Democratic Republic of Congo:

Key Populations Strategic Priorities

Introduction

In the Democratic Republic of Congo (DRC), the estimated HIV prevalence among adults aged 15–49 was 0.7% as of 2023[1] with an estimated 520,000 people living with HIV[2]. Among key populations (KPs), HIV prevalence among female sex workers (FSWs) is estimated at 5.4% in Kinshasa, 7.4% in Lualaba and 4.6 % in Katanga, 7.1% among men who have sex with men (MSM), and 3.9% among people who use drugs (PWUD) respectively[3]. The report on the mapping and estimation conducted in 2022 reported 315,133 (SW), 124,053 (MSM), 110,139 (PWID), 56,530 Transgender (TG)[4].

Prior to the funding cuts, the DRC had made progress toward achieving treatment and prevention goals despite conflict and instability which affected implementation of programs for both the general populations (GPs) and KPs. In support of the National AIDS Control Program (PNLS), the PEPFAR allocation supporting HIV-related programs was $105,000,000 for COP 23 year 2. PEPFAR/ DRC implemented programs in three key provinces (Haut-Katanga, Lualaba, and select health zones in Kinshasa), which represented approximately 50% of the total number of people living with HIV (PLHIV) in the DRC.

PEPFAR alongside other partners supported the provision of testing, treatment, care, prevention, the establishment of several ARV treatment centres, strengthened local capacities and the drug supply chain, for KP prevention and treatment, among others. However, additional efforts were needed to improve access to health services and the legal framework for KPs who are still persecuted in the DRC. Access to services in remote areas also remained challenging especially for KPs and sexual and gender minorities and stigma and discrimination also contributed to limited testing and treatment.

17 out of 26 (65%) provinces had HIV and STI interventions for KPs. The Ministry of Health (MoH) had planned for 182 KP care sites, and 116 were operational by the end of December 2024. With the loss of PEPFAR funding, only the Global Fund (GF) supported KP sites (25 sites) remain operational, including 16 friendly centres and 9 integrated centres.

Access to antiretrovirals (ARVs) had improved in 2024, with an increase in the number of patients on treatment, but in 2025, access reduced following the end of the PEPFAR funding. The program only had HIV medication and condoms for 3-6 months by May 2025. All programmes on stigma and discrimination were stopped, affecting KP service delivery[5] and stigma has intensified due to the lack of civil society organisations (CSOs) to educate communities.

The funding disruptions have directly affected service delivery continuity and coverage and put KPs at even greater risk of HIV. SW, MSM, PWID, and other key LGBTQIA+ populations, who are often the most affected by HIV and the most marginalized, are bearing the brunt of the reduction in prevention services (particularly PrEP) and testing tailored to their specific needs.

While some efforts to strengthen prevention have continued, there is reduced capacity at service delivery points for HIV prevention and a discontinuation of outreach programs. KP community-led prevention activities have also stopped due to lack of funding.

In a country like the DRC, where humanitarian crises are frequent, displaced populations and those living in remote areas occupied by rebels already have difficulty accessing health services. The funding freeze will exacerbate these inequalities, leaving them with no alternative for HIV testing, treatment, and prevention.

[1] https://www.cdc.gov/global-hiv-tb/php/where-we-work/drc.html? [2] https://dndi.org/press-releases/2025/new-hiv-project-drc-brings-life-saving-care-closer-to-people-advanced-hiv-disease/? [3] The IBBS 2018-2019 survey report [4] Report on the mapping and estimation of these sizes conducted in 2022 [5] https://www.unaids.org/en/resources/presscentre/featurestories/2025/may/20250502_drc

What does the data say about HIV prevalence among KPs in the DRC?

- **Female sex workers (FSWs)** is estimated at 5.4 percent in Kinshasa, 7.4 percent in Lualaba and 4.6 percent in Katanga
- **MSM:** 7.1% among men who have sex with men
- **PWUD:** 3.9% among people who use drugs respectively[6]
- The report on the mapping and estimation conducted in 2022 reported:
  - **SW:** 315,133
  - **MSM:** 124,053
  - **PWID:** 110,139
  - **TG:** 56,530[7]

Where was the DRC on the 95/95/95[7] track? Due to the Congo Démocratique Population-based HIV Impact Assessment (COPHIA)[8] data not being released, there is no recent public data available the first and the last 90, however 91%[9] of adults living with HIV are on antiretroviral therapy.

