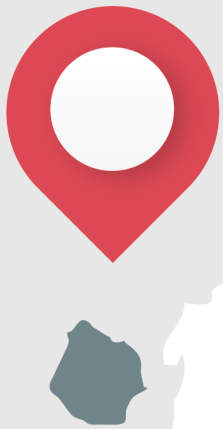
Eswatini:

Key Populations' Strategic Priorities



Introduction

By the end of 2024, Eswatini's Key Population (KP) programme operated through support from USAID and The Global Fund for HIV TB and Malaria (GFATM) and technical support from the Ministry of Health (MoH), with services provided in two Drop-in Centres (DICs) and at community hotspots through mobile clinic outreach. USAID was supporting a comprehensive KP HIV programme, including support for structural, biomedical and behavioral activities, Integrated Biobehavioral Surveillance Survey (IBBSS) studies, capacity development for KP organisations, clinical services in DICs and mobile outreach remuneration for programme staff. On the other hand, the Global Fund supported part of the structural interventions, outreach workers remuneration for certain districts, and mobilisation for pre-exposure prophylaxis (PrEP) services.

KP groups had been fully engaged with the MoH in national HIV planning, including inputting into the country's HIV response strategic documents such as the national strategic framework and the sustainability roadmap, which identified no government funding support for KP programme service delivery. KP-led organisations and other civil society organisations (CSOs) participated in all technical working groups convened by MoH. KP CSOs also participated in CCM meetings and have a representative member. Furthermore, KP CSOs also participated in other national and regional-level activities coordinated by MoH, especially those related to HIV programmes.

The suspension of PEPFAR funding in January 2025 resulted in the complete cessation of mobile clinic outreach to KPs and the suspension of services at both the mobile clinics and KP Drop-in Centres (DIC) that operated as comprehensive service delivery points, providing HIV clinical services including testing, treatment, and prevention, psychosocial support services, among others. This has led to a total shut down of all KP-specific service delivery, with 0% of KP sites operational in June 2025 as compared to December 2024. Public facilities continue to operate without KP-specific accommodations or data collection.

As of June 2025, KPs continue to cope with a complete shutdown of community-based services that has forced KPs to access care through public facilities that are not receptive and lack KP competency. Anti-transgender rhetoric and Executive Orders[1] from the United States government (USG) have undermined sexual orientation and gender identity (SOGI) sensitization training for healthcare workers. As a result, some KPs seeking care in mainstream facilities are being told to return to community-based services.

The cuts have also resulted in the complete loss of KP-led organisations, advocacy capacity, and community infrastructure representing one of the most severe contractions of KP programming documented in the region. The only 2 PEPFAR-funded KP-led service delivery DIC have lost all their service delivery funding and the ability to retain KPs in care and treatment programmes.

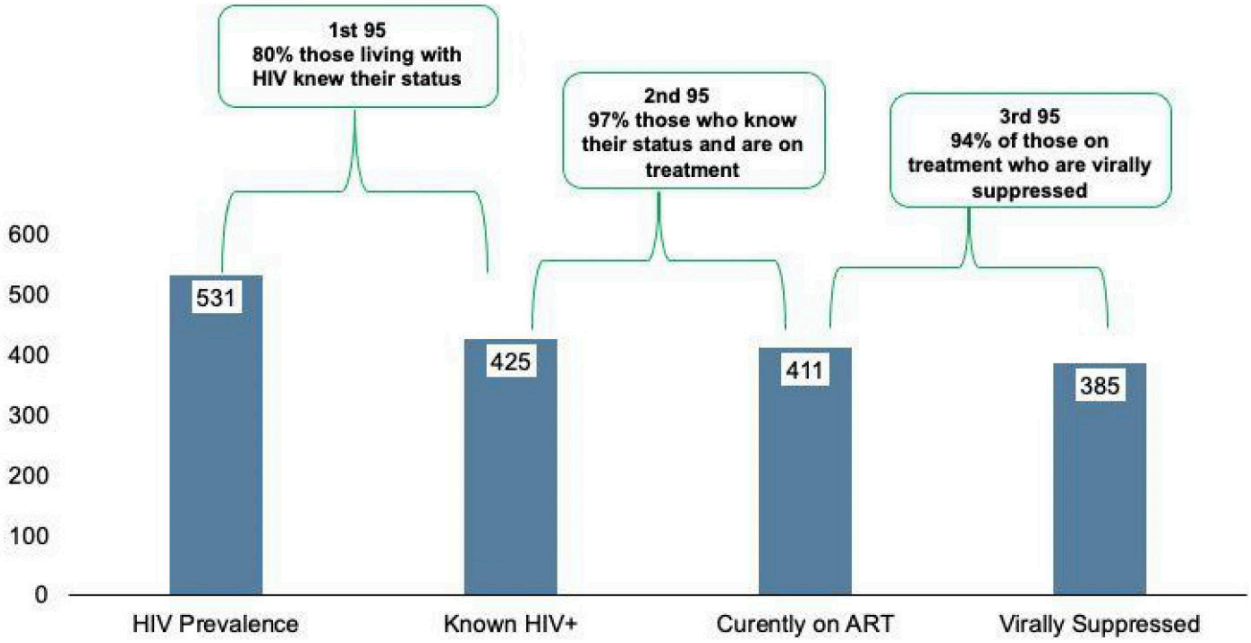
The Eswatini coalition of KP organisations have identified essential elements for restoring critical services and rebuilding the foundation for sustainable KP programming, recognising that complete reinstatement of previous service levels is not just essential but imperative.

