

Experiencing the Fallout: The Felt Impact of US HIV Funding Reductions Across 13 Sub-Saharan African Countries

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Abstract

To date, there is limited empirical research following the 2025 funding reductions by the US Government. This is the first multi-country qualitative exploratory study to examine the lived consequences of these funding cuts based on 26 semi-structured in-depth interviews with stakeholders at global, national, and sub-national levels across 13 Sub-Saharan African countries. Data were analyzed using rapid qualitative analysis. Participants highlighted disruptions regarding HIV prevention, operational uncertainties in offering pre-exposure prophylaxis and diminished outreach to key populations and adolescents who had to access services at health facilities, with many dropping out. Treatment was rationed in many countries requiring more frequent trips to health facilities. Follow-up services, distribution of health products and monitoring suffered through workforce loss, with restrictive reporting requirements additionally affected monitoring. Adaptive strategies included service integration, prioritization of essential services, and efforts to expand domestic financing with participants highlighting the need for sustainable financing also for prevention.

Introduction

Over the past two decades, the global HIV response has achieved major reductions in HIV-related deaths and new infections. Central to this progress has been the US Government through global HIV financing and health initiatives.^{1,2,3,4} Its 2025 funding reductions threaten to undermine these hard-won gains.

The US President's Emergency Plan for AIDS Relief (PEPFAR) has been a central global HIV funding instrument.⁵ PEPFAR-supported programs have contributed to reductions in millions of HIV-related deaths and new infections, expanded access to testing and treatment, and supported major prevention initiatives such as voluntary medical male circumcision (VMMC) and pre-exposure prophylaxis (PrEP).^{6,7} PEPFAR has been particularly important in case-finding and scaling up PrEP among vulnerable populations, i.e., key populations (KPs) and adolescent girls and young women (AGYW) in high-burden settings.⁷

However, in January 2025, the newly elected US Government through its freeze on foreign development assistance, including PEPFAR and USAID-funded programs, generated widespread uncertainty across recipient countries.⁸ It subsequently announced its withdrawal from WHO funding, ended its agreement with UNAIDS, terminated most USAID-funded programs⁹ and reduced funding.¹⁰ Although a waiver issued in February 2025 allowed the continuation of core HIV treatment services and prevention of vertical transmission, several HIV interventions remained excluded, including PrEP for high-risk populations, post-exposure prophylaxis (PEP) for rape survivors, and programs for orphans and vulnerable children.¹¹ At the same time, the US Government's adoption of a binary and "immutable" sexual classification curtailed support for men who have sex with men (MSM) or transgender persons.¹² Funding and procedural uncertainties thus resulted in widespread disruption of the provision of HIV services to clients and communities.¹³

Given the unprecedented nature of these rapid funding reductions, it is crucial to corroborate emerging narratives with empirical evidence on their impact on HIV treatment and prevention programs across SSA. To date, the literature has focused largely on modelling the impact of funding cuts in terms of millions of additional deaths and new infections and commentaries on the need for greater domestic financing and sustainability.^{5,14–16} Empirical evidence through primary research studies remains limited^{13,17,18} documenting disruptions to HIV prevention, treatment, monitoring, and support services, as well as workforce and operational challenges. The studies have, however, provided limited insight into how such disruptions were experienced on the ground. Only two qualitative studies could be identified – a Ugandan study with clinic health workers highlighting disruption in routine operations,¹⁹ and a local Kenyan study with a small number of health workers and HIV clients underscoring frequent trips to facilities because of commodity shortages, the workload of health personnel, and concerns regarding the sustainability of HIV programs following funding reductions.²⁰

There is thus an urgent need to understand how ongoing funding reductions are affecting HIV programs across diverse settings in SSA, where the HIV burden is greatest and health systems remain highly dependent on external financing. Our qualitative study is the first study that addresses this need for a wider geographic area by exploring the perceived and experienced impacts of US funding reductions or discontinuation on HIV programs from the perspective of global experts, national and sub-national stakeholders in 13 countries across SSA. By examining stakeholder assessments of the consequences of funding reductions, local responses to emerging challenges, and potential mitigation and sustainability strategies, the study aims to provide a nuanced understanding of how HIV programs are navigating a period of reduced external financing.

Results

Participant characteristics

We interviewed a total of 26 stakeholders, from 13 SSA countries and globally, who had received US HIV-related funding. This included representatives from ministries of health, implementing partners, non-governmental organizations, networks of people living with HIV, clinics, multilateral agencies and research institutions.

Table 1
Participant socio-demographics

CHARACTERISTICS	N (%)
Total Participants	26 (100)
Age group (years)	
Mean Age	51
35–44	5 (19.23)
45–54	14 (53,8)
55–64	5 (19.23)
65+	1 (3.85)
Undisclosed	1 (3.85)
Gender	
Female	11 (42.31)
Male	14 (53.84)
Undisclosed	1 (3.85)
Highest education level	
Tertiary	26 (100)

Participants operated at subnational (n = 12), national (n = 12), and global levels (n = 2). In addition to global participants, participants were based in the following SSA countries: South Africa (ZAF), Zimbabwe (ZWE), Ethiopia (ETH), Cameroon (CMR), Malawi (MWI) Mozambique (MOZ), Uganda (UGA), Tanzania (TZA), Kenya (KEN), Zambia (ZMB), Botswana (BWA), Gambia (GMB) and Rwanda (RWA).

We present our findings with a special focus on vulnerable populations, while also highlighting emerging strategies for adaptation and sustainability across SSA countries and globally. Quotes refer to the interviewee's country and stakeholder level, as described in Table 1 (e.g., country, level).

