15.4%) also playing a notable role. In Kenya, social media was the most dominant (43.8%), followed by a combination of sources (31.1%) and communication from PEPFAR IPs (18.8%). Rwanda saw social media (40.0%) as the leading source, but colleagues (26.7%) were also a significant channel, with fewer relying on a combination of sources (26.6%). In Tanzania, a combination of sources was the most prevalent (44.5%), followed by social media (33.3%) and news media (11.1%). Uganda differed from the other countries, with a combination of sources (50.9%) and PEPFAR IP communication (20.7%) playing a stronger role, while social media had the lowest influence (12.1%).

3.4 Familiarity with the HIV/TB Health Services/programmes

When asked about the familiarity about the HIV/TB services, general feedback pointed to HIV/TB health services having the highest awareness across all ICWEA countries of operation, with Rwanda and Burundi showing the strongest familiarity. However, other key services, including PrEP, PEP, EMTCT, and CLM, had significantly lower recognition rates in most regions. Countries like Kenya and Tanzania showed moderate engagement, while Uganda had consistently low awareness levels. These findings highlight the need for increased education, outreach, and advocacy efforts to ensure that all individuals have access to and understand the range of available HIV prevention and treatment programs.

Burundi: The data indicates minimal familiarity with HIV-related services and programs in Burundi. The only recorded awareness is in relation to HIV treatment, care, and support, which was acknowledged by 21.43% of participants. Other programs such as Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), and Community-Led Monitoring (CLM) appear to be largely unfamiliar to participants from Burundi. This suggests a potential gap in awareness and accessibility of comprehensive HIV prevention and support initiatives.

Kenya: Kenya shows a slightly more diverse engagement with HIV-related services, particularly in Community-Led Monitoring (CLM) and its integration with HIV treatment, care, and support, with 5.88% awareness. Some participants were also familiar with services that included PrEP, PEP, Early Infant Diagnosis (EID), and cervical cancer screening. However, awareness remains relatively low across most services, indicating a need for more targeted awareness campaigns and education efforts.

Rwanda: Rwanda demonstrates a higher level of awareness compared to other countries, particularly in relation to HIV treatment, care, and support (21.74%). Additionally, there is notable familiarity with the Dapivirine Vaginal Ring (13.04%), Counselling (13.04%), and combinations of PrEP, PEP, and CLM (8.70%). Despite this, awareness of programs addressing orphans and vulnerable children, cervical cancer screening, and EMTCT appear to be limited. This suggests that while Rwanda has significant awareness of core HIV services, gaps exist in specific prevention and care areas.

Tanzania: In Tanzania, the highest reported awareness is in HIV treatment, care, and support (9.09%), as well as combinations of PrEP, PEP, and Community-Led Monitoring (18.18%). Other services, including cervical cancer screening, CLM, and EMTCT, are less well known. This suggests a need for broader awareness efforts to ensure people are familiar with the full spectrum of HIV prevention and treatment services.

Uganda: Uganda has relatively low awareness levels across the board, with the highest reported recognition (1.69%) in multiple service areas, including CLM, counselling, PrEP, PEP, and HIV treatment and care. This indicates that while there is some level of knowledge about available services, it is not widespread. Strengthening community outreach and education efforts could be key to improving familiarity with and utilization of these services.

3.5 Access to funding from US Government

Participants were asked if they had been receiving funding from the US government, and the following descriptive statistics informed the findings.

TABLE 3: WHETHER THE ORGANISATION IS FUNDED BY US GOVERNMENT

Your Org, funded by US Government	Burundi	Kenya	Rwanda	Tanzania	Uganda	Average %
I am independent consultant	0.0%	0.0%	0.0%	0.0%	1.7%	0.8%
I don't know	0.0%	5.9%	0.0%	0.0%	0.0%	0.8%
No	0.0%	35.3%	17.4%	18.2%	6.8%	12.9%
Yes	100.0%	58.8%	82.6%	81.8%	91.5%	85.5%

The data indicates that many participants across all five countries (85.5% on average) reported that their organizations were funded by the US government, with the highest percentages in **Uganda (91.5%)**, **Burundi (100%)**, and **Rwanda (82.6%)**. However, **Kenya (58.8%)** had the lowest percentage, with **35.3% explicitly stating their organizations weren't US-funded.** A small percentage (0.8%) were either independent consultants or unsure about their funding source. This suggests that while US government funding plays a significant role in HIV-related programs in East Africa, Kenya shows a relatively higher presence of non-US-funded organizations compared to the other countries.

TABLE 4: EMPLOYMENT STATUS BY A US FUNDED ORGANISATION

Employment status by a US funded Organisation	Burundi	Kenya	Rwanda	Tanzania	Uganda	Average %
No	35.7%	47.1%	26.1%	18.2%	11.9%	22.6%
Yes	64.3%	52.9%	73.9%	81.8%	88.1%	77.4%

The data shows that, on average, **77.4%** of participants across the five countries are employed by a **US-funded organization**, with the highest employment rates in **Uganda (88.1%)** and **Tanzania (81.8%)**. **Burundi (64.3%)** and **Kenya (52.9%)** have the lowest percentages, meaning a higher proportion of participants in these countries were affected by the funding freeze.