The KP organisations have identified priorities for sustaining effective programming in the context of severely constrained resources and a costed strategy for essential elements designed to prevent further collapse and restore critical services, as detailed below.

KP Community Core Priorities

1.Antiretroviral Therapy (ART) and Service Continuity

Prior to the funding cuts, PEFPAR intended to find the people and populations historically missed, place them on treatment and maintain treatment continuity. They also intended to maximise multi-month dispensing (MMD) so that 30% of patients, receive three-month ARV supplies[10], and 70% receive six-month ARV supplies as good progress had been seen in the multi-month dispensing of ARVs.

However, currently the coverage of ART among KPs remains limited to areas covered by the GF with only 30% coverage among priority HIV populations[11]. Targeted programs aimed at reaching MSM and LGBTQIA+ that were supported by PEPFAR, were discontinued, leaving a 70% coverage gap.

An estimated 91 PEPFAR-supported clinics and care centres have closed or drastically reduced their services, leading to drug shortages and the inability to pay staff (estimated 910 staff). As of July 2025, 12,467 HIV positive KPs were without access[12]. The multi-month dispensing of ARVs and viral load monitoring, essential for treatment effectiveness, has also been severely compromised in several areas.

The challenges that persisted due to stockouts of ARVs and test kits prior to the funding cuts have now been exacerbated with the cessation of funds especially in the PEPFAR-supported areas and access to ART services for those in rural and conflict zones is also more limited due to logistical difficulties and security challenges.

While policies and strategies emphasised the necessity of realising human rights and ending stigma and discrimination against people living with HIV as an essential pillar for improving access to services and retention in care, they did not take into account sexual and gender minorities creating major barriers to accessing services for KPs that have now also increased due to the funding cuts.

[6] The IBBS 2018-2019 survey report [7] Mapping and estimation of key population report, 2022 [8] https://phia.icap.columbia.edu/surveys/timeline/
[9] https://www.globalissues.org/news/2025/06/29/40308 [10] Democratic Republic of the Congo Country Operational Plan (COP) 2023 Strategic Direction Summary [11] WHO reports (February 2025) [12] ART/PNLS Annual Report 2024

Programmatic Disruptions

- **KP ART sites losses:** PEPFAR + PNLS coverage in December 2024 - 116 operational sites for KP across the country and in June 2025 a reduction to 16 operational KP sites across the country.
- **Geographic disruptions:** Disruptions were more severe in certain areas (e.g., Goma, Haut Katanga, and Lualaba), resulting in lower coverage.
- **Loss of access for KPs:** In July 2025, 12,467 HIV-positive key populations no longer have access to ARVs, and deaths among KP/MSM have already been recorded in Kinshasa.

Non-negotiable Priorities:

- **Scale up access to ART commodities for KPs living with HIV.** Strengthen coverage and access to ART commodities for KPs living with HIV (KPLHIV) by extending the provision of ART in all regions, particularly in rural areas, PEPFAR-abandoned zones, and conflict-affected areas.
- **Strengthen the supply chain** to ensure there are no commodity stockouts at the facilities and **continue and expand the multi-month dispensing of ARVs**, ensuring a constant availability of commodities.
- **Increase access to mental health services** as a support for those seeking services at the health facilities.
- **Invest in the reduction of stigma and discrimination** to protect KPs from human rights violations **by increasing staff training** on KP service delivery and program management.
- **Introduce innovative models** such as integration of telemedicine, mobile services, and community-based strategies to effectively reach KPs.
- **Improve viral load monitoring and active tuberculosis screening** among KPLHIV. Ensure sustained availability of viral load testing commodities and reduce result turnaround times to support clinical decision-making and treatment monitoring.
- **Strengthen community ART delivery models for KPs** through community-led and safe platforms. Decentralize services and strengthen capacities at the provincial and local levels, particularly in areas affected by humanitarian crises and restore mobile clinics and community fixed points that have been reduced, limiting access to testing and prevention services.