Three interrelated themes were identified: **(1) shifting from differentiated service delivery to centralized facility-based care** highlighting shifts in service delivery due to decreased funding and hand-over to the Ministry of Health; **(2) experiencing system disruption** related to workforce, supply-chains, logistics, and data monitoring systems and **(3) sustaining HIV services under financial constraints**, presenting stakeholders' vision as to how HIV services should be adapted and funded to increase resilience and economic independence.

Shifting from differentiated service delivery to centralized facility-based care

Most participants, irrespective of country, reported a structural shift in previously established differentiated service delivery (DSD) models across HIV prevention and treatment systems, whereby decentralized, client-centered approaches of service provision were discontinued and service provision reverted to health facilities. This affected drop-in centers, pick-up points for medication, special weekend services as well as mobile, community and group services. “Those mobile clinics are no longer going to those communities, and people from those communities have to walk or travel long distances to the nearest health facility” (ZAF, Subnational 1). The change in service provision thus increased the burden on both clients and health facility staff, raising concerns about continuity of care, transport costs, client satisfaction and adherence to PrEP and antiretroviral therapy (ART).

Participants highlighted that HIV prevention services were hardest hit by the funding cuts or the anticipation thereof. Several participants reported a decline in HIV testing uptake as community outreach and demand-creation activities were scaled back and/or stopped.

Many people were only accessing services because they had developed trust and rapport with outreach workers, but these outreach workers have now been laid off... We visited a drop-in center and documented that there was no condom distribution program, no PrEP, and no outreach. Far fewer people were coming in for HIV testing. (ETH, National)

The quote highlights the importance of personal relationships that had been built through community services. The laying off of outreach workers affected uptake of severely reduced community services. Before the funding cuts, clients who did not want to ask for condoms in a clinic setting could obtain them from various community locations, a service that was also discontinued.

We previously used condom dispensers in high-risk settings such as bars, drinking areas, and hair salons, where sex workers and other community members could obtain them. The aim was to ensure that no one had an excuse for not using protection because condoms were unavailable. (ZWE, National)

Participants across countries but most prominently from South Africa, Zimbabwe, Kenya, Uganda, Cameroon, Botswana and Malawi described how the abrupt suspension of community and prevention services affected particularly those at highest risk of HIV infection, such as KPs.

And then, the other areas that were affected like the condom distribution, distribution of PrEP, these were drastically affected because we actually saw a decline ..in uh, the number of people that were accessing PrEP and condoms. So, uh, the whole prevention cascade, uh, was drastically affected. And then we also had the closing of the drop-in-centers for mainly for KPs. Those were completely closed because, h, they did not get any funding to continue their programs..... the injectable PrEP was discontinued. Um, the PrEP among key populations, it was also discontinued. (MWI, National)

In addition, the reduction or discontinuation of PrEP affected outreach-based health information and prevention services in general as reported from Cameroon: “Prevention services is done by the same staff. They conducted community outreach, provided health education, and offered services such as PrEP. Since they are no longer available, it simply means the prevention services will really be lagging behind” (CMR, Sub-national).

With tailored services closing, KPs had to make use of general HIV services not tailored to their needs. Participants described facility-based services as more stigmatizing, as illustrated by a participant who recounted health workers telling clients: “When we get time, we'll attend to you. If we don't get time, it's okay for you to die... You are not human, you're different from the rest of us” (UGA, Sub-national), illustrating overt stigma in the facility-based service delivery that KPs had to revert to.

In addition to KPs, the shift in service provision from community to facility-based services also affected AGYW and men. “We scaled back some community empowerment services, including DREAMS [a PEPFAR-funded adolescent-tailored HIV programme] and youth-friendly spaces that required rental costs. VMMC campaigns were shifted to facility-based delivery” (ZMB, National).

Participants from Mozambique, Zimbabwe, Uganda, South Africa and Zambia also detailed significant disruptions to HIV treatment programs. They highlighted the discontinuation of community ART groups, peer-led interventions, home drop-off services, and external medication pick-up systems. As one participant explained, “The majority of people who depended on external pick-up points have since returned to their clinics... medicines were also being distributed to people at home. Those services are no longer happening” (ZAF, Subnational 1). A participant from Zimbabwe described the reasoning for discontinuing community ART groups:

Previously, people could collect ART through community group models, where one person would pick up medication on behalf of others. However, fears of potential ART shortages led to concerns that some individuals might keep medication intended for others. As a result, each person was required to return to the clinic to collect their own medication, creating additional financial burdens for rural clients who could not afford transport costs and were often forced to walk long distances to access their medication. (ZWE, Subnational 1)

Participants commented on an increasing number of treatment defaulters. “We have seen in provinces like KZN [Kwa Zulu-Natal] a huge number of people who have disengaged from care, and in some other provinces, as some of the services previously supported through US funding are no longer available” (ZAF, Subnational 1). Another participant was able to put figures to this problem: “I was sitting at a defaulter rate of uh less than five [percent]. My defaulter rate now is 9.8 [percent] when it comes to HIV” (ZAF, Subnational 2). Participants described widespread uncertainty regarding the continuity of HIV services during the initial phase of the disruptions. As a participant from Botswana explained, “But my understanding, just from social media postings and things, is just lamentations from the clients... there's definitely been an outcry just on the level of provision of services, availability of ARVs [antiretrovirals] and staff at the facility level” (BWA, National).