3.6 Impact of the funding freeze

The impact of the funding freeze was diverse in nature, including economic and employment-related challenges across the five ICWEA Countries of operation, with some nations experiencing more pronounced effects than others. A key theme emerging from the data is **economic instability** as a major negative impact. Many participants reported financial hardships, saying "I lost my job", "I faced other financial challenges" appearing frequently across multiple countries, particularly in Kenya, Rwanda, and Uganda. Additionally, a significant proportion of participants experienced a decrease in income, with Burundi (30.77%) and Rwanda (13.33%) being most affected. The compounding effect of job loss and financial struggles is evident in responses that mention multiple hardships, such as loss of livelihood and

income reduction. This suggests that economic disruptions have had widespread consequences, leading to long-term financial insecurity.

Another critical theme is the **social and psychological impact** of these financial difficulties. Some participants explicitly linked economic distress to mental health struggles, such as concerns about stigma, job contract terminations, and future uncertainty. For example, individuals in Burundi reported concerns about the inability to access treatment, while others mentioned stress from losing colleagues or having relatives impacted by economic downturns. Furthermore, a notable percentage of participants (especially in Tanzania) indicated they were not affected by recent events, highlighting disparities in how different populations experienced economic instability. These findings suggest that beyond financial loss, the psychological and social ramifications of economic hardship require urgent attention in policy interventions.

A thematic analysis of the discussion with Implementing Partners, district PLHIV leaders, service recipients, and health works, pointed to the following findings:

- **Implementing Partners**

The funding freeze significantly affected implementing partners, with PEPFAR-supported staff initially being halted from work. While most staff providing direct healthcare services resumed work on **February 10, 2025**, those involved in **health systems strengthening programs**, including community-led monitoring, remained on hold. Several essential HIV services, including **DREAMS, OVC, VMMC, PrEP, and quality improvement programs**, were still suspended. Facilities were encouraged to continue **PMTCT, ART, and HUB work** directly. Although negotiations between organizations and PEPFAR are ongoing, uncertainty remains regarding when all staff will be reinstated. One consultant noted, "Negotiations are still ongoing with PEPFAR, so we hope everything goes back to normal."
On another note, when implementing partners were interviewed whether any of their programs were affected, some of the responses that came through include:

"All programs we delivered got disrupted immediately after 24th January. We have a total of 3 result areas and 100 activities to deliver as part of our program by September 2025. All of these were discontinued. Critical technical areas affected include outreaches, support for education, adherence support activities, home visits, and nutritional support." **Additionally, operational costs such as fuel and administrative costs have been discontinued," "Upon issuance of a limited waiver on 6th February, only 1/3 of our result areas with a total of 14/100 activities have resumed" shared a representative of the implementing partner in the Eastern region**

- **Health Workers**

Health workers have faced direct consequences from the funding freeze, including **suspensions, layoffs, and increased workloads**. At Kawaala HC IV, only two staff members under KCCA remained at the ART clinic, leading to severe service interruptions, including **the inability to conduct viral load tests, overwhelmed pharmacy services, and missed follow-ups**. Some health workers volunteered to sustain service delivery, but this was insufficient to prevent a backlog. By **February 10, 2025**, staff were recalled, allowing for the resumption of essential services like **viral load testing, literacy sessions, and TB screening**. However, critical programs, including **targeted KP services, counselling, and recency testing**,

remained on hold, affecting service recipients' access to comprehensive HIV care. One health worker stated, "Even now the workload is much... clients who missed their refills are crowding the facility."

In **Wakiso HC IV**, the ART in-charge explained,

"When the funding freeze took effect, the facility retained one health worker at each point of care but provided them with lunch. Clients continue to pick up their drugs, but second-line drugs have been out of stock for three months." The ART in-charge also noted, "Since the fund freeze, 37 clients have not returned to the facility... previously, they were reminded of their refill times, but the person responsible for making these calls was put on hold. There is no airtime for follow-ups.". However, according to another health worker, "Community members who benefited from outreach and pharmacy clients were totally left without support", says a medical officer in Masaka, Wakiso and Kampala region.

- **Facility-Level Challenges**

At Kasangati HC IV, the impact of the freeze was evident in **supply shortages**, with clients being required to **purchase gloves for viral load testing**. Health workers reported that **KP services were overwhelming**, and some expressed support for their discontinuation, reflecting ongoing challenges in providing tailored care for key populations. Outreach activities, including **community drug distribution points (CDDPs), remained suspended**, further limiting access to services. A health worker mentioned, "Currently, we experience shortages with gloves... so for us to continue bleeding those due, we send them anywhere to buy."