What does the data say about HIV prevalence among KPs in Eswatini[2]?

Population Group	HIV Prevalence (%)	Data Source
Female Sex Workers (FSW)	58.8%	IBBS 2021
Men who have Sex with Men (MSM)	21.5%	IBBS 2021
Transgender Individuals	42.5%	IBBS 2021

[1] https://www.whitehouse.gov/presidential-actions/2025/01/defending-women-from-gender-ideology-extremism-and-restoring-biological-truth-to-the-federal-government/ [2] Eswatini_EpiC_FY24Q4_POART 2

Where was Eswatini on the 95/95/95 track[3]?



The IBBS 2021 data shows progress in the 2nd and 3rd 95 in the KP HIV response, however significant gaps exist in the 1st 95. The gaps are likely to be widened by the current PEPFAR funding cuts as well as the GFATM reprioritisation.

KP Size Estimates[4]

- FSW: 14,581
- MSM: 4,000
- Trans & Non-Binary Persons: 120
- PWID: 754

[3, 4] Eswatini_EpiC_FY24Q4_POART 2

Programmatic Disruptions

- **Termination of Community-Level Service Delivery:** Services provision at community level through mobile clinic outreach to KP stopped from January 2025.
- **ART Service Losses:** Service delivery at the two KP-led DICs has been stopped since January 2025. This has resulted in treatment interruptions, poor linkage to government facilities, and experiences of stigma from facility staff.
- **Suspension of Prevention Initiatives:** All HIV prevention services at community level have been stopped, including provision of health information and services.
- **Reversal of Stigma reduction gains with Healthcare Workers:** Milestones achieved from sensitising health care workers (HCWs) on stigma against KP have been reversed due to the precedence set by the anti-LGBTQ agenda of the current US government.
- **Stalling of Sustainability Planning Efforts:** The ongoing development of the sustainability roadmap for HIV programmes at national level which were largely PEPFAR funded have since been stopped. The MoH has not allocated resources to continue the effort.
- **Deterioration of GBV and Mental Health Services:** Access to GBV services and psychosocial support are not conditional to life saving services.

With these gaps, KPs are facing forced integration into unfriendly public facilities. Access to prevention and treatment programmes including health information is no longer available at KP service delivery sites. KPs have already reported experiences of stigma at public facilities, demonstrating a deterioration in the quality of care in the KP programme.

KP Community Core Priorities

1. Antiretroviral Therapy (ART) and Service Continuity

As of December 2024, ART service delivery remained available at all public health facilities serving both general and KPs. KP-led service delivery platforms—including two PEPFAR-funded DICs and outreach programmes at community level. Community-led infrastructure—played a critical role in ensuring differentiated care for KPs.

The programme achieved substantial coverage with an estimated 21,031 KP reached between October 2023 and September 2024, 8932 tested for HIV in that same period. Furthermore, 321 KP were tested positive for HIV and 311 were initiated on treatment. There were 8611 KP who tested negative for HIV and 3663 were initiated on PrEP[5]. These numbers reflect the effectiveness of the community-based service delivery model in reaching KPs who might not otherwise access care through public facilities.