In most countries, participants noted that funding reductions led to increased number of required clinic visits, largely driven by reductions in multi-months drug dispensing (MMDD) from 3–6 months to 1–2 months, with even two-weekly refills observed in some parts of Kenya and Zimbabwe. As one non-governmental organization (NGO) interviewee explained, “we stopped giving three months’ ARVs. I think everyone got scared, so people started getting bi-weekly refills” (KEN, Subnational 1). A notable exception was South Africa, which reportedly expanded MMDD from 3 to 6 months to reduce facility congestion and maintain continuity of care. Meanwhile, in Zimbabwe, treatment dispensing patterns reported mixed accounts. While NGO participants reported reduced refill intervals, including two-weekly dispensing, a national representative described overall stability in ART dispensing practices, attributed to domestic procurement through the AIDS Levy, “a 3% state income tax for individuals and 3% tax on profits of employers and trusts” of which 50% are used for purchasing ARV drugs.²¹ As one participant explained, “In terms of treatment, there has been no change. We are still providing three- and six-month supplies for ARVs because they are procured locally through the AIDS Levy” (ZWE, National).

Participants thus characterized a systemic shift from differentiated, client-centered and tailored care toward centralized, facility-dependent models marked by reduced accessibility, and responsiveness to population needs.

Experiencing system disruption

Changes in service delivery were closely associated with operational and logistical challenges, which often limited access to commodities despite their availability in central storage facilities.

Additionally, a dominant narrative across interviews was the loss of human infrastructure supporting HIV service delivery. Participants highlighted substantial reductions in community health workers, peer educators, counsellors, and outreach staff across multiple countries, which they attributed to the manifesting in weakening or discontinuation of outreach, adherence support, and client tracing services. A participant in Ethiopia noted, “Without community outreach, client tracing and follow-up mechanisms have weakened” (ETH, National).

US policy changes required programs to drop references to gender which had repercussions for the work with key populations.

People employed under key populations stopped working. If you have got a job linked to key populations, you had to change it. We had to change terminology and indicators... Where you had written MSM, you can't. Where you had said sex workers, you can't report on those things anymore. If an indicator changes, you have misplaced data. You can't collect data. (ZWE, National)

Participants suggested that this invisibility extended beyond reporting systems and affected service access. Prior to the funding disruptions, Botswana had integrated KP services into public health facilities and trained government staff to provide KP-competent services with PEPFAR support. However, this existing infrastructure did not shield KPs from experiencing disruptions in access to services following

the funding cuts. The participant could only speculate what was happening to KPs as the data situation had become murky.

It's not clear what's happening. We're no longer allowed to report those, that, that detail. So, you're not, we're not capturing KP, in a sense KP data. We can only suspect that they're probably not coming to the facilities anymore. Or if they are, they're just being treated like general pops and general population and their issues are not particularly being addressed. (BWA, National)

Across several settings, participants identified a growing disconnect between commodity availability and service delivery capacity. ARVs and HIV prevention commodities were available in-country or held within central medical stores in countries such as Uganda, Mozambique, Cameroon and South Africa, but were not reliably reaching end users due to system constraints. "The commodities are available, but technically not accessible" (UGA, Subnational). Similar patterns were observed for prevention commodities, including unused stocks of long-acting injectable cabotegravir for PrEP (CAB-LA). In South Africa, for example, a participant commented on approximately 6,000 CAB-LA vials remaining unused due to a lack of trained personnel to administer the injections, until later reallocation to an organization with appropriate capacity.

Participants reported substantial disruption across the HIV prevention cascade following reductions in operational capacity and program support. VMMC programs were halted or significantly reduced in countries including Mozambique, Zimbabwe, and Malawi due to the inability of implementing partners to sustain delivery. As one participant explained, "What they have now is enough to continue providing the service, but what they do need is skilled personnel to provide the procedures" (MOZ, Subnational).

PrEP provision in health facilities was also affected, not primarily due to insufficient personnel, but because of a narrowing of US Government eligibility stipulations which participants reported from Zimbabwe, Mozambique, Uganda and Botswana.

PEPFAR partners, even when they're like um, like let's say a community health worker, they cannot talk about PrEP unless the person is pregnant and breastfeeding. So, it means that information is not being shared to the patients. So even if.. they're eligible by national standards. (MOZ, National)

Participants from Uganda and Kenya further described uncertainty and confusion among providers regarding whether PrEP could still be offered to populations beyond pregnant and breastfeeding women, contributing to perceptions that services had been discontinued. The uncertainty related to which commodities were funded through PEPFAR versus other sources, resulting in overly cautious restrictions on service provision:

People temporarily halted PrEP to all other populations apart from pregnant and breastfeeding women, who are not that many... we later communicated that not all the PrEP at those facilities was PEPFAR-funded. Some of it was Global Fund PrEP, and providers should continue offering it to key populations and all the other populations, including adolescent girls and young women. (UGA, National)

Operational disruptions extended to logistics and laboratory systems. Participants described settings in which viral load samples continued to be collected but results were not returned, as observed in Tanzania. “The machines are present, but the service is dead” (TZA, National). Across several countries, participants recorded declining viral load testing coverage driven by shortages of staff, laboratory bottlenecks, and transport failures. Transport systems responsible for blood sample movement were reported as significantly disrupted in Kenya, where the suspension of courier riders and shortages of blood collection tubes reportedly halted sample collection and transport. As one participant noted, “about 70% of clients who needed viral load testing were not able to have it. There were insufficient tubes for collecting blood, so they stopped collecting the samples. The riders went home. They were suspended” (KEN, Subnational 1). Participants further indicated that early infant diagnosis services were also severely affected. In Malawi, some facilities reverted to CD4-based monitoring due to failure of viral load systems.

Data and monitoring systems, including electronic medical records and monitoring and evaluation (M&E) platforms as well as routine clinic-level monitoring and supervision mechanisms, were described in countries such as South Africa, Kenya, Zimbabwe and Botswana as weakened, thereby compromising client tracking, outcome monitoring, and program decision-making.