In **Wakiso HC IV**, one health worker quoted that "The facility is not ready for the integration proposed by the Ministry of Health in Uganda. There are gaps in infrastructure and human resources needed to administer integrated services. If integration happens without proper planning, quality of care will be compromised, leading to issues such as poor retention and increased loss to follow-up cases." Relatedly, in Uganda, the Ministry of Health issued a directive to integrate **HIV/TB and non-communicable diseases (NCDs) into OPD services**. However, health workers noted that **the directive lacked consultation, a framework, and capacity-building measures**. While some acknowledged integration as a cost-effective response, concerns were raised about **overcrowding, increased stigma, compromised quality of care, and the need for specialization**. A health worker stated, "I believe if everything was specialized, clients would get that extra care and treatment they deserve."

"Health Centre IIs and IIIs are not ready for integration due to infrastructure challenges. Seeking different points of care compromises the quality of care." One Health Care work reiterated,

At MJAP ISS Clinic, it was reported that all Key populations services had been discontinued. However, ART refills for Key populations living with HIV was continuing. It was also revealed that upon issuance of STOP Work Orders, other than disruptions in cervical cancer screening, viral load services, and shortage of Abacavir (which was due to the uncertainty) forced the facility to ration abacavir for the clients who reported to the health facility between 25th January to 7th February. Other services continued normally with a few implementation adaptations including half day service delivery time up to 2:00pm, rotational rotter for health workers volunteering.

- **Service Recipients**

A significant number of service recipients expressed **awareness of the funding freeze**, with their sources of information being **TV, social media (TikTok), and community interactions**. Many participants experienced **anxiety, fear, and uncertainty** about their future access to HIV treatment. Some reported **rationing their medication**, while others worried about the **cost of ARVs if donor funding stopped entirely**. Misconceptions, such as the belief that **all PEPFAR support had ended**, contributed to distress among PLHIV.

"When I heard on TV that support was cut off, I resolved to break each of my remaining pills into two pieces, so that they could last longer." A recipient of care stated

In **Mbarara City**, one service recipient was quoted, "Many people have been hearing rumors that there will be no drugs after three months. If their doses run out before the freeze is lifted, they may not be able to visit health facilities for refills, or even eventually die." This was collaborated by the ICWEA community led monitor, who added that recipients of care were in a panic mode and ready to do anything including offering money to buy extra tins of medication, fearing that after three months, there will be no more drugs available at health facilities due to the freeze." As such, the service recipients made several recommendations to enhance sustainability and reduce reliance on external donors. These included **promoting herbal medicine research, providing tax incentives for local drug manufacturers, increasing public awareness, and redirecting government funds toward healthcare instead of political salaries**. Others emphasized addressing long-standing facility-level challenges, such as **reducing stigma by improving ART clinic locations**. One client expressed frustration, saying, "For all the years U.S America has given us help, do you mean we have no scientists that can copy what Americans do and we do it from here so that we stop begging?" Again in **Wakiso HC IV**, the peer mother highlighted another pressing issue: "There is a stock-out of Septrin for children, and breastfeeding mothers are not bringing their children for the third PCR test because they are no longer reminded, and this poses a serious risk to these children, as they might contract HIV."

- **Unresolved program data and service gaps**

The funding freeze resulted in **significant data gaps**, as follow-ups and viral load tests were missed during service suspensions. While it is too early to determine the impact on **new infections and treatment adherence**, an **increase in lost-to-follow-up cases** is expected. Health workers emphasized that a comprehensive assessment would be required in the next **quarterly report** to measure the long-term effects of the freeze.

One health worker noted, *"It's too early to tell, but I am sure we have an increase in lost-to-follow-up cases since no follow-ups are being done."*

Therefore, the funding freeze has disrupted **health service delivery, employment, and supply chains**, creating significant challenges for **implementing partners, health workers, and service recipients**. While some services have resumed, critical programs remain suspended, contributing to **anxiety, misinformation, and gaps in care**. Moving forward, it is essential to **strengthen financial sustainability, improve service integration frameworks, and enhance stakeholder engagement** to mitigate the long-term effects of funding uncertainties on HIV response programs.

3.7 Impact of the Funding Freeze on Access to HIV Treatment: Challenges Faced by Participants

The data reveals that **Burundi and Rwanda** had the highest percentage of participants facing medication access issues. **Kenya and Uganda** reported long waiting times due to fewer staff, indicating service delivery challenges. **Tanzania**, on the other hand, had the lowest reported impact, suggesting stronger resilience in handling the funding freeze. Across all countries of operation, the primary challenges included **staff shortages, reduced medication availability, and longer waiting times**. These findings highlight the need for continued support and resource allocation to ensure uninterrupted HIV treatment services.

In **Burundi**, a significant proportion (35.71%) of participants reported no challenges in accessing HIV treatment. However, a notable 28.57% faced difficulties in obtaining their medication, highlighting the impact of the funding freeze. Long waiting times due to fewer staff were also a concern for 14.29% of participants. Some (7.14%) indicated that health facilities were still using security stocks, while the same percentage referenced the effects of multi-month dispensing (MM3/MM6), suggesting that supply chain management played a role in mitigating shortages.