However, since January 2025, the only 2 KP-led DICs were terminated, and all other community level service delivery was terminated, resulting in a 100% reduction in ART service delivery capacity at the community level by June 2025, while public facilities continued to operate at 100% capacity but without KP-specific accommodations or data collection capabilities.

The termination of community-level services created severe disruptions in treatment continuity. Many reported cases of treatment interruption occurred among KPs who had been receiving services at the community level. Challenges emerged when linking these clients to government facilities, as these facilities proved not receptive, citing that KP clients should continue with services at the community level that no longer existed.

[5] Eswatini_EpiC_FY24Q4_POART 2

KPLHIV Currently on ART[6]	FSW	MSM	TG	PWID
October - December 2024	753	531	12	26
January - June 2025	346	184	9	8
Total Reduction By June 2025	407	347	3	18

During this period, the number of KP clients on ART declined from 1,322 (December 2024) to 547 (Community June reports 2025), representing a net loss of 775 clients, a 58.6% loss[7]. Service reductions extended across the prevention and treatment cascade, including STI and TB services.

Key Estimates of Reductions on ART (December 2024 - June 2025):

The suspension of PEPFAR funding in January 2025 resulted in the complete collapse of Eswatini's PEPFAR-funded KP-led service delivery infrastructure, representing one of the most severe disruptions documented in the region.

AREA OF IMPACT	DEC 2024	JUNE 2025	REDUCTION
Number Tested HIV Positive	79	0	79
Total Number KPLHIV Currently on ART	1,322	547	775
Number Screened for STI	2473	0	2473
Number Diagnosed with STI	146	0	146
Number Treated STI	146	0	146

Non-negotiable Priorities:

- **Restore and fund KP-led service delivery:** Prioritise funding and operational support for the terminated KP-led DICs to restore trusted access points and client-centered service models.
- **Scale up access to ART commodities for KPs living with HIV in the DICs.** Ensure uninterrupted access to ART commodities for KPLHIV in DICs to mitigate risks of loss to follow-up and treatment interruption.
- **Scale up support for additional peer cadres to fill the gaps created by the closure of KP-led sites.** Ensure uninterrupted deployment of peer educators and lay cadres to address service continuity gaps and re-engage clients lost during the disruption.
- **Train health service providers in KP serving general population ART sites on KP service delivery.** Implement targeted training for healthcare workers in public ART sites to enhance delivery of KP-competent services and reduce stigma-related barriers.
- **Scale up KP centres and ensure they have the capacity to be one-stop centres of excellence offering opportunistic infection diagnosis and treatment and TB diagnosis, prevention and treatment.** Equip KP centres to function as one-stop hubs delivering comprehensive care listed in the KP core package of care.
- **Scale up and maintain viral load access by ensuring commodities are available and wait times are shorter.** Ensure sustained availability of viral load testing commodities and reduce result turnaround times to support clinical decision-making and treatment monitoring.

[6,7] Eswatini_EpiC_FY24Q4_POART 2

Strategic Element	Current Status	Annual Funding Required	KP Community Impact
ART commodities	Available	$100,000	The commodities are available. The government should ensure no stock out resulting in interruptions.
KP-specific ART sites	100% terminated in the 2 KP DICs resulting in 100% loss in KP ART service capacity.	$202,408	Clinical programmes at KP-service delivery sites need to be restored. **including the 2 DICs and community mobile clinic outreaches in 56 districts**
KP-friendly public sites, including community HIV based testing	Funding stopped in January 2025	$180,000	Stigma reduction interventions need to be reintroduced along with facility-level KP competency training.
Peer cadres and support	Funding will be not available from August 2025	$311,655	Comprehensive re-engagement strategy including peer outreach, mobile services, and facility-based support
Opportunistic infections (OI) diagnosis and treatment	100% terminated in the 2 KP DICs	$74,600	OI was provided in DICs and at community level through mobile clinic outreach and stopped since January 2025.
Viral load (VL) monitoring	Not available at community level	$75,200	Currently community-level mobile clinic facilities are terminated and KP cannot access VL services closer to them.
TB diagnosis and prevention	100% terminated in the 2 KP DICs	$73,400	Currently community-level mobile clinic facilities are terminated and KP cannot access services closer to them.

ART Funding Gap: Approximately **$1,017,263** annually to restore comprehensive, peer-supported ART services for KPs.

