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EMBIBO GENDER INITIATIVE WORKING PAPER:

SHIFTING SUPPORT: AN ASSESSMENT OF THE CONSEQUENCES OF USAID REDUCTIONS ON RURAL WOMEN'S HEALTH AND GRASS ROOTS RESPONSES.

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LIST OF ACRONYMS

AIDs: Acquired Immunodeficiency Syndrome

ARVs: Antiretroviral Drugs

HIV: Human Immunodeficiency Virus

PEP: Post-Exposure Prophylaxis

PREP: Pre- Exposure Prophylaxis

USAID: United States Agency for International Development

ORGANIZATION BRIEF:

Embibo Gender Initiative is a feminist community-based organization that focuses its efforts on advocacy, capacity building and service provision towards rural women and girls affected by HIV/AIDs and violence. Through several community focused and led programs, the organization offers legal, medical, mental and economic support to increase gender justice and health access for the most marginalized rural women and girls. The organization operates in 3 districts and works with HIV positive individuals, survivors of violence, female sex workers and teenage mothers

ACKNOWLEDGEMENTS:
This working paper was developed by Ms. Abbo Bridget Gloria, the Legal Officer for Embibo Gender Initiative and Ms. Tendo Mirembe Namata, the Executive Director for Embibo Gender Initiative together with the invaluable support of rural women of Kamwenge, Kitagwenda and Ibanda districts. Rural women have always been invaluable participants in knowledge creation leading to stronger social justice movements.

Bell Hooks, a feminist theorist, in her writing, "Feminist Theory: From Margin to Center," highlights the importance of creating knowledge that centers the voices of the most oppressed paying attention to the various intersectionalities affecting women.

The rural women interviewed in this paper are often under represented and their experiences as female sex workers, teenage mothers and survivors of violence invalidated in advocacy and policy review. The purpose of this paper is to bring their voices to the center of USAID aid cuts.

1.0 INTRODUCTION:

Uganda has made significant progress in the HIV epidemic response. By the end of 2020, 91% of adults living with HIV in Uganda knew their HIV status, of whom 95% were on treatment and 90% of those on treatment achieved viral suppression. New HIV infections declined by 61% (94,000 in 2010 to 38,000 in 2023). AIDS-related deaths have declined by 60% from 89,200 to 22,000 . Uganda also made specific progress in curbing Mother to Child transmissions with a case rate of 466 of 10,000 .

Despite these reductions, there have been significant concerns in the high burdens of new infections among specific sub groups like pregnant women, adolescent girls and key populations. The Uganda Based HIV Impact Assessment report (2022) for example shows that HIV prevalence and new infections increased, among adolescent girls and young women aged 15 to 25 years. Global and national statistics also indicate that Key Populations especially Female Sex workers have up to 12 times more than the national prevalence and account for 37 percent of HIV prevalence and 18 percent of new infections in Uganda

Yet significant HIV and sexual reproductive health achievements have been made in recent decades with the formation of localized health systems, Information education and communication as well as drugs (ARVs, PREP and PEP) to meet the needs of the most marginalized rural groups such as sex workers and survivors of violence.

In rural areas, health facilities already face a number of issues such as limited specialized health personnel, long distances to health facilities, limited financing and frequent stock outs. USAID program funding has been key in strengthening rural localized community health systems that follow up on clients from their homes offering adherence and nutritional support, early diagnosis as well as mental health support that have been deeply impacted by these cuts.

Community members trekking long distances with a patient to seek medical services

1.1 BACKGROUND:

Uganda has been one of the beneficiary African countries of the USAID fund since its independence in 1962 and has since won a number of awards for its outstanding performance including its significant role in making pregnancy and child birth safer for Ugandan women . Historically, the country has received over 350 million annually to support its development agenda towards HIV programming .
For a country like Uganda that heavily relies on USAID assistance for health efforts towards malaria, HIV/AIDs, tuberculosis and other SRH services for marginalized groups, the Executive Order 14169 has not only caused a stampede in our community but also constitutes a significant violation of the right to health. This right is enshrined in international agreements such as the International Covenant on Economic, Social, and Cultural Rights, SDG 3 and 5 that cater for child and maternal health, HIV/AIDs and infectious disease control and surveillance that Uganda is privy to.