When the program was being run, we had a database through the District Health Information System and could monitor statistics and trends ourselves. Now that the funding has been taken away, we are forced to rely on what we are told without verification. We previously had reliable, real-time data, but without that it has become difficult to comment on statistics or regard them as reliable. (ZWE, Subnational)

Collectively, participants characterized a shift from previously well-functioning HIV service delivery systems with embedded coordination and follow-up mechanisms to more fragmented configurations in which supply chains, workforce capacity, and information systems were no longer aligned, resulting in disruptions between commodity availability and service access, see Fig. 2.

Sustaining HIV services under financial constraints

Despite widespread disruption, participants across multiple countries such as Zimbabwe, Zambia, Rwanda, Gambia and Uganda reported that core HIV treatment services had largely been maintained, albeit under increasing constraint. One stabilizing factor was the Global Fund which ensured access to ARVs, as commented on by a Malawi participant. “For HIV, we still have some stocks, and there is also support from the Global Fund that is helping to fill the gaps” (MWI, National). A dominant theme when discussing future prospects, was the prioritization of treatment over prevention, often framed as a strategy to protect prior public health gains. “The care and treatment for those already in the program is key—that should continue” (RWA, National).

Yet the question was how this should be done. While most countries had shortened the periods to maintain their ARV stock, a participant in Cameroon suggested that MMDD may need to be expanded

and also suggested introducing treatment fees:

Dispensing will have to be stepped up from one month to three months... But that would mean giving larger quantities of drugs to patients... and that will cause shortages. So, but you have to do that since you now have many, many people that are working. So, if a patient gets his way to the, to the health facility, it will be good to give enough drugs to last a little longer.... So, if we can organize it in such a way that people will also know that they have to pay something for their treatment. That, that income will help recruit some people locally that will take care of the patients. So, we have all these things running through our minds. (CMR, Subnational)

As countries grappled with identifying a promising way forward, HIV treatment was highlighted as being paramount for also having a positive effect on HIV prevention. “Making sure that those who are on ARVs are retained on treatment so that we don’t lose those gains is critical because we all know that treatment is prevention” (BWA, National). Prevention services, however, seemed to be deprioritized. “It is difficult to reduce the ART budget because everyone needs ARVs... Instead, adjustments have been made to some laboratory testing and prevention services. Treatment services have largely been maintained at previous standards” (ZMB, National).

Yet, there were also others who felt that prevention should be supported in the future, building on the fact that their country (South Africa) was already doing quite well on the treatment side. “I would say PrEP for sure because we want to prevent those children, um, from uh, well, not just the children, but the population that we are really focusing on from getting HIV” (ZAF, Subnational 2).

Most participants described a broader transition landscape shaped by dwindling external support and financial constraints. Countries pursued varied strategies to manage this shift, including exploration of domestic financing mechanisms (health levies, earmarked taxes, and insurance schemes), integration of HIV services into broader health systems, setting up of regional funds, and engagement with alternative funding partners.

We need stronger resource mobilization, particularly domestic resource mobilization. In Gambia, we have been advocating for the government to budget for ARVs because it is not sustainable for donors to continue funding them... We are also exploring national health insurance for all diseases, and it is important that HIV services are integrated so that people enrolled in the scheme can access HIV care. While we will continue mobilizing external resources, this is becoming increasingly challenging. The way forward is greater domestic financing—not only from government, but also from the private sector, philanthropic organizations, and civil society. (GMB, National)

Yet many participants described these efforts as fragmented, reactive, and insufficiently coordinated. Some critiqued continued reliance on external donors on the part of their governments combined with a denial of system-level constraints and overly optimistic expectations. One interviewee from Kenya noted, “Some officials said, ‘We are okay. We are well organized. We will be able to move on with services.’ We were shocked because we realized they were not in touch with reality” (KEN, Subnational 1). A

participant from Tanzania reflected similar sentiments, stating, “Some people said, ‘We don’t care. USAID never supported us directly... we will go to China, we’ll get it from somewhere else’” (TZA, National).

A recurrent perception was that the sustainability discourse had outpaced actual preparedness for transition. Where sustainability strategies were being implemented, they often involved reducing service packages and prioritizing only those interventions considered essential—effectively creating what a participant described as a system of “doing less with less” (ETH, National).

We developed what we call the Zambian HIV Minimum Service Package for Sustainability, where we removed services considered desirable but not necessary for achieving epidemic control... We also discontinued services such as research testing, community index testing, baseline viral load testing before ART initiation, and HIV testing at birth. For prevention of mother-to-child transmission, we reduced the frequency of maternal HIV testing to specific time points in order to save both operational resources and testing commodities. (ZMB, National)

Thus, a number of effective diagnostic interventions for prevention and care had to be axed due to financial constraints. Local pharmaceutical production, digital health interventions, and private sector engagement were further mentioned as potential strategies for strengthening long-term sustainability, although participants acknowledged that these efforts would require substantial investment and coordination. One participant from Tanzania noted that “there are opportunities in online platforms, electronic systems, and digital health information exchanges. Many of these innovations are not very expensive and can be implemented. There is some hope, but we need to invest in making them work” (TZA, National). Substantial research and innovation investments and boosting self-reliance in countries of the Global South for producing health products was seen as lacking.

We need greater investment in research and development for innovative technologies such as injectable PrEP and the vaginal ring. This also requires collaboration with pharmaceutical companies, greater use of generics, local production of medicines, and potentially more South–South collaboration. (MOZ, National)

Overall, participants characterized the transition as uneven, under-resourced, and marked by substantial variation across countries. This variation was often linked to differences in countries’ economic capacity and ability to assume greater ownership of HIV programs. A global participant argued that there was no universal blueprint for sustainability and that future transition strategies would need to be tailored to individual country contexts.