What is the cost of inaction? In just 6 months access to KP specific ART, peer support, OI, TB and viral load monitoring services in Eswatini has been significantly degraded as a result of the PEPFAR funding cuts that resulted in the termination of the 2 KP-led DICs in the country. Without a swift and speedy remedy to this situation, it will only get worse.

2. Primary Prevention

Prevention is a key component of the HIV programme for KPs in Eswatini. Historically, Eswatini has been at the forefront of PrEP implementation, which commenced in 2015 with one of the largest national pilots in Africa. This work rapidly expanded through innovative differentiated service delivery and ongoing implementation science to improve services and increase uptake and use. The national plan included the two KP-led DICs, which until January 2025, provided access to condoms, lubricants, KP-friendly HTS services, PrEP and post-exposure prophylaxis (PEP) services, STI services, TB and OI related services in addition to GBV and mental health support services among others. In addition, these services were also available at the hotspots and through outreaches and mobile clinic services facilitated by peer cadres.

However, since the US government (USG) funding cuts in January 2025, the two KP-led DICs have been unable to provide services. Outreaches and mobile clinics for KPs have also been terminated, representing a 100% reduction in community-level service delivery models in Eswatini. This has had a negative impact on prevention and treatment interventions such as access to KP friendly HIV testing services, PrEP/PEP, OI, and GBV. All prevention services for KPs can only be accessed in public health facilities where community members have reported ongoing stigma and discrimination concerns.

The programme achieved meaningful coverage with approximately 7,875 KPs offered PrEP services.[8] and 3,242 new PrEP initiations in the same period. This service became unavailable at community level after the cuts, forcing reliance on public facilities that lacked KP-specific service models.

Key Estimates of Reductions on Primary Prevention (December 2024 - June 2025)

Reduction of services among KP (These number represents the reduction in KP receiving services across all KP-serving health facilities and DICs in Eswatini)

Area of impact	Dec 2024	June 2025	Reduction
Number reached	2947	4191	-
HIV Testing	1826	0	1826
Number receiving condoms	22560	0	22560
Number receiving needles & syringes	0	0	-
Number receiving lubricants	14434	0	14434
Number Screened for STI	2473	0	2473
Number Screened for TB	2467	0	2467

[8] Eswatini_EpiC_FY24Q4_POART 2

Current Planning for Long-Acting PrEP Rollout

In April 2024, PEPFAR planned to introduce two-monthly long-acting injectable CAB LA in partnership with the MOH with an initial 2,000 vials to 333 end users including KPs with additional doses expected for an additional 5,165 people. It is unclear, at this point, whether the investment in CAB LA will continue to move forward with PEPFAR support, however, continued investment on oral PrEP and long-acting PrEP is crucial for the KP programme.

While the government plans to roll out long-acting, six-monthly, injectable lenacapavir (LEN), ensuring KPs are not left behind is key. Current processes include engaging stakeholders (partners, WHO, USG representatives, Global Fund, among others) through a country PrEP core team that is led by MoH. MoH leadership have approved the introduction of LEN and are engaging partners for financial and technical support. The MoH is also preparing to integrate LEN in the current PrEP guidelines which will be informed by the WHO LEN guidelines newly released.

Non-negotiable Priorities:

- **Restore PrEP access:** Re-establish oral and injectable PrEP access points within community-led DICs to reverse coverage declines and meet current demand among KPs.
- **Reinstate KP-led prevention sites:** Prioritise operational support for the 2 KP-led prevention service delivery sites to increase PrEP initiation and retention.
- **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.
- **Expand condom and lubricant distribution:** Condom and lubricant access has not been available since the stop-work orders began as a result of the termination of peer-led outreaches. Scale up peer-led outreach programmes to ensure consistent availability of condoms and lubricants in high-burden areas.
- **Initiate harm reduction programmes:** Harm reduction interventions are crucial for PWID communities, however these services including the provision of NSP and other key harm reduction programmes have not been available.
- **Scale up Opioid Substitution Therapy (OST):** Increase availability of buprenorphine and methadone at community sites, including provision of take-home dosing, to improve adherence and retention in care
- **Prepare for LEN rollout:** Restore foundational systems to ensure Eswatini is ready to fully implement the GF-supported introduction of injectable Lenacapavir for PrEP among KPs.