In **Kenya**, 29.41% of participants stated they had not encountered challenges in accessing HIV treatment. However, long waiting times were a major issue, affecting 17.65%, indicating possible staffing shortages or increased demand. A small percentage (5.88%) reported receiving less medication than usual. Additionally, 23.53% of participants experienced both long waiting times and medication access issues, suggesting that the funding freeze had a more complex impact on service delivery.

In **Rwanda**, 26.09% of participants reported no challenges in accessing HIV treatment. However, 21.74% faced difficulties obtaining their medication, and 13.04% reported long waiting times, pointing to staffing constraints or supply chain disruptions. A worrying 8.70% were unable to access their medication at all. Additionally, 4.35% of participants experienced both medication access challenges and long waiting times, reinforcing concerns about healthcare service efficiency.

In **Tanzania**, the highest percentage (45.45%) of participants indicated they had not experienced challenges in accessing HIV treatment. Comparatively, fewer participants reported issues, with only 9.09% stating they had not received their medication. Similarly, 9.09% faced long waiting times, but the overall impact of the funding freeze appeared to be lower than in other countries. This suggests that Tanzania's healthcare facilities may have been better equipped to handle the disruptions.

In **Uganda**, 16.95% of participants reported no challenges, while 11.86% faced difficulties in accessing their medication. The most significant issue was long waiting times, which affected 23.73% of participants, pointing to staffing shortages or logistical hurdles. Additionally, some participants noted receiving fewer drugs than usual or struggling to travel to facilities due to financial constraints, further complicating access to treatment.

Connectedly, some major services were not accessible by the community members according to the assessment as per previously scheduled across five countries (Burundi, Kenya, Rwanda, Tanzania, and Uganda) indicated key gaps in healthcare services. The most commonly unavailable service was HIV viral load monitoring, reported as inaccessible by 6.5% of participants overall, with the highest incidence in Burundi (21.4%) and Kenya (11.8%)'; Counseling services were also notably lacking, particularly in Rwanda (13.0%) and Uganda (3.4%). Additionally, access to condoms and other HIV prevention services was an issue in Burundi (7.1%) and Uganda (8.5%). Some participants cited systemic issues such as

funding cuts, delayed appointments, and fear at healthcare establishments. Encouragingly, 14.5% of participants across all countries reported receiving all their scheduled services, with Tanzania having the highest proportion (36.4%). However, the data highlights disparities in service accessibility, particularly for HIV-related care and counseling.

3.7.1 Impact of the Funding Freeze on Maternal and Child Healthcare

A key theme emerging from the data is **disruptions in maternal and child healthcare services**, particularly the lack of essential medication, food supplements, and early infant diagnosis (EID) services. In Kenya (11.8%) and Rwanda (13.0%), participants reported, *"I did not receive food supplements/formula for my child,"* indicating a critical gap in nutritional support for HIV-positive mothers and their infants. Additionally, access to **EID services** was affected in Kenya (11.8%), Rwanda (4.3%), and Uganda (6.8%), with some participants stating, *"I did not receive the EID services,"* highlighting concerns about delays in infant HIV testing. Another pressing challenge is **medication shortages**, with participants from Burundi (14.3%), Kenya (29.4%), and Uganda (16.9%) stating, *"I was given medication for a shorter time than I always get,"* suggesting restricted access to life-saving treatments. In some cases, caregivers could not access essential medicines for their children, as noted in Burundi (14.3%), Rwanda (13.0%), and Uganda (5.1%), where participants reported, *"I wasn't able to get the medication for my child."*

Another recurring issue was **reduced access to healthcare personnel and services**, with participants in Burundi (28.6%), Rwanda (8.7%), and Uganda (15.3%) stating, *"I wasn't able to see the clinical officer,"* reflecting staffing shortages or service delays. Despite these concerns, some individuals in Rwanda (34.8%), Tanzania (18.2%), and Uganda (6.8%) reported positive experiences, stating, *"I received everything I had wanted."* However, the overall trend suggests that the funding freeze has led to **service disruptions, medication shortages, and limited access to specialized care** for HIV-positive mothers and their children, particularly in Kenya, Burundi, and Uganda. These findings underscore the urgent need to address resource constraints and ensure the continuity of maternal and child health services for vulnerable populations.