Strategic Element	Current Status	Annual Funding Required	Key notes
ART Commodities	Limited supply	$802,646	The commodities are in limited supply and prone to stockouts
Commodity supply chain	Challenges with supply	$200,000	The supply chain needs to be fixed to reduce stockouts of commodities and increase MMD
Mental health services		$175,000	Include mental health support for KPs seeking services
KP-friendly public sites	Limited KP sensitivity	$1,496,196	Support mentorship and training for providers on KP-friendly services to reduce stigma and discrimination
Innovation	Not available	$30,798	Support telemedicine, mobile services, and community-based strategies to effectively reach KPs
TB diagnosis & treatment	limited	$500,000	Addresses co-infection; needs integrated TB/HIV services
Viral load access	Significantly reduced	$150,000	Ensure commodities and reduce turnaround time

ART Funding Gap: Approximately **$3,354,640** annually to restore comprehensive, peer-supported ART services for KPs.

What is the cost of inaction? The complete loss of the PEPFAR-supported KP ART program is devastating to the HIV program and needs immediate response. A lack of reopening of KP specific service delivery in a country that has conflict and high stigma will lead to an increase in AIDS-related mortality, a resurgence of opportunistic infections, and the development of drug resistance among KPs.

2. Primary Prevention

Prior to the funding cuts, emphasis was placed on combination HIV prevention, including the promotion of knowledge of HIV status through testing, as well as condom use, post-exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP) for KPs.

The DRC prevention program relied on testing as an entry to prevention services. The program had scaled-up community-based HIV testing services (mobile and linkage through index modalities), other sexual network and partner notification strategies, and integrated supervised self-testing to increase the reach of first-time testers, people with undiagnosed HIV, and those at ongoing risk, including TGs and MSM.

The funding cuts however represent a catastrophic setback, threatening progress, with an 86% loss of testing coverage. HIV tests have become rare and less accessible. Testing campaigns, including targeted testing and self-testing, have been severely reduced. Out of the 348,000 KPs targeted for HIV testing services in Q1 2025, only 48,000 (16 sites) had access to testing, leaving 300,000 without access[13].

Prior to the funding cuts, PrEP was still in the expansion phase, with efforts concentrated on urban areas and certain priority sites for MSM and LGBTQIA+ communities. Coverage was still insufficient to meet the national need and PrEP initiations were low. For FY24, the program had plans to revise policies and scale up programmatic access to PrEP for higher-incidence populations including SWs, MSM, TG, and other identified higher-incidence populations[14].

The program also intended to expand PrEP at facility/community entry points and ensure direct and immediate assessment for and offer of PrEP to HIV-negative clients found through testing, HIV-negative partners of index cases of KPs and adult men engaged in high-risk sex practices.The commodity supply plan was going to accommodate PrEP expansion in FY24 and be closely monitored to avoid stock-outs[15].

By the end of December 2024, only PEPFAR-supported sites (91/116) offered PrEP and by July 2025, following the cessation of PEPFAR support, all KP PrEP sites shut down. 21,630 KPs had no access to PrEP by July 2025[16].

Shortages of condoms and a reduction in combined HIV prevention education programs are also visible on the ground.

Programmatic Disruptions

- **KP PrEP site losses:** All PEPFAR-supported sites that offered PrEP (91/116) shut down.
- **Community PrEP losses:** 21,630 KPs had no access to PrEP by July 2025[17]
- **Testing losses:** Only 48,000 out of the 348,000 KPs targeted for HIV testing services in Q1 2025 had access to testing[18].

[13] Source: estimation of attendance at friendly centers. [14, 15] Democratic Republic of the Congo Country Operational Plan (COP) 2023 Strategic Direction Summary [16, 17] The Excel tool on rational KP/PNLS targets - Micro Planning 2024 [18] Source: estimation of attendance at friendly centers.