Strategic Element	Current Status	Annual Funding Required	Key notes
Oral and injectable PrEP commodities	PrEP medication, HIV rapid test kits, HIV self-test kits commodities are available but supply is uncertain	$383,680	Without continued investment from both the GF and PEPFAR, gaps in commodities will occur.
PrEP sites (free-standing)	Access to PrEP at KP sites has been disrupted.	$100,000	Support stopped from January 2025. As a result, there is no funding to continue providing services in the DICs and hotspots through mobile clinic outreaches.
Len PrEP commodities	New PrEP Commodities unavailable yet.	$200,000	Investment in LEN PrEP for KP should be prioritised.
Condoms and lubricants	Access to condoms and lubricants has been disrupted since January 2025.	$86,500	Condoms, lubricants, and HIV self-testing kits distributed through community networks need to be restored.
MAT sites, safe injecting equipment	No investment in harm reduction services or commodities.	$100,000	Initiate and scale up access to MAT services, procurement of commodities, including safe injecting equipment.
Demand creation and awareness building	Continued investment needed to ensure use of prevention and PrEP products in particular.	$100,000	Scale up demand generation activities with a heavy focus on social media.

Primary Prevention Funding Gap: Approximately **$970,180** annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? Access to prevention commodities such as condoms, lubricants, testing, health information, PrEP among others is essential. In Eswatini, however, these services have been severely disrupted and are no longer available or accessible without the risk of experiencing stigma and discrimination. Without access, gains achieved over decades will be eroded and lost.

3. Sexual Transmitted Infections

In Eswatini, the STI programme has made some progress within the key populations (KP) programme. Though gaps exist, the Eswatini National AIDS Programme has integrated HIV and STI prevention and treatment programmes for KPs to ensure increased access. Supported by PEPFAR, these services were accessible to KPs at the KP-led DICs and through outreach services prior to the implementation of the stop-work orders. Partners used online outreach and community based approaches to promote demand and increase access.

Since January 2025, STI services for KPs have been in decline due to the termination of KP-led service delivery sites as well as the peer outreaches and mobile clinics for KPs, access to stigma free STI services is no longer guaranteed.

Non-negotiable Priorities:

- **Restore STI service access at community level:** Screening and treatment of STI for KPs have been significantly degraded since the stop-work orders began. These services must be fully restored
- **Ensure STI commodities availability:** The disruption in the HIV funding landscape has cast doubt in the future of STI programmes for KPs. Investment in STI Treatment, diagnostic and other laboratory necessities must be restored and scaled up.

The non-negotiables and costs are shown in the table below:

Strategic Element	Annual Funding Required (USD)	Implementation Notes
Service delivery	260,200	Include management and follow-up
STI Treatment	74,000	Including commodities
STI Lab Monitoring	82,000	Including Lab commodities

Sexual Transmitted Infections Gap: Approximately **$416,200** annually to restore comprehensive STI screening, prevention and treatment.

4. Community Infrastructure

The Eswatini KP Consortium that represented KPs in Global Fund CCM process, government led health sector technical working groups, among others, ceased operation from January 2025 after the statement of funding cuts. By June 2025, the number of active KP-led organisations whose funding for advocacy and accountability work was reduced/terminated rose to 4.

These 4 organisations played a crucial role in providing safe spaces, shelter, food and psychosocial support to KPs and were involved in the KP-led community-led monitoring activities which were also terminated in January 2025.

a. Rights Protection and Advocacy Losses

All investments and gains made in sensitising health care workers on stigma against KPs were reversed due to the cessation of sensitisation programmes and policy changes that emphasised only biological sex recognition. Legal and rights protection services that had been implemented through PEPFAR-supported organisations were suspended, along with violence prevention education programmes.

b. Drop-in centres and Community Services

The 2 DICs operating as comprehensive service delivery points, providing HIV clinical services since 2019 lost their funding and the capacity to provide comprehensive KP services. These service delivery sites included, the Mbabane TRUE KP Community Centre and Manzini TRUE KP Community Centre. These centres provided access to the following key services for KPs.