3.7.2 Experiences of Health and Support Workers in PEPFAR-Funded Facilities Amid Funding Changes

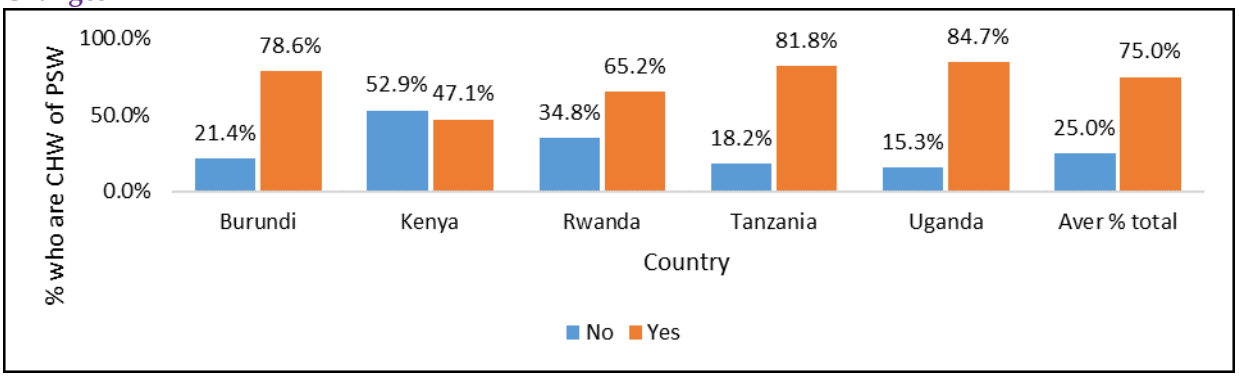


FIGURE 4: EXPERIENCES OF HEALTH AND SUPPORT WORKERS IN PEPFAR-FUNDED FACILITIES AMID FUNDING CHANGES

The analysis table above presents the percentage distribution of Community Health Workers (CHWs) or Personal Support Workers (PSWs) in five East African countries—Burundi, Kenya, Rwanda, Tanzania, and Uganda—categorized as either "No" (not CHWs/PSWs) or "Yes" (CHWs/PSWs). The average percentage of individuals identified as CHWs/PSWs across these countries is 75.0%, with the highest

proportions in Uganda (84.7%) and Tanzania (81.8%), while Kenya has the lowest at 47.1%. Conversely, those not identified as CHWs/PSWs account for 25.0% on average, with Kenya having the highest percentage (52.9%) and Uganda the lowest (15.3%). The data suggests significant national variations in CHW/PSW representation, with Kenya being the only country where the majority are not CHWs/PSWs, whereas other countries have a stronger presence of such workers.

3.7.3 Thematic Analysis of Disruptions in Health Services

- **Disruptions in HIV Prevention and Treatment Services:** A significant proportion of participants across the five countries reported being unable to access critical HIV services, particularly HIV viral load monitoring and access to condoms or other HIV prevention tools. In Burundi, 21.43% of participants were unable to receive their scheduled viral load monitoring, while in Kenya, the figure stood at 11.76%, and in Rwanda, 8.7%. A respondent from Burundi stated, *"Arret des presentations des soins différenciés au niveau communautaire suite au gel du financement" (Discontinuation of differentiated care services at the community level due to funding freeze).* This highlights the impact of funding cuts on decentralized HIV services.

- **Barriers to Counselling and Psychosocial Support:** Counselling services were another area significantly affected. In Rwanda, 13.04% of participants could not access counselling services, while in Uganda, 3.39% reported similar difficulties. A respondent from Uganda shared, *"I have not been able to access any services, so I can't support other vulnerable populations."* This emphasizes the broader implications, where disruptions in services not only affect direct beneficiaries but also peer educators and community health workers who provide support to vulnerable populations.

- **Limited Access to Gender-Based Violence (GBV) Services:** In Tanzania, 9.09% of participants reported that they could not access GBV services along with other essential health services. Some participants mentioned an intersection of GBV services with HIV-related care, such as a Kenyan respondent who stated, *"GBV services; Counselling services; Cervical Cancer screening services; Access to Condoms or other HIV prevention services; HIV viral load monitoring; Review by a Clinical Officer."* The disruption of such integrated services poses a serious risk to those who rely on them for both medical and psychosocial support.

- **Challenges in Cervical Cancer Screening and Clinical Reviews:** Cervical cancer screening was another key service that faced disruptions, especially in Kenya and Uganda. In Kenya, 5.88% of participants cited missing their scheduled screenings, while Uganda saw 3.39% reporting difficulties in accessing both cervical cancer screening and other essential services. A respondent from Kenya highlighted, *"Cervical Cancer screening services; HIV viral load monitoring; Review by a Clinical Officer,"* indicating the extent to which essential preventative services have been compromised.

- **Service Availability vs. Fear of Utilization:** Interestingly, while some participants reported disruptions in service access, others stated that services remained available but were insufficient or underutilized due to fear. A respondent from Burundi noted, *"The services are functional but not enough since there is fear at the establishment level."* This suggests that, in some cases, clients are

hesitant to seek care due to uncertainty about service continuity or potential stigma associated with returning to facilities affected by funding cuts.

- **Regional Disparities in Service Access:** While many participants faced service disruptions, a notable proportion reported receiving all services as expected. In Tanzania, 36.36% of participants stated, *"I received all services from the facility,"* compared to 21.74% in Rwanda and 17.65% in Kenya. However, this does not negate the experiences of those who faced challenges, particularly in accessing specialized services such as viral load monitoring and GBV-related support.