Restoration of PrEP Access and Readiness for Injectable PrEP Rollout

Long-acting injectable PrEP in DRC would be a game changer in HIV prevention. The country's conflicts and the effects of war make long-acting PrEP a vital addition to the health care system. The country needs to focus on policy development and demand creation to hasten the process of access and ensure that the products are widely available and taken up by those at high risk. Offering injectable PrEP services and restoring the prevention infrastructure are also vital to the success of prevention options in the country. The country should restore KP-led prevention services, rebuild commodity supply chains and delivery, and invest in outreach infrastructure capable of supporting equitable, stigma-free access for next-generation PrEP tools.

Non-negotiable Priorities:

- **Restore HIV testing and awareness.** Access to testing creates the gateway to prevention and the loss of testing in DRC will have a great impact on the uptake of prevention. Prioritise targeted screening in high-risk populations and communities, with an emphasis on differentiated approaches to reach missing cases.
- **Restore PrEP access:** Restore access to PrEP for KPs who lost access due to the funding cuts.
- **Reinstate KP-led prevention sites:** Prioritise operational support for KP-led prevention service delivery sites to increase access to testing and prevention, including PrEP initiation and retention.
- **Create policy and demand for long acting PrEP.** Create inclusive policies that prepare the country for the introduction of long-acting PrEP
- **Strengthen coverage and accessibility:** Extend the provision of PrEP in all regions, particularly in rural areas, PEPFAR-abandoned zones, and conflict-affected areas.
- **Train health providers on KP-competent prevention:** Strengthen capacity of public and private sector providers to deliver non-judgmental, evidence-based prevention services tailored to KP needs.
- **Restore access to other prevention options:** restore condom and lubricant distribution systems and stop the frequent stockouts especially in remote areas. Strengthen awareness campaigns on HIV prevention methods, using adapted and innovative communication channels and ensure commodities are available for uptake by KPs and ensure availability of commodities for uptake.

What is the cost of inaction? The loss of prevention tools represents a catastrophic setback for the DRC, threatening decades of progress and the lives of millions of people. Access to prevention is critical to reducing HIV infection. The current status where testing and prevention options are not available presents a dangerous future for the country that will lead to increased HIV transmission due a lack of awareness of HIV status or access to protection from HIV.

Strategic Element	Current Status	Annual Funding Required	Key notes
HIV Test Kits	HIV testing commodities limited	$69,820	These commodities are needed to increase HIV status awareness
KP-serving public sites, including community HIV testing	Unsafe	$7,776,704	Scale up KP sensitisation at general health facilities and KP-specific service capacity and training. KPs experience a lot of stigma in public facilities which are not friendly or professional towards KPs.
Oral PrEP Commodities	No commodities	$15,149,424	Include support for commodities, supply chain and last-mile delivery
Len PrEP Commodities	New PrEP Commodities	$6,842,360	Include setting up sites and support for commodities, supply chain and last-mile delivery
Prevention Commodities (condoms, PEP etc)	Supply chains disrupted	$40,090	Condoms, lubricants, and HIV self-testing kits distributed through community networks
Demand creation and awareness building	Unavailable	$400,900	Expand demand creation and include those in rural settings as well
Facility HIV testing, including public facility integration	Reduced by 86%	$159,696	Training and support for KP-competent care in mainstream facilities and restore HIV testing
Service delivery: Index testing-community	Reduced	$ 402,958	Restore index testing in the communities
Support for KP engaged policy updates to expand prevention access		$200,000	Update policies to expand HIV Prevention

Primary Prevention Funding Gap: Approximately **$31,041,952** annually to restore comprehensive prevention services with peer support networks.

3. Sexual Transmitted Infections

In the DRC, STI treatment for key populations is managed by the Ministry of Health (MoH), supported by international partners and local organisations. The strategies used to reduce STIs—particularly among KP are implemented through a combination of medical, behavioral, structural, and community-led approaches and include treating based on symptoms without lab testing (syndromic case management), routine STI screening for KPs, promotion and free distribution of condoms and lubricants, peer education and outreach, partner notification and treatment, and mobile and community clinics. Compared to Jul-Dec 2024, STI screening dropped significantly due to the closure of community clinics.