- HIV testing
- ART
- Condoms and lubricants
- Mental health support
- Psychosocial support services
- PrEP/PEP

The mobile clinic outreach complemented the DIC services by reaching KPs at community hotspots, ensuring that those who could not or would not visit fixed facilities could still access essential services. This dual approach of facility-based and mobile services had proven effective in reaching KPs across all four regions of Eswatini.

c. Engagement in National HIV Planning

Before the funding cuts, Eswatini had established a vibrant network of KP organisations, including the Eswatini KP Consortium, which played a central role in coordination and advocacy on behalf of KPs. KP-led organisations represented their communities on national technical working groups and on the Global Fund Country Coordinating Mechanism (CCM).

These organisations led a range of community-based activities, including Super Group meetings, small group discussions for KPs, and national, regional, and community forums tailored to advocacy for specific KP sub-populations. By December 2024, KP engagement in national HIV planning was robust, with strong collaboration between KP organisations and the Ministry of Health.

However, the sustainability roadmap identified critical gaps — most notably, the complete lack of government support for service delivery within the KP programme. This underscored the programme's total reliance on donor funding.

Guiding Principles for Sustaining Effective KP Programming

- **Emergency restoration of community access:** Immediate priority on restoring community-level service delivery through mobile clinics and community-based distribution to bridge the gap created by public facility barriers.
- **Government engagement and integration:** Advance concrete actions to ensure general population public facilities provide KP-competent service.
- **Rebuilding organisational infrastructure:** Restore the collapsed KP-led organisational network, including the Eswatini KP Consortium, to rebuild advocacy capacity and community representation.
- **Data visibility and monitoring:** Reinstate KP-disaggregated data collection systems that were suspended, ensuring visibility of KP outcomes along the HIV cascade.

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

Area of Impact	Estimated Reduction	Narrative Explanation
KP-led DICs	100% capacity reduction	2 KP-led DICs were not able to resume service delivery.
Peer support Outreaches and mobile clinics	100% reduction	All peer outreaches and mobile clinic programmes for KPs were terminated, reducing the ability to find community members .
Peer cadres	100% reduction	Peer navigators essential for treatment continuity and adherence support and need for outreaches were terminated
Violence Prevention & Response	100% reduction.	Structural interventions are not considered life saving and have since been discontinued.
Advocacy organisations	Limited capacity/reduced funding	6 KP organisations experienced reduced capacity/termination of their advocacy/accountability programmes including the KP Consortium.
Social support programmes	50%+ capacity reduction	More than half of organisations providing food, shelter, and psychosocial support were negatively impacted
Community-led monitoring	100% elimination	CLM funding completely cut following stop-work orders

Non-negotiable Priorities:

- **Restore and scale up funding for the national KP coalition:** Resources terminated in January need to be restored to support the Consortium's capacity to convene, coordinate, convene and mobilise communities.
- **Restore and scale up KP advocacy and accountability funding:** Approximately 6 KP organisations lost funding that supported advocacy and accountability efforts targeting the government and relevant stakeholders. This support should be restored and scaled up.
- **Restore and fund KP-led CLM activities:** We recommend the restoration of funding towards community-led monitoring led by all communities, including KPs.
- **Restore and scale up violence prevention and response interventions:** KPs are often targeted by violence and abuse. Funds must be restored and scaled up to support prevention and response efforts. Criminalisation and stigma predisposes KPs to violence and funding and support need to be restored to respond to violence response against KPs and facilitate increased access to services.
- **Restore and fund KP-led service delivery:** Prioritise funding and operational support for 2 KP-led DICs to restore trusted access points and client-centred service models.

Component	Status	Annual Funding Gap	Explanation
National KP coalition	Ceased operation from January 2025	$65,444	PEPFAR-supported KP groups partners need funding to conduct critical activities including structural interventions, coordination and advocacy.
KP advocacy and accountability organisations	Organisations ceased or reduced operations	$80,000	Support for the 6 organisations that represented KPs on GF CCM and TWGs to resume advocacy functions.
Community-led monitoring	All programmes ceased operations	$30,200	Support four organisations conducting community-led monitoring. DIC are costed in the ART section
Legal and rights protection services	Support for structural interventions were fully terminated.	$37,500	Support for training of health care workers and police to protect rights for KP and other marginalised populations and support KP to conduct activities that support their rights.

Violence prevention services	Comprehensive violence prevention is currently not provided; only sexual violence response available	$20,600	Reinstate interventions previously implemented by KP-led PEPFAR-supported organisations

Community Infrastructure Funding Gap: $233,744 to rebuild essential community systems and protective mechanisms.