Sustainability plans are best developed on a country-by-country basis because countries are very different... If you look at GDP [gross domestic product] across eastern and southern Africa, there are major differences. Countries such as Kenya and South Africa have experienced relatively stronger economic growth, while countries such as Mozambique and Malawi may continue to require greater global support. Greater country ownership will be necessary, but the pathway to sustainability will not be the same for all countries. (Global 2)

The participant further noted that future donor support may increasingly need to shift from direct service financing toward technical assistance for service integration, sustainability planning, and monitoring systems.

Across the three themes, participants described a coherent system-level trajectory in which HIV programs across SSA were undergoing simultaneous service recentralization, operational disruption, and financial transition. Provision of HIV services was upheld at the time of data collection for this study, often thanks to the Global Fund stepping in, as noted above. However, participants emphasized that this short-term continuity masked growing concerns about long-term sustainability. As one global participant noted, “Self-reliance is key, but time is important to allow countries to put structures in place to finance these services” (Global 1). Declining HIV prevention capacity, weakened service delivery systems, and uncertainty about future financing were repeatedly highlighted as major challenges.

Discussion

This multi-country qualitative study explored stakeholder perspectives on the effects of reductions in US funding for HIV programs across SSA. Participants highlighted system-level changes characterized by a recentralization of HIV services, operational disruption, and growing uncertainty regarding long-term financial sustainability. Although ART services were prioritized and largely maintained in 2025, prevention services and community-based approaches for vulnerable populations groups were portrayed as disproportionately affected.

To interpret these findings, we considered four interrelated dimensions of service delivery: **who** should benefit from HIV services, **where** and **how** the services should be offered and **what** resources including financial, human, commodity, and system-level inputs, are needed. Although these dimensions are analytically distinct, our findings demonstrate substantial interdependence, particularly between the *where* and *how*, as location and approaches were frequently reshaped following funding disruptions. People most affected by HIV and most vulnerable to service disruption sit at the center of the framework. The findings are discussed separately before considering their intersections (Fig. 3).

Who: Person-centered HIV approach

Our study highlighted how funding reductions disproportionately affected services tailored to KPs, adolescents (particularly AGYW), and men, all of whom remain central to HIV prevention and epidemic control efforts in SSA, particularly in high-burden settings where HIV incidence is concentrated within specific sub-populations. Consistent with previous research, our findings indicate that HIV programs that do not adequately tailor services to the needs of vulnerable populations groups risk exacerbating inequities in access to care and HIV-related outcomes.²²

Concerns regarding AGYW were particularly prominent. Participants, especially in Zambia, associated reductions in prevention services with increased HIV vulnerability among young women. Given the

continuing disproportionate burden of new HIV infections among AGYW in SSA²³ and the demonstrated effectiveness of targeted prevention interventions, these concerns are significant. Studies have highlighted the importance of peer support, youth-friendly services, and community-based platforms in sustaining prevention engagement among adolescents facing social and structural barriers.²⁴

Similarly, male-focused HIV services at risk of being discontinued were seen as important for addressing historically lower uptake and retention of HIV services among men in SSA,²⁵ often shaped by masculinity norms and stigma-related barriers as shown in Malawi, Eswatini and Uganda.^{26,27}

Changes in reporting terminology and restrictions on categories such as KPs, MSM and sex workers, could reduce the visibility of these populations within monitoring systems and mask inequities in service coverage and outcomes. This is particularly salient in settings where KPs are criminalized and data are already limited. Existing gaps in surveillance, population size estimates, and HIV survey data, together with limited integration surveillance, programmatic, and routine health information systems, limit efforts to monitor HIV epidemiology and service needs among KPs.^{28,29} Restrictions on reporting may therefore further weaken the ability to identify for identifying service gaps and monitoring inequities. Maintaining visibility of KPs within monitoring systems remains critical for equitable service delivery and epidemic control.³⁰

Where: Community or Facility-based approaches

Community-based DSD models play a critical role in extending to HIV services to populations underserved by conventional facility-based approaches, particularly in contexts of geographic, social, and economic vulnerability.³¹ Decentralized, client-centered service models have been shown to improve retention while reducing transport costs, stigma-related barriers, and other obstacles to care.³²

Our study showed that the withdrawal of community-based platforms diminished opportunities for HIV testing, prevention uptake, and continuity of care while increasing pressure on facility-based services. Reduced outreach and community-based delivery limited access points for services such as PrEP and VMMC, increasing reliance on facility-based models. These changes may be particularly consequential for interventions that depend on community engagement, demand creation, and decentralized delivery to achieve broad coverage.³³

Concerns that the loss of community follow-up services could reduce retention in care and viral suppression, observed in our study, has been echoed in a systematic review.³⁴ Peer-support interventions are known to strengthen psychosocial wellbeing, social connectedness, and sustained engagement in care.³⁵ The loss of these community interfaces, as reflected in our findings, may therefore weaken structural and relational foundations of HIV service access.³²

How: Approach and Interventions

Beyond the shift from community- to facility-based models, our study highlighted changes in ART delivery, diagnostic and monitoring systems, and increasing integration of HIV services into broader health systems.

