Uganda:

Key Populations' Strategic Priorities

Introduction

Uganda's HIV response for key populations (KPs) is currently facing significant challenges as of June 2025, with the United States Government (USG) PEPFAR funding freeze compounding an already strained system, following the enactment of the Uganda Anti-Homosexuality Act[1]. The response is now characterised by widespread service closures, commodity stockouts, a sharp decline in community-led systems, and an increase in stigma and discrimination.

Prior to January 2025, the KP programme offered pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), medication assisted therapy (MAT), HIV testing services (HTS), anti- retroviral therapy (ART), viral load monitoring, psycho-social counselling, condoms, lubricants, sexually transmitted infection (STI) treatment, gender based violence (GBV) protection, emergency response support among other services. The Ministry of Health had approved PrEP options like the Dapivirine vaginal ring, daily oral PrEP pill, and the long-acting injectable (cabotegravir) for KPs. KPs were served through all the available health service delivery models, including outreaches, drop-in centres (DICs), KP-specific clinics and other differentiated service delivery models. The 103 KP-led and health facility-based DICs[2] were a central part of service delivery recognised by the government, subgranted and facilitated to offer KP services to all KPs in their catchment areas.

The coverage of HIV prevention and treatment drugs like ART and PrEP, varied significantly across KP groups. Men who have sex with men (MSM) and transgender (TG) people had lower coverage due to the stigma associated with the Anti-Homosexuality Act (2023). Many MSM and TG individuals relied on confidential services, including peer-led outreach and testing, as well as prevention and treatment provided on-site or via referral at community drop-in centres. People who use drugs (PWUD) had extremely low coverage rates for all services, with harm reduction programmes- such as needle exchanges and opioid substitution therapy (OST)-limited to urban areas like Kampala and Mbale[3].

What does the data say about HIV prevalence among KPs in Uganda? Men who have sex with men are at 12.7%, Female sex workers are at 31.3%, Men who inject drugs are at 8%, Women who inject drugs are at 24%, Transgender people are at 20%[4].

Where is Uganda on the 95/95/95[5] track? Diagnosed: In Uganda, 80.9% of adults living with HIV (aged 15 years and older) were aware of their HIV-positive status: 83.5% of women and 76.1% of men. Individuals were classified as aware if they reported their HIV-positive status or had a detectable antiretroviral (ARV) in their blood. On Treatment: Among adults living with HIV who were aware of their status, 96.1% were on ART: 96.7% of women and 94.7% of men. Individuals were classified as being on ART if they reported current ART use or had a detectable ARV in their blood. Viral Load Suppression: Among adults on ART, 92.2% had VLS: 92.6% of women and 91.3% of men[6].

As of June 2025, ART coverage among HIV-positive KPs was estimated at 54% (37,313/69,558), with ART coverage higher among people in prison (57%) and sex workers (52%) than men who have sex with men (39%), people who inject drugs (38%), and transgender people (14%)[7]. About 40% (87,148/216,433) of those initiating oral PrEP were KPs, with the majority being sex workers at 36% (77,085/216,433), followed by clients of sex workers at 16%[8 9].

By the end of 2024, Uganda's KP programming had made some critical progress despite facing serious challenges in the legal landscape. This progress was largely funded by international donors like PEPFAR, Global Fund, and others. PEPFAR funds 60% of Uganda's HIV programme and 90% of prevention efforts, while the Global Fund funds 37% of treatment and 7% of prevention efforts[10].

[1] https://www.parliament.go.ug/sites/default/files/The%20Anti-Homosexuality%20