Non-negotiable Priorities:

- **Ensure 100% STI service delivery to reach all KPs with STI services** including screening and treatment.
- **Ensure access to STI screening and treatment commodities** is available easily in the community especially among KP led organisations as part of comprehensive services.

Strategic Element	Annual Funding Required	Key Notes
Service delivery	$491,900	Include management and follow-up
STI treatment	$2,405,400	Including commodities
STI lab monitoring	$801,800	Including lab commodities

4. Community Infrastructure

Prior to the funding cuts, PEPFAR in collaboration with the National AIDS Control Program (PNLS), implemented programs in three key provinces and intended to continue saturation efforts in 57 health zones and select military sites, reaching patients in over 600 clinical sites. However, stigma and discrimination was still a big barrier to access for KPs who did not benefit from the policies and strategies that emphasised human rights and ending stigma and discrimination against people living with HIV.

The "One-Stop Shop" approach integrating HIV/FP (Family Planning) services was well accepted and the strategy of decentralising care was underway, with the integration of PODIs (Points of Dispensation) into the national plan and the expansion of ART sites. By the end of December 2024, there were 91 PEPFAR-supported sites and 25 GF-supported sites operating that served KPs.

CLM was a PEPFAR requirement, and a component of PEPFAR's strategy and was allocated $1,500,000 (from 2023-2025) to ensure quality data collection by communities to improve the quality of services[19]. CLM implementers gathered quantitative and qualitative data about HIV services, developed and advocated for solutions to the gaps identified during data collection, in collaboration with service providers and health care leadership. PEPFAR/DRC supported five CLM actors within all the PEPFAR-supported provinces who shared findings, including stock outs of some HIV/AIDS commodities in some health zones, the long delay in the return of viral load results to beneficiaries, reception of some ARVs with short shelf lives, and stigma and discrimination.

[19] Democratic Republic of the Congo Country Operational Plan (COP) 2023 Strategic Direction Summary

However after the cuts, service delivery by community-led organisations was affected by the reduction/ suspension of services. While there was increased demand there was fewer resources and loss of staff[20]. KP community services including ART which were available in specialised KP and LGBTQIA+ PEPFAR-supported sites until the end of December 2024, where no longer available by July 2025. There was a complete shutdown of the 91 PEPFAR supported sites. Only the 25 GF supported sites remained, of which 16 are community sites and 9 are integrated sites. Peer support programs to improve adherence, awareness, and testing were also terminated at PEPFAR-supported sites and 910 staff lost employment.

There is increased difficulty in accessing government or donor support. There is also a loss of funding for monitoring activities and a reduced ability to collect and report data[21].

Prior to the cuts, increased government commitment resulted in strengthened national strategic plans, with the integration of HIV control into health policies such as the PSN/KIPOP (National Strategic Plan for Key Populations) and the network of identity organizations in the DRC, supported by the HIV control program. However the work remains unfinished even though it remains an absolute priority for HIV control in the DRC.The funding and assistance in program supervision that was provided by PEPFAR and UNAIDS is also at a standstill following the end of the PEPFAR program and the freeze on GF funding.

The involvement of community-led organisations in policy design, advocacy, and work on societal enablers has been affected, resulting in a limited ability to advocate for key issues, a shift in focus due to funding constraints, and a reduced participation in policy discussions[22].

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Peer navigators/Outreach workers	100% reduction	All outreaches were terminated reducing ability to find community members
Outreaches	100% reduction	All outreaches were terminated reducing ability to find community members
Drop-in centres	100% reduction	All PEPFAR-funded drop-in centres terminated, significantly reducing safe space availability
Community-led monitoring programmes	100% reduction	All 5 PEPFAR-supported CLM programmes due to loss of training, tools, and coordination support

[20, 21, 22] https://www.unaids.org/en/resources/presscentre/featurestories/2025/may/20250502_drc

KP organisations conducting legal and rights protection services	70% reduction	All PEPFAR-supported sites were closed leaving only the GF site with account for 30% coverage
Community infrastructure reduction	Between 78-86% reduction	As of July 2025, only 16 community-led structures remain operational, providing services to KPs compared to 116 operational at the end of December 2024.