Funding and commodity pressures prompted most countries to shorten ART refill intervals, while only a few countries expanded MMDD approaches. Shorter refill intervals increased facility workload and client travel burdens and risked sub-optimal adherence and treatment outcomes but were viewed as strategies to manage anticipated shortages and prevent stock-outs. Conversely, longer dispensing intervals improved convenience, reduced travel costs, and supported continuity of care and retention in treatment, while reducing health system burden when supported by reliable supply chains.³⁶

Concerns about medication hoarding, stock management challenges, and duplicate client registration during periods of resource uncertainty have also been reported in HIV studies where implementing partners had to meet high output objectives.³⁷ This may not only undermine confidence in community-based delivery models, but also affect provider-client relationships in which trust, empathy, and clear communication are essential in maintaining engagement during periods of uncertainty. Evidence indicates that respectful and supportive care promotes treatment adherence and retention,³⁸ while well-monitored community ART models strengthen trust, social support, and sustained engagement in care while reducing pressure on health facilities.³⁹

Reductions in viral load monitoring and early infant diagnosis may hinder detecting treatment failure, and timely diagnosis among HIV-exposed infants. The reported challenges of reduced laboratory capacity, stock shortages, interruptions in routine testing, and delayed turnaround have been shown to have negative impact on HIV treatment outcomes.⁴⁰

Systematic reviews reported disruption to electronic medical records (EMR), monitoring and evaluation, and routine supervision, which may undermine client tracking, program oversight, outcome monitoring, and evidence-informed decision-making.⁴¹ Sustained HIV monitoring requires investment in both laboratory services and robust health information infrastructure.³⁰

Reported reductions in free condom distribution, alongside disruptions to VMMC services, suggest that HIV prevention interventions relying on outreach, community-based delivery, and dedicated personnel are particularly vulnerable during periods of financial constraint and may affect prevention coverage and population-level HIV outcomes.⁴²

Together, these findings underscore that HIV service delivery depends not only on service models, but also on the operational systems supporting monitoring, quality assurance, and continuity of care. Although service integration was frequently discussed as a sustainability strategy, its effectiveness depends on implementation design, with poorly differentiated models potentially weakening client-centered and equity-oriented care.⁴³

With What: Resources for Sustaining HIV Services

Despite emergency mitigation measures, Global Fund support, and domestic financing that largely sustained ART services, funding reductions left persistent shortages of commodities, personnel, infrastructure, and operational support. Stock-outs, workforce shortages, and supply chain constraints—including difficulties distributing centrally available commodities—undermined the consistent delivery of HIV prevention, diagnostic, and treatment services.

Disruptions extended beyond resource constraints. In several settings, uncertainty surrounding donor eligibility criteria created confusion regarding PrEP provision, sometimes resulting in temporary restrictions despite continued commodity availability. These findings suggest that prevention access depends not only on resources but also on clear policy guidance and communication within health systems.⁴⁴ The lack of CAB-LA provision, a long-acting injectable PrEP, due to shortages of trained personnel and limited distribution, highlights that workforce, infrastructure, and organizational readiness are vital for the successful implementation of services.⁴⁵

To strengthen sustainability, countries considered health levies, earmarked taxes, expansion of national health insurance, domestic resource mobilization, local pharmaceutical production, digital innovations, and selective service integration, reflecting broader shifts toward more diversified and domestically driven HIV financing models.

However, sustainability cannot be separated from national context. Countries entered this transition period with differing levels of fiscal capacity, health system strength, and economic resilience, resulting in uneven opportunities for domestic financing and program adaptation. Consistent with this, literature indicates that sustainability outcomes are shaped by donor transition processes, aid delivery mechanisms, and domestic political priorities.⁴⁶ While some settings appeared better positioned to expand DSD and domestic financing, others remained dependent on continued official development assistance (ODA) suggesting that sustainability may be strengthened through context-specific financing strategies that mobilize domestic and private-sector resources.⁴⁷

Participants did not equate sustainability with reinstating all services affected by funding reductions. Rather, sustainability was understood as strategically adapting services, e.g., integrating HIV services with other health services while maintaining equitable access to essential prevention, treatment, and care. This aligns with DSD literature emphasizing adaptive, patient-centered service redesign under resource constraints.⁴⁸

Within this context, continued ODA was viewed as part of a managed transition. External financing remains essential while countries strengthen domestic financing and institutional capacity. Persistent disparities in health expenditure indicate that many countries presently lack the fiscal space required to sustain HIV programs without external support, underscoring the need for context-specific transition pathways and continued international assistance where domestic financing capacity remains limited.⁴⁹

Sustainable HIV programs require resources to support equitable population coverage (*who*), appropriate service platforms (*where*), and effective delivery modalities (*how*). Sustainability therefore depends not only on the volume of available resources, but also on the equity, efficiency, and predictability with which they are mobilized and distributed. The pathways from funding and resource reductions to addressing pertinent issues for achieving sustainability have been summarized in Fig. 4.

This study has several strengths. This study is among the first multi-country qualitative analyses of the felt impact of US funding cuts across SSA. Including multiple countries and stakeholders enabled comparison across contexts and a broad understanding of how funding disruptions affected HIV service delivery.

However, the study did not include client or community perspectives, limiting insights into service-user experiences. This will be addressed in a subsequent mixed-methods study. As data were collected early in the funding transition, findings primarily reflect short-term effects and may not capture longer-term adaptation. Cultural and contextual differences across countries may also have influenced the comparability of participant accounts.

Conclusion

Our qualitative study highlights that, reductions in external funding for HIV programs across SSA influence who will benefit, and where and how HIV programs are organized, delivered, and sustained. While ART services have remained relatively resilient, the weakening of prevention, community-based delivery, operational systems, and workforce capacity undermine long-term progress, particularly for vulnerable populations.

Sustaining HIV services will require increased domestic financing alongside context-specific strategies to strengthen health systems, including community-based and differentiated service delivery models. Well-planned, gradual financing transitions aligned with national capacity are essential to preserving gains toward HIV epidemic control.