1. https://cquin.icap.columbia.edu/wp-content/uploads/2021/08/Mudiope_Session-2_FINAL.pdf
https://www.cdc.gov/global-hiv-tb/php/success-stories/uganda-pmtct.html
2. https://www.unfpa.org/sites/default/files/Evaluation_of_the_UNFPA_support_to_the_HIV_response_2016-2019.pdf
3. https://healthgap.org/wp-content/uploads/2021/09/PEP-FAR-Key-Populations.pdf
4. https://2017-2020.usaid.gov/uganda/history

Although the USAID funding cuts have affected several programs nationally including health, education and economic livelihood programs, health programs lost a significant chunk of financing.

On March, 25th of 2025, Dr. Jane Acheng, the minister of Health in Uganda appeared before parliamentary health committee informing them of over 604 billion lost towards critical health financing with 243.2 billion being HIV funding and 67.8 being human resource support .

With these cuts there is likely to be regression with current gains that have been made by Uganda. For example, the lifesaving medical services and medications that are offered under the PEPFAR program will affect over 1.4 million HIV patients Also, subsequently, great strides made in mother to child transmission will be lost. Uganda has often shone bright in mother to child transmissions with treatment and prevention support from PEPFAR program. 41 new born children are estimated to contract HIV during the 3-month stoppage period thus leading to more than 3,690 babies being born with HIV thus costing the government more in life long treatment costs.

Beyond beneficiaries, Uganda's localized health systems have been heavily impacted with over 12,551 community workers that support adherence and early testing receiving a stop work order.

The abrupt discontinuation of HIV/AIDS programs has particularly exposed marginalized communities to severe health risks, with many patients left without life-sustaining treatment and jeopardized progress in addressing key challenges such as adherence and drug resistance. For rural communities, already marginalized women will have limited access to health care services such as life saving medications, vaccinations and contraceptives.

This will present lifelong treatment costs creating much higher burden on the health sector by increasing government spending.

This working paper's main purpose is to center the voices of rural women in policy discussions around sexual reproductive health amidst USAID and donor cuts

Embibo Gender Activists enagaging communities in HIV testing, Family planning & Maternity care awareness in rural areas

2.0 STRENGTHENING RURAL HIV AND SEXUAL REPRODUCTIVE HEALTH INTERVENTIONS FOR VULNERABLE POPULATIONS IN UGANDA:

In rural areas, health facilities already face a number of issues such as limited specialized health personnel, long distances to health facilities, limited financing and frequent stock outs. USAID program funding has been key in strengthening rural disaggregated and localized community health systems. The USAID program cut was instrumental in setting up and strengthening rural disaggregated localized community health systems therefore affecting the adherence to treatment and drug up take.

5.https://www.urc-chs.com/news/usaid-uganda-health-activity-recognized-for-outstanding-contribution-to-safe-motherhood/
6.https://eprcug.org/blog/unaided-navigating-ugandas-hiv-response-post-usaid-withdrawal/
7.https://www.state.gov/implementing-the-presidents-executive-order-on-reevaluating-and-realigning-united-states-foreign-aid/
8.https://parliamentwatch.ug/news-amp-updates/us-aid-freeze-triggers-ugx-604bn-health-sector-funding-crisis/

9.https://uac.go.ug/images/2024/facttsheets/hiv-aids-fact-sheet-2022.pdf#:~:text=An%20estimated%201.4Million%20People%20were%20Living%20With,improved%20access%20and%20utilization%20of%20HIV%20services.&text=This%20has%2C%20in%20part%2C%20resulted%20in%20a,and%2067%%2C%20respectively%2C%20from%202010%20to%202021.
10.https://www.parliament.go.ug/news/3626/govt-addressing-funding-gaps-following-us-aid-cuts-pm

The discipline of beneficiaries that relied on the system has also been significantly disrupted thus increasing the burden in already strained public health facilities. This has undermined years of progress on disease control and community health outcomes.
This not only threatens individual well being but also poses broader health risks due to potential transmission rates and preventable complications.