Non-negotiable Priorities:

- **Scale up the national KP coalition or network with capacity** to convene, consult with and mobilise communities by supporting the finalising of the establishment of the network of KP organizations.
- **Restore the peer cadres and outreaches** that were significantly weakened, to strengthen peer-led prevention, testing, initiation, treatment and adherence support and tracing to re-engage those lost to care after service disruptions.
- **Restore institutional support systems for KPs** by restoring and funding KP-led service delivery and rebuilding the capacity for HIV prevention and treatment response among KPs by reopening the 91 community sites, implementing differentiated service delivery models and restoring the inadequate or degraded community health centres dedicated to KPs that are outdated or inaccessible.
- **Strengthen the advocacy for a safer legal environment for KPs** and sexual and gender minorities. The uptake of services is better where people feel safe to receive services. Ensure confidentiality and fund programs that support the protection of human rights and reduction of stigma/discrimination.
- **Restore CLM programs** to ensure that communities have the ability to monitor the quality of services offered to peers and improve the programs outcomes.
- **Restore staff to health facilities.** A big barrier to access is few staff at health facilities which often leads to increased stigma and reduced quality of services.
- **Ensure effective governance and adequate funding** for the HIV program. Increase domestic funding for the HIV/AIDS response, aligning with the objectives of the GF and other partners.

Strategic Element	Current Status	Annual Funding Required	Key notes
KP-led drop-in centres	All PEPFAR-funded centres terminated	$7,577,010	Drop-in centres are needed to ensure safe spaces for KPs
Outreaches	100% reduction	$12,380,211	All outreaches improve KP outcomes
Peer cadres	100% reduction	$12,027,000	Peer education programmes are needed to increase service to KPs
Staff support	Extremely Limited	$26,890,191	Restore the capacity of KP led organisation to hire staff, including clinical staff
Community-led monitoring	Completely eliminated	$2,004,500	Restore CLM capacity with training, tools, and coordination mechanisms
Human rights & legal protection	Restore structural intervention programmes	$701,575	Violence prevention and response, legal aid, law enforcement engagement, and human rights monitoring across priority counties.
KP Network support	Support and coordinate KP programing	$260,585	Coordination of KP organisation and KP programmes.

Community Infrastructure Funding Gap: $61,841,072 to rebuild essential community systems and protective mechanisms.

What is the cost of inaction? The HIV program needs community infrastructure to be successful. Many civil society organisations (CSOs) and associations of KPLHIV, who play a vital role in access to services, stigma reduction, psychosocial support, and patient monitoring, are experiencing partial and total funding losses, massive layoffs and the suspension of essential programs.

5.Data and Monitoring Systems

data to understand which populations (gender, age, risk groups) are missed or lag behind other populations in the clinical cascade, to identify evidence-based short-and long-term solutions appropriate to reaching those populations and to implement and scale those solutions according to standards and fidelity.

Prior to the funding cuts, PEPFAR invested in strategic information (SI), technical assistance, including the scale-up of the electronic, HIV-specific, patient-level reporting system known as Tier.net, and the ongoing roll out DHIS2 as the national health management information systems (HMIS). Modest targets were set for COP23 as the program improved program data and undertook population-based HIV incidence and impact assessment (PHIA) survey to better understand the epidemic.

After the funding cuts, no summary sheets, preliminary results, or public reports from the DRC PHIA survey (CODPHIA) had been released and KP data collected at the community level was lost due to the closure of KP sites.

Key Estimates of Losses (December 2024- March 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Data Disaggregation	Complete loss	Data tools no longer disaggregated for KPs; no access to up-to-date KP-specific data.
Data collection and entry	Partial loss	Key data collection staff were terminated impacting data collection and reporting efforts
PHIA	Data not released	No summary sheets, preliminary results, or public reports from the DRC PHIA survey (CODPHIA) had been released.