Conclusively the findings highlight the significant impact of funding freezes and structural changes in healthcare service delivery, particularly for people living with HIV (PLHIV) and key populations. The most affected services include HIV viral load monitoring, counselling, GBV support, and cervical cancer screening. The disparities in service access across countries indicate that some regions have been more resilient than others. Identifying best practices from areas where service continuity was maintained can provide a model for strengthening healthcare and community systems in affected regions.

3.7.4 Increased Human Rights Violation

TABLE 5: INCREASED VIOLATION OF HUMAN RIGHTS

Experience of human rights violations	Burundi	Kenya	Rwanda	Tanzania	Uganda	Average %
No	35.7%	50.0%	52.2%	77.8%	41.8%	47.0%
Yes	64.3%	50.0%	47.8%	22.2%	58.2%	53.0%

The data reflected in table 6 indicates varying perceptions of human rights violations across five ICWEA Countries of operation: Burundi, Kenya, Rwanda, Tanzania, and Uganda. On average, 53.0% of participants across all countries reported an increase in human rights violations, while 47.0% did not perceive an increase. Notably, Tanzania had the lowest percentage (22.2%) acknowledging an increase, whereas Burundi had the highest (64.3%). Kenya and Rwanda were evenly split at 50.0% and 47.8%, respectively, suggesting mixed opinions. Uganda also showed a higher percentage (58.2%) recognizing an increase. These figures highlight regional disparities in the perception of human rights trends, possibly influenced by local political, social, and legal contexts.

3.7.5 Analytical experiences of Participants on Gender Based Violence (GBV)

Generally, across all countries, *stigma and discrimination* were the most common GBV experiences, with involuntary disclosure and intimate partner violence also notable in Kenya and Uganda. Rwanda had the highest reports of community discrimination, while Tanzania had more participants denying GBV experiences. Uganda showed the most diverse types of GBV, with categorical analyses shown below:

Burundi: The most reported experience was *increased stigma and discrimination in the community* (44.4%), highlighting the social exclusion faced by participants. Some also reported *involuntary disclosure of their status leading to GBV* (11.1%). A significant proportion (22.2%) stated, *"I have not received any GBV from the community,"* indicating mixed experiences within the country.

Kenya: *Increased stigma and discrimination in the community* was the dominant theme (55.6%), with some also facing *involuntary disclosure of their status leading to GBV* (11.1%) or *intimate partner violence* (22.2%). One respondent noted, *"People started treating me differently after my status was revealed without my consent."*

Rwanda: The most prevalent issue was *increased stigma and discrimination in the community* (63.6%), the highest among all countries. *Involuntary disclosure leading to GBV* was also reported (9.1%). However, 9.1% mentioned, *"I have not received any GBV from the community."*

Tanzania: While *increased stigma and discrimination in the community* was significant (25.0%), a high percentage (25.0%) stated they had not experienced GBV. A unique theme emerged with 25.0% indicating they were *"Not a PLHIV,"* suggesting varied experiences based on HIV status. One respondent shared, *"My community has limited information about the stop work order, but I see a lot of discrimination messages on social media."*

Uganda: Experiences were diverse, with *a combination of stigma, discrimination, involuntary disclosure, and intimate partner violence* reported. The highest number of participants (38.9%) mentioned *increased stigma and discrimination in the community*, while 13.9% cited *involuntary disclosure of status leading to GBV*. Additionally, intimate partner violence (5.6%) and emotional distress related to job loss (2.8%) were noted. A respondent described, *"This happened when I had a loan in the bank, but people started laughing at me, saying they wanted me imprisoned."*

All in all, a general description indicated that gender-based violence (GBV) is primarily experienced in a form of increased stigma and discrimination within the community, often linked to involuntary disclosure of HIV status. Many individuals report facing social exclusion, negative attitudes, and discriminatory behavior, which exacerbates their vulnerability. Intimate partner violence is also a recurring concern, suggesting that GBV extends beyond public stigma into personal relationships. While a few participants state they have not personally experienced GBV, the overwhelming majority highlight discrimination as a key issue. Additionally, some mention challenges such as the lack of community awareness, the role of local leaders in handling GBV cases, and emotional distress related to job loss and financial struggles. The responses reflect the intersection of health status, social perceptions, and personal safety, emphasizing the need for stronger community support and protective measures.

3.7.6 Psychological Distress: Worries created due to funding freeze

The primary concerns arising from the funding freeze revolve around job loss, lack of access to HIV services, ARV shortages, and the resulting stigma and discrimination. In Rwanda (26.1%) and Burundi (14.3%), a major fear is the **complete loss of access to HIV services**, highlighting the direct impact on healthcare availability. Similarly, in Uganda (20.3%), Tanzania (27.3%), and Kenya (17.6%), a **combination of job loss, ARV shortages, and stigma** is prevalent, showing that economic instability and healthcare disruptions are deeply interconnected. Quotes such as "No ARV supply at the health facility and thus opting to buy from private suppliers" (Kenya, Tanzania) emphasize the financial burden on individuals who might need to pay out-of-pocket for life-saving medication. Meanwhile, in Uganda, participants mention, "My heart beats for clients on third line (already it was a struggle to get them drugs and the situation worsened)," highlighting the unique challenges of those requiring specialized HIV treatment.