2.1 VOICES FROM THE GRASS ROOTS: ASSESSING THE CHALLENGES OF AID CUTS:

Embibo has engaged some of the direct beneficiaries of their programs in a participatory survey and in-depth interviews in order to ascertain the impact and lived experiences of women in rural communities in regards to the disruption of health service systems.

2.1.1 RISING STIGMA AND DISCRIMINATION AMID THE BREAKDOWN OF COMMUNITY HEALTH SYSTEMS

One of Uganda 's responses to the USAID funding cuts has been the return of HIV and SRHR specialized services supported by the donor entity to main stream health.

Health centers III that the organization interfaced with had a well-trained and accountable health personnel including laboratory staff, community health workers and focal persons in charge of family planning, HIV, key populations and mental health.

This has been especially tough for rural areas that face higher social stigma arising from stricter gender and social norms. The end to such systems has led to a greater risk to confidentiality and privacy of patients. There is reported risks in terms of un willingness to test and thus increased rates of new HIV infections and un intended pregnancies especially among marginalized groups such as sex workers.

This has also increased stigma for young people who have been freshly enrolled on ART and are un-sure about adherence as long periods of time with no access to medication may lead to drug resistance.

In addition to this, drop in centers led by sex worker and sexual minority groups have been highly restricted over time and yet these structures played a big role in ensuring mobilization, testing, counselling and access to health products such as condoms, lubricants and PREP. They were also essential conduits in linking clients to health centers for treatment of Urinary Tract Infections, Sexually Transmitted Diseases among other infectious diseases

Respondent Clients confessed that they many times feel the pressure to only seek for what they feel is culturally acceptable in health centers such as primary health medication.

In a different one safe space, a participant confessed that:

> ***"I don't know what is going on as health workers that I often freely associate with are no longer at the health center. Right now, if we go to the hospital with everyone yet we do not want everyone at the health status to know our status."***

Self-stigma is also a key tool that keeps sex workers and survivors of violence from accessing critical medication, information and service as they often feel judged and mis understood.

Illustratration shows one of the members seems isloated because of the HIV status results

Stigma and discrimination are also a key factor in reducing social cohesion as minoritized rural groups often feel un heard within policy and social service conversations.

With an increase in un trained and non-disaggregated care, intersectionality of care will not be practiced. This will over time increase unwarranted violence, chronic poverty and lifelong poor health outcomes.

2.1.2 NAVIGATING MENTAL HEALTH AND CONFUSION

From the health center at Kamwenge Health Center III during a safe space session, participants expressed their concerns, worries and tragedy. This has greatly affected the mental health of persons living with HIV as they described the situation of funding cuts arising from the executive order as a death penalty for persons living with HIV partly due to un certainty in communication.

> ***"I heard the news from radio that the HIV drugs are no longer going to be supplied. I felt fear because I thought I may die within a month as my drugs were almost finished and I was not sure I would be able to get other drug (Safe space participant).***

Other participants reported being told to take the medicine properly because there was no more medicine at the facility while others still-noticed that they had not been offered new appointment dates due to the 90 day pause on USAID funding.

> ***"After coming for my appointment date, I was told that I would not be getting medication for a while and yet usually the ART attendance book usually indicates the next appointment date."***

11.https://parliamentwatch.ug/news-amp-up-dates/us-aid-freeze-triggers-ugx-604bn-health-sector-funding-crisis/ https://parliamentwatch.ug/news-amp-up-dates/us-aid-freeze-triggers-ugx-604bn-health-sector-funding-crisis/

Beyond HIV medication, there has been difficulty in accessing comprehensive health services such as those around Gender Based Violence support, contraceptive access and STI screening and treatment. For example, respondents reported a temporarily stock out of short-term contraception. This has increased the worry of having un planned pregnancies and births especially for rural key and vulnerable population groups that usually have multiple partners, low condom use as well as client initiated sexual violence.

Members of Embibo Gender Initiative sensitizing community members on condom usage as a form of family planning & HIV prevention

This confusion has further led to service providers exploiting the situation for personal benefit. For example, charging high costs of up to 20 dollars to ensure access to medication. These costs cannot be sustained by already ailing and poor clients.

Similar concerns have been raised by other communities. Richard Lusimbo, the director general of Uganda Key Populations Consortium (UKPC), says that beyond financial strain, the funding disruptions have triggered severe mental health challenges, heightened uncertainty around medication access, and exacerbated structural inequalities that disproportionately impact marginalized communities such as the LGBTIQ+ communities who are at high risks of exposure to HIV.

12.https://76crimes.com/2025/02/16/uganda-ngos-denounce-usaid-cuts/

2.1.3 AN EVOLVING PANDEMIC LANDSCAPE: THE MONKEY POX (MPOX) PERSPECTIVE:

In August, 2024 the first case of MPOX was confirmed in Uganda. As of February, 2025, a total of 3,685 confirmed cases has been reported across 93 districts . The most at-risk age group is 18 to 39 years particularly among sex workers and those living with HIV highlighting a need for integrated management strategies

Through USAID, the United States of America government channeled over 1.4 million through the World Health Organizations with 400,000 dollars to the USAID Uganda Health Activity implemented by the University Research Collaborative (URC) to support MPOX preparedness and response plan.

Embibo Gender Initiative has been working with many MPOX survivors with counselling, nutrition, information as well as linking them to treatment and isolation centers in Kamwenge and Ibanda.

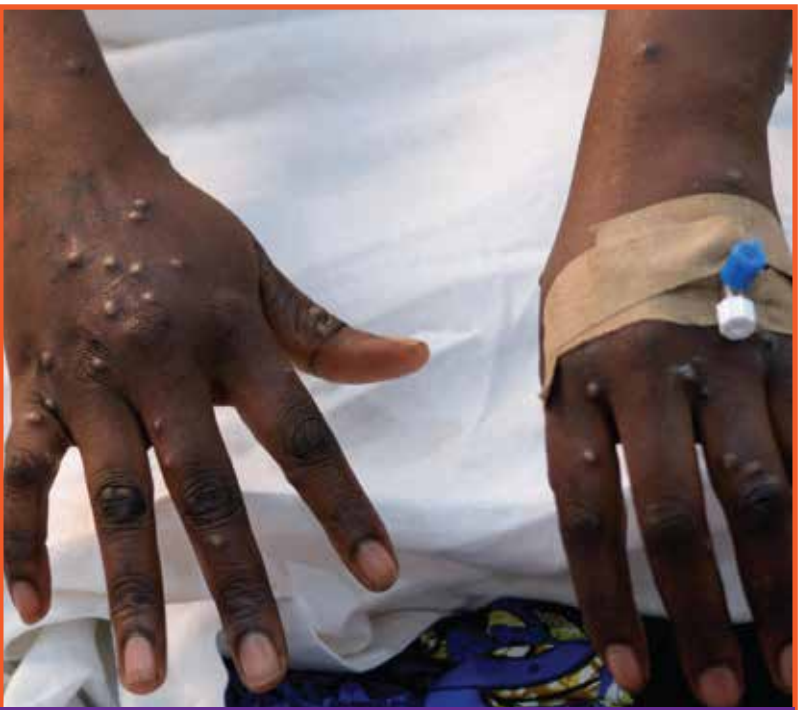

Image shows one of the victims of Mpox who are a living testimony of the hard work of Embibo Gender Initiative through counselling, nutrition & treatment.

With already strained community localized systems that many health centers and organizations rely on, beneficiaries have limited access to quality information on treatment and prevention strategies. This has increased the number of infections in key hot spots and the organization has even received a number of reports on deaths.

Additionally, there is a lot of myths from beneficiaries that the disease is from witch craft and hence nothing can be done to prevent or manage it except through spiritual interventions. In one instance, a beneficiary went into a church in order to receive healing from the disease that she believed was sent to her from her co- wife and later affected the husband.

Conclusively, with limited and timely service and information access, another pandemic has simply increased care work for HIV affected households as clients are usually sent back home for treatment.

2.1.4 LAYERED IMPACTS ON GRASSROOTS ORGANIZATIONS AND SOCIAL MOVEMENTS:

Grass root organizations and movements are often first line of response in rural and under served areas where health care may be costly due to transport, medication as well as the huge barriers on mental health. When funding is pulled, smaller grassroot organizations under USAID programs face reversals in gains, reduce on programs and lose community trust.

For organizations such as Embibo Gender Initiative that have been one of the few grassroot movements working with rural women and girls affected by HIV and violence such as sex workers and violence survivors, there is burden on the limited resources. These often have to be re directed to emerging priorities such as MPOX, HIV/AIDs and other comprehensive sexual reproductive health services like contraceptives, Sexually Transmitted Diseases, post abortion care and mental health support.

Embibo Gender Initiative working with rural women and girls in combating HIV and violence and other emerging community needs relating to human health and gender based in Kamwenge and Ibanda.

With the closure of USAID funded clinics, community-based organizations are also forced to re- configure linkages and referral pathways to handle growing number of clients.

More notably, gender justice advocacy landscape has significantly changed as there is much more to worry about. For example, a sexually abused person has to worry about PEP access, un intended pregnancies, stigma, cost of medication from possible culminating sexually transmitted diseases as well as un friendly policies that delay court related justice.

3.0 RECOMMENDATIONS:

3.1 STREAM LINE ALL HEALTH FUNDS INTO THE NATIONAL HEALTH INSURANCE SCHEME ESPECIALLY IN RESPONSE TO HIV/AIDS AND REPRODUCTIVE HEALTH GAPS WITH A CONCENTRATION ON DOMESTIC FINANCING:

Uganda has developed several policies that provide health funding for the most vulnerable of the population including the HIV/AIDs trust fund under the HIV and AIDs Control Act (2015). The Insurance scheme promises financial protection for the rural poor. Proper screening criteria should however be made to identify those most marginalized not just economically but exposed to un-intended pregnancies, sexually transmitted diseases and risks of maternal death and complications.

3.2 DECENTRALIZE ACTION TO DISTRICT AND SUB COUNTY LEVEL TASK FORCES:

Picking a leaf from Uganda's response to COVID-19 where establishment of district task forces led by RDCs (Resident District Commissioners) and District Health Officers were instrumental in shaping grassroot response through information sharing, tracking, management and treatment of new infections is vital.

District level interventions will similarly ensure resources are shared thus encouraging community-based organizations, private institutions and trained former USAID personnel like data clerks, community health workers and counsellors to become absorbed and consolidate resources to swiftly respond to HIV/AIDs, sexual reproductive health and other emerging pandemics.

3.3 STRENGTHENING OF ADVOCACY COALITIONS WITH FOCUS ON RURAL WOMEN AND GIRLS' VOICES AND INFORMATION AROUND HEALTH:

Gender Justice, health and feminist advocacy coalitions have achieved several policy wins overtime promoting women's economic, social and political rights. These coalitions build resilience, ensure resource sharing and are able to amplify the voices of rural women and grassroots movements.

Building resilience, ensuring resource, sharing and being able to amplify the voices of rural women and grassroots movements.

Rural communities represent more than half of Uganda's population with the majority of these being women and girls. Advocacy coalitions can play a major role in translating specific rural women's needs around health into actionable policy language as well as finding community-based solutions such as alternative models of organizing and financing.

4.0 CONCLUSION:

Rural community-based organizations and structures are often the first points of access to information and services for women in regards to gender justice and health.

Donor funding plays a key role in sexual reproductive health and rights by ensuring access to information, medication, testing and care for marginalized communities. Above all this, donor funding supports the government to address key gaps in health financing.

Abrupt cuts and shrinking donor funding for countries like Uganda underscore the importance of strengthening domestic financing alternatives in the long term.

This paper also stresses the need to prioritize rural marginalized women's voices in creation and implementation of policy solutions.

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