Non-negotiable Priorities:

- **Restore high-quality, disaggregated data** for an effective prevention and treatment programme for KPs.
- **Replace outdated monitoring and data collection tools** with digitalised collection tools and train staff to use it effectively.
- **Restore staff who supported data collection.** This includes data clerks, health records and information officers (HRIOs) and M&E officers including peer educators and field officers/outreach workers.
- **Improve reporting and management systems for ARV** stockouts and other essential commodities and organise regular performance reviews with partners and stakeholders to assess progress and adjust strategies.
- **Finalise and share the results of the PHIA.** The data collection was done, however no new information has been released on the status of the PHIA and its results.

Strategic Element	Current Status	Annual Funding Required	Key notes
Disaggregated data	Not collected	$550,000	Restore high-quality, disaggregated data
Data collection and entry	Terminated	$550,000	Restore data collection staff support
Updated data collection tools	Unclear	$354,500	Support digitalised data collection on all parts of the country
Commodity tracking	Ineffective	$250,000	Track data on commodities to reduce stockouts
PHIA	Incomplete	$300,000	Release PHIA data to support programming

Data and Monitoring Systems Gap: $2,004,500 annually to rebuild data and monitoring

What is the cost of inaction? Data on KPs is vital for a successful HIV program.The elimination of KP-disaggregated data collection creates critical blind spots in the response. If the data is not effectively collected, the country will not be able to effectively respond and plan for the HIV program.

Summary of the proposed cost of the DRC Key Population Plan

Targeting and Costing Methodology

In DRC, the methodology used the national population size estimates from PEPFAR and UNAIDS KP Atlas. Where lacking an estimate for TG, a standard percentage from the region is used. We considered the percentage of KPs that need prevention services (set initially at 90%). We further estimated KP living with HIV using HIV prevalence from PEPFAR or the KP Atlas. Where lacking prevalence data, a standard percentage from the region is used. We had considered % of KPLHIV in need of treatment services (set initially at 100%). To meet the DRC budget, the country will focus on 100% of treatment and 100% as indicated below. Prisoners and clients of FSW are not included in the costing exercise. It will cost DRC $101,941,264 for prevention and treatment for 500,400 KPs.

The itemised costing of each intervention is found on this link: DRC Targeting and Costing

DR Congo Priorities	Costs	Total	Cost per target	General costs	GBV	Testing	TX	Biomedical Prev	STI
Priorities	Costs	**$101,941,264**	$185	$7,451,040	$329,226	$4,490,026	$7,722,301	$74,330,870	$7,617,802
	Percent of total			7.31%	0.32%	4.40%	7.58%	72.92%	7.47%
		National Targets							
Targets	KP Treatment	**51,800**							
	KP Primary Prevention	**498,600**							
	Total	**550,400**							

Methodology

This rapid strategy and budgeting exercise was designed as a structured assessment process to capture country-level impacts of foreign aid transitions and identify essential services requiring continued investment for KPs. The methodology began with orientation to a standardised Excel worksheet framework designed to systematically capture country coalitions' assessments across three critical domains: ART service delivery, HIV prevention programming, and community infrastructure (including civil society engagement, community-led monitoring, community mobilization, and advocacy capacity).

The assessment process examined three distinct time periods: baseline status at the end of 2024, immediate impacts following foreign aid transitions that began in January/February 2025, and current conditions as of June 2025. Country coalitions collected quantitative and qualitative data through surveys, key informant interviews, organisational assessments, and coalition consultations to document service disruptions, funding gaps, and programmatic changes across these timeframes.

Following data collection, coalitions engaged in facilitated consensus-building processes to analyze findings, identify priority concerns, and develop collective views on current programming status. Through these discussions, coalitions articulated their "essentials"—critical activities, services, and investments necessary to maintain effective HIV responses for KPs in their contexts. This worksheet was used as the basis for a strategy narrative, developed by the GBGMC support team, that included a summary table of priority interventions requiring funding and attention.

DRCs Methodological Guide:

KP communities held a hybrid workshop in-person meeting in Kinshasa and online with delegates from key population organizations from provinces such as Haut Katanga, Lualaba, Goma, Bukavu, and Mbuji-Mayi, with technical support from the PNLS (National AIDS Control Program) and financial support from a local partner, GAVIES (Guardians of Life), to review the various reports on data concerning KPs at the national level. Evidence from all stakeholders was used to develop the document.

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