Methods

Study setting

We conducted this study in SSA, the region: a) most affected by the HIV epidemic and b) the principal recipient of US Government HIV funding.⁵⁰

Study design and sampling

For this exploratory qualitative study, we used purposive sampling⁵¹ to conduct semi-structured in-depth interviews (IDIs) with male and female stakeholders working for multinational organizations,

governments, non-governmental organizations including networks of people living with HIV (PLHIV), clinics or research institutes in SSA and globally. We sampled those with an overview or direct experience of HIV programs at the global, national or sub-national level as had been done in a study on voluntary assisted partner notification.³⁷ We included countries across Southern, Eastern, Central, and Western Africa to capture variation in HIV burden, health system contexts, and reliance on external HIV funding. Based on personal networks, a desk review and snowball sampling,⁵¹ the research team developed a list of 73 potential interview candidates engaged in HIV programs globally and across SSA countries and subsequently contacted them. In addition to non-responders, some declined participation because they had not yet received a final US funding decision for HIV programs and were concerned that involvement in the study might negatively affect continued support from the US Government.

Data Collection

Between June and December 2025, a team of seasoned qualitative HIV researchers with diverse geographic backgrounds conducted the in-depth interviews virtually after developing and pilot testing the interview guide within the research team. The guide explored HIV prevention and treatment programs before the January 2025 US Executive Order, changes following the stop-work order, and the future outlook for HIV services. Potential participants were sent an information sheet and consent form which they signed prior to the interview. At the start of each interview, the interviewer reviewed the study information, answered any questions, and reconfirmed participants' willingness to participate. All interviews were conducted in English and audio-recorded. The research team held weekly debriefing sessions to share and reflect on insights, and further adapt interview guides.⁵² We followed the SRQR guidelines for reporting qualitative research.⁵³

Data analysis

Audio-recorded interviews were transcribed verbatim using MAXQDA transcription software and checked against the recordings for accuracy. We analyzed the data using rapid qualitative analysis, an approach increasingly used in implementation science to generate rigorous, qualitative findings through systematic data condensation and synthesis.⁵⁴ The first and last author conducted the analysis, each independently reviewing and condensing the full set of interview transcripts according to domains drawn from the interview guide, capturing key points and illustrative quotations that highlighted the essence of the transcripts. Discrepancies in interpretation were discussed and resolved. Thereafter, we identified key themes by collating the data into tables on HIV prevention and treatment. Thematic interpretations were reviewed and refined during weekly meetings with core members of the research team until consensus was reached on the final themes. To interpret the findings, we used a framework of four interrelated dimensions of service delivery: **who** should benefit from HIV services, **where** and **how** the services should be offered and **what** resources including financial, human, commodity, and system-level inputs, are needed., see Fig. 3.

Declarations

Ethical Approval and Informed Consent

The ethics committee of Heidelberg University's Medical Faculty approved the study (S-218/2025). Participation was based on voluntary written consent; participants could withdraw from the study at any time without consequences. To protect confidentiality, all interview data were collected and analyzed under pseudonyms. We stored all data in a password-protected folder accessible only to the research team. Audio recordings were deleted following transcript verification and quality checks.

Data Availability Statement

Due to the sensitive nature of the study with participants sharing personal information in the interviews which may make them identifiable, data cannot be made publicly available. Pseudonymized transcripts can be made available from the corresponding author on reasonable request.