What is the cost of inaction? The KP programme has suffered a devastating blow with the termination of key KP community infrastructure. The termination of CLM, KP-led service delivery, KP violence prevention and response programmes including legal and rights protection services only stands to cripple the KP programme further. These challenges not only threaten the gains that have been made in the KP programme but they further undermine the sustainability of the KP programme.

5. Data and Monitoring System

Access to KP-specific data became severely compromised as public facilities do not collect KP-disaggregated information. The loss of community-level service delivery eliminated the primary source of KP-specific data along the HIV cascade, from testing through treatment and viral load monitoring.

The Integrated Biological and Behavioral Surveillance Survey (IBBSS) that was planned to start in March 2025, with protocols approved by all relevant IRBs, was immediately stopped when the US Government funding cuts took effect. This eliminated critical surveillance capacity for understanding KP epidemiology and programme impact.

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

Area of Impact	Estimated Reduction	Narrative Explanation
Data Disaggregation	100% reduction. No longer available.	Public facilities providing KP services do not collect disaggregated KP data.
Data collection and entry	Significant loss	Data disaggregation was only collected at KP-led DICs which are now not operating.
IBBSS and surveillance	100% reduction when ongoing IBBSS was placed on pause.	The protocol was approved and data collection was set to begin in March 2025. PEPFAR should restore funding and support full resumption.

Non-negotiable Priorities:

- **Restore high-quality, disaggregated KP data for an effective prevention and treatment programme for KPs.**
- **Restore staff who supported data collection.** This includes data clerks, health records and information officers and M&E officers including peer educators and field officers/outreach workers.
- **Restore the funding and implementation of the IBBSS for KPs:** The protocol was approved and data collection was set to begin in March 2025. PEPFAR should restore funding and support full resumption.

Strategic Element	Current Status	Annual Funding Required	Key notes
Disaggregated data	Data disaggregation stopped from January 2025 and KP services are no longer provided.	$75,570	Restore high-quality, disaggregated data
Data collection and entry	Terminated	$186,400	Salary support for programme staff to collect and disaggregate data and report to MoH and other relevant stakeholders for tailored academic control.
IBBSS and surveillance	Ongoing IBBSS data collection set to begin in March 2025 was paused.	$600,000	The process to implement IBBSS started in 2024 and stopped in January 2025 when the protocol was approved and before data collection started.

Data and Monitoring Systems Gap: $861,970 annually to rebuild data and monitoring

What is the cost of inaction? The stalling of the IBBSS negatively impacts the KP programmes ability to assess success and gaps and develop plans for improvement. Further, lack of access to disaggregated KP data impacts the KP programmes capacity to track outcomes, or advocate effectively for the necessary policy or programmatic changes needed.

Eswatini Key Populations Costed Strategy Summary

Targeting and Costing Methodology

In Eswatini, 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 Eswatini 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.

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

Eswatini Priorites	Costs	Total	Cost per target	General costs	GBV	Testing	TX	Biomedical Prev	STI	MAT
Priorites	Costs	**$3,502,457**	$184	$257,213	$11,365	$138,407	$1,520,607	$1,311,897	$262,969	$0
	Percent of total			7.34%	0.32%	3.95%	43.42%	37.46%	7.51%	0.00%
		National Targets								
Targets	KP Treatment	**10,200**								
	KP Primary Prevention	**8,800**								
	Total	**19,000**								

Methodology

This rapid strategy and costing 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 mobilisation, 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. The country coalition made of representatives from KP-led ad LGBTQI organisations collected quantitative and qualitative data from surveys, reports, and coalitions and community organisations consultations to document service disruptions, funding gaps, and programmatic changes across these timeframes.

Following data collection, the coalition engaged in facilitated consensus-building processes to analyze findings, identify priority concerns, and develop collective views on current programming status. Through these discussions, the coalition 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.

This narrative report with draft/indicative cost components was shared with subject matter experts who provided technical input on unit costs, coverage targets, implementation approaches, and country-specific considerations. Finally, the updated comprehensive narrative documents were shared back for validation processes with the originating in-country coalitions to ensure accuracy and authentic representation of community perspectives and needs.

The Team

We thank the many advocates, organisations, and government partners who participated in national consultations and supported the drafting of each plan. Your leadership and lived expertise are at the heart of this work.

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