Another recurring theme is the **fear of stigma and discrimination**, particularly in Kenya (11.8%), Rwanda (8.7%), and Uganda (varied responses). Some participants explicitly mention, "KPs not going to facilities

to access HIV treatment due to fear of being seen and identified, thereby increasing the spread of HIV" (Uganda), indicating the broader public health risks tied to these barriers. Additionally, concerns about death due to a lack of ARVs appear significantly in Tanzania (9.1%), Burundi (7.1%), and Uganda (3.4%), reinforcing the life-threatening consequences of treatment interruptions. Notably, Rwanda (30.4%) had the highest proportion of participants stating they had **no worries**, a unique outlier that may suggest alternative coping mechanisms or differing funding structures. Overall, the responses reveal that beyond immediate healthcare concerns, the funding freeze exacerbates existing vulnerabilities related to employment, financial strain, and social stigma.

3.7.7 Thematic Analysis of the Impact of the Funding Freeze Directive

The freeze in funding has had profound effects across multiple aspects of people's lives, particularly those relying on health services and financial support from donor-funded programs. From economic struggles to deteriorating mental health, the consequences are far-reaching and deeply concerning.

Economic and Livelihood Impact: One of the most immediate effects of the funding freeze has been widespread job losses. Many participants report losing their primary sources of income, leaving them unable to meet basic needs such as food, rent, and transportation. Others, who were previously employed by donor-funded organizations, express deep uncertainty about their future, as many community-based organizations (CBOs) have shut down or significantly reduced their operations. The resulting financial strain has forced some individuals into debt, while others face difficulties in paying for education, leading to an increase in school dropouts.

Health and Medical Services Disruptions: A major concern raised by participants is the disruption of HIV-related healthcare services, particularly access to antiretroviral (ARV) medication and preventive treatments like Pre-Exposure Prophylaxis (PrEP). Many individuals are now facing delays in receiving their refills, while others worry about complete stockouts in the near future. The freeze has also affected viral load (VL) and CD4 testing, essential for monitoring and managing HIV treatment effectively. Without these services, the goal of eliminating HIV by 2030 seems increasingly unattainable. Additionally, the fear of being unable to access treatment has led to increased non-compliance, raising concerns about drug resistance and worsening health outcomes.

Psychological and Emotional Impact: The uncertainty surrounding the funding freeze has taken a severe toll on the mental health of affected individuals. Many participants report experiencing heightened levels of stress, anxiety, and depression. The constant worry about access to medication, job security, and financial stability has left people feeling emotionally drained. The loss of peer-to-peer counselling services and psychosocial support networks has only exacerbated this issue, leaving many without a crucial support system. Some participants even express suicidal thoughts, reflecting the depth of the emotional distress caused by the funding freeze.

Increased HIV Risk and Public Health Concerns: The disruption in healthcare services is expected to contribute to a rise in new HIV infections. With reduced access to prevention tools such as PrEP, condoms, and testing services, vulnerable populations are at an increased risk of exposure to HIV. Furthermore, misinformation and fear within communities have intensified stigma and discrimination amongst people living with HIV (PLHIV). Some participants report being insulted or labelled as "dying soon" due to rumours about ARV shortages. The breakdown of community-based health services means that outreach efforts, awareness campaigns, and education initiatives are no longer reaching those most in need, further compounding the problem.

Community and Structural Impact: Beyond individual struggles, the funding freeze has significantly impacted the broader healthcare infrastructure. Many organizations that once provided essential HIV-related services have had to scale down or shut down completely. This has left a gap in service delivery, making it difficult for those in need to access support. Health facilities, already strained, are expected to experience declining service quality, with fewer healthcare workers available to provide care. The impact is particularly severe on key populations, who already face challenges in accessing healthcare due to stigma and discrimination.

Conclusively, the effects of the funding freeze are widespread, affecting individuals, communities, and the healthcare system. Without urgent interventions, the progress made in the fight against HIV&AIDS is at risk of being reversed. The loss of jobs, disruption of medical services, deteriorating mental health, and the likely increase in new HIV transmission rates paint a bleak picture for the future. Addressing these challenges requires immediate action, including securing alternative funding sources, strengthening local healthcare and community systems, and ensuring continued access to lifesaving treatment for all affected individuals as well as ensuring that prevention remains a priority.

3. 8 Thematic Analysis of Key Recommendations for Policy Makers in Addressing the Funding Freeze Crisis

The funding freeze has triggered widespread concerns, with individuals and communities proposing various solutions to mitigate its impact. The recommendations provided by participants revolve around six key themes: advocacy and negotiation, domestic resource mobilization, healthcare service continuity, economic stability and livelihood support, policy adjustments, and community engagement.

1. **Advocacy and negotiation with key stakeholders.** A significant number of participants emphasized the need for continuous advocacy and active engagement with policymakers, international donors, the private sector anthropologists and governments. Many suggest holding dialogue meetings with the Ministries including Ministries of Finance; governments directly engaging with the U.S. government in diplomatic discussions, advocating for a phased or gradual freeze rather than an abrupt halt of funding. Others propose lobbying for alternative donors such as China or the European Union to step in and bridge the funding gap;
2. **Strengthening Domestic Resource Mobilization**. Many participants highlight the urgency of reducing dependency on foreign aid by investing in domestic resource mobilization. Recommendations include:
    - Budget realignment to prioritize the health sector;
    - Increasing government allocations for HIV/TB programs to sustain service delivery;
    - Exploring local revenue sources and implementing sustainable financing mechanisms such as an HIV/AIDS Trust Fund for the case of Uganda;
    - Encouraging partnerships with private entities, including pharmaceutical companies and corporate sponsors, to supplement funding for essential health services;

Several contributors stress the importance of national self-reliance, citing the current crisis as a wake-up call for the affected nations to invest in local manufacturing of essential medicines to prevent similar vulnerabilities in the future.

3. **Economic Stability and Livelihood Support**. The freeze has caused massive job losses, particularly for individuals employed in donor-funded programs. Participants recommend:
    - Immediate intervention to restore lost jobs, especially in healthcare and community outreach programs;
    - Financial support for affected workers during the transition period;

- Encouraging entrepreneurship by providing financial aid to individuals looking to start small businesses as an alternative source of income;
- Promoting skill-building initiatives to help affected workers transition into other employment sectors.

Many emphasize that economic instability directly affects healthcare access, as individuals who have lost jobs struggle to afford transport to health facilities, leading to missed appointments and increased treatment non-compliance.

4. **Policy Adjustments for Sustainable HIV Response.** Several recommendations focused on long-term policy reforms to ensure a sustainable HIV response. Key suggestions include:
   - Reviewing the national budget to allocate a higher percentage to the health sector;
   - Revising funding policies to ensure that HIV programs are safeguarded from abrupt external funding cuts;
   - Establishing a contingency plan to mitigate future funding disruptions;
   - Strengthening health governance structures to ensure transparency and accountability in fund allocation and expenditure.

Furthermore, some participants called for reviews of their National Development Plan budgets to integrate key health sector priorities.

5. **Community Engagement and Awareness Creation**. Community-based approaches are seen as critical in addressing the crisis. Recommendations include:
   - Strengthening civic education and awareness campaigns to combat misinformation as well as rally communities to engage with their leaders for resource allocation;
   - Mobilizing local resources through community-led initiatives;
   - Encouraging community-led monitoring (CLM) programs to ensure services remain accessible;
   - Strengthening partnerships between government, civil society organizations (CSOs), and communities to sustain advocacy efforts.

Some participants stressed the importance of directly involving communities of PLHIV and those affected by HIV in decision-making processes, ensuring that policies and solutions are inclusive of those most affected by the crisis. As such, the recommendations provided highlight the urgent need for immediate action and long-term policy reforms to mitigate the impact of the funding freeze. A combination of strong advocacy, domestic financing, policy adjustments, economic support, and community engagement is essential to ensuring the sustainability of HIV programs and protecting the health and livelihoods of affected individuals. Governments and policymakers must act swiftly to implement these recommendations and prevent a potential public health crisis.

CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

The funding freeze has created significant challenges for ongoing projects, leading to resource constraints, operational slowdowns, and uncertainties in achieving strategic objectives. This analysis highlights the critical need for adaptive financial planning, stakeholder engagement, and innovative funding approaches to mitigate risks and sustain impact. Moving forward, strategic interventions must focus on resilience, efficiency, and diversification to ensure long-term sustainability and continued service delivery.

4.2 Strategic Recommendations

1. **Diversification of Funding Sources at local, national, and global levels.**
    - Explore alternative revenue streams, such as public-private partnerships, Government CSOs social contracting as well as domestic financing;
    - Strengthen relationships with philanthropic organizations and impact investors to secure flexible funding.
2. **Operational Efficiency & Cost Optimization**
    - Conduct a comprehensive review of operational expenses and identify areas for cost reduction without compromising quality.
    - Implement lean management practices to enhance efficiency in project execution.
3. **Stakeholder Engagement & Advocacy**
    - Increase communication with key stakeholders, including government agencies and donors, to negotiate potential funding reinstatement.
    - Develop an advocacy strategy to highlight the impact of funding freezes on communities and gain public support.
4. **Strategic Program Adjustments**
    - Prioritize high-impact projects and reallocate resources to critical areas.
    - Implement phased project execution to manage financial constraints while ensuring progress.
    - Review of political positions by Government to align funding for Health and community services
5. **Strengthening Financial Resilience**
    - Establish a financial contingency plan to mitigate future funding risks.
    - Develop a reserve fund strategy to cushion against similar financial disruptions in the future.