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Figures

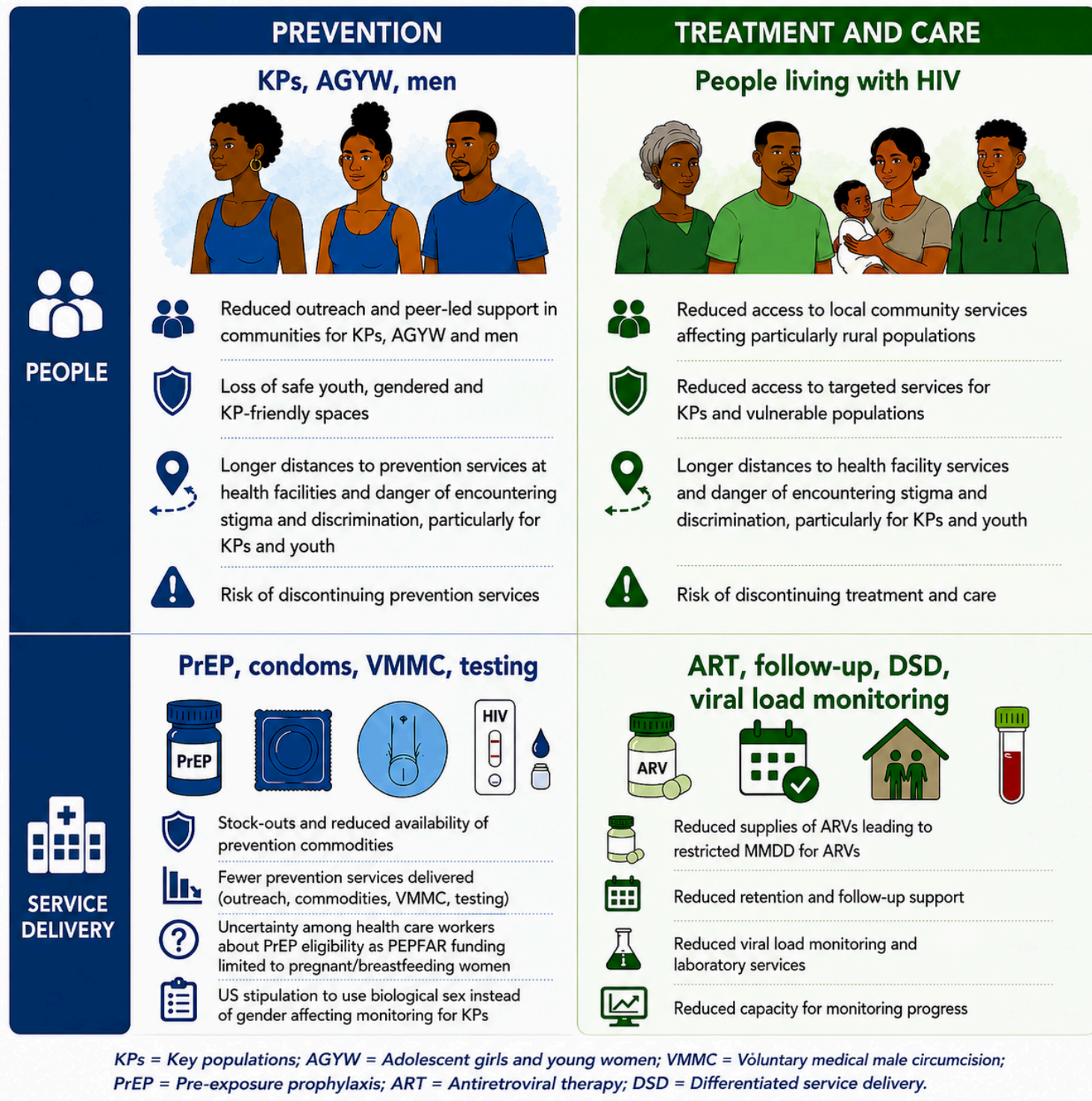


Figure 2

Impact of US funding cuts on people and service delivery



Figure 3

Conceptual Framework

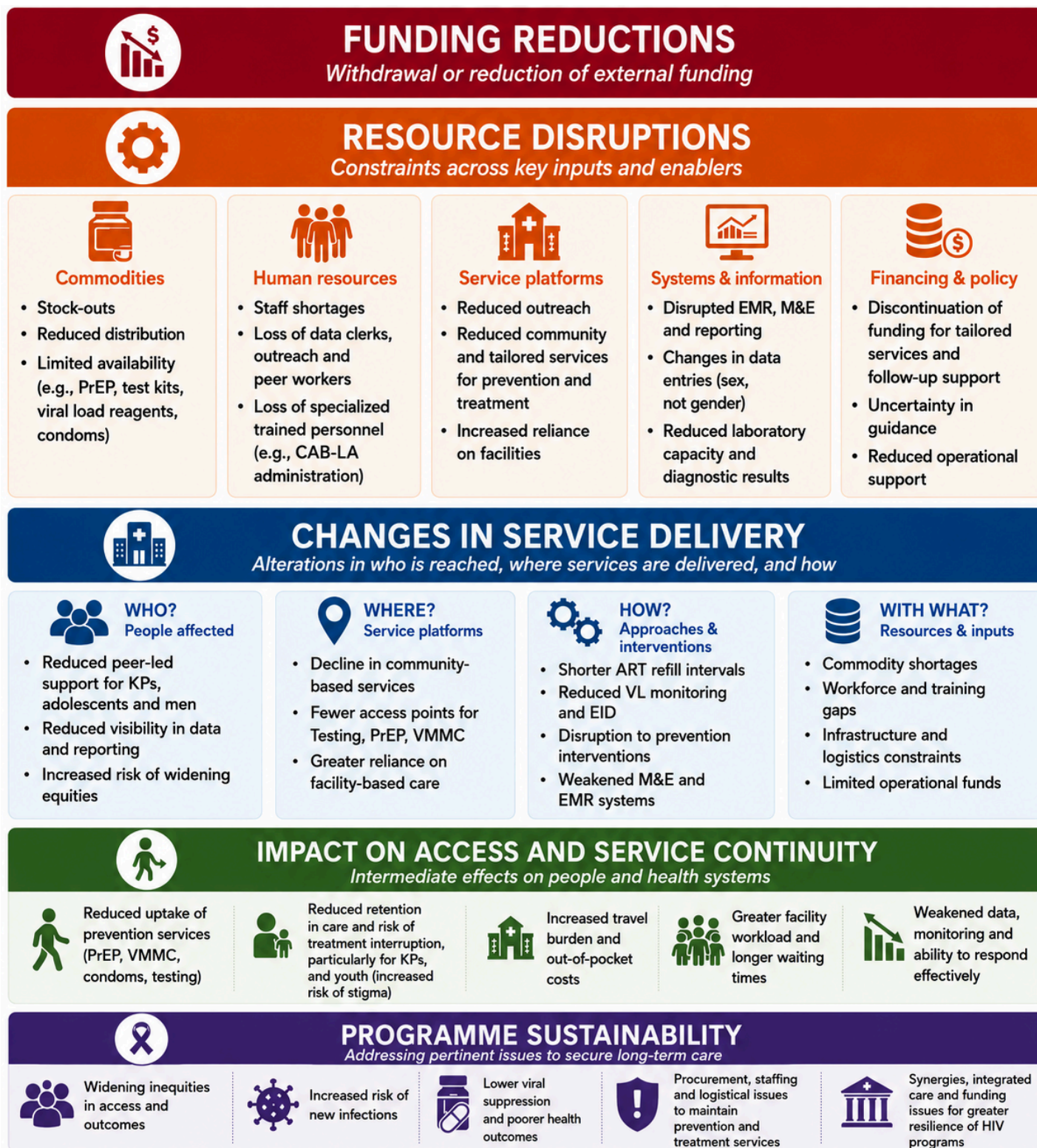


Figure 4

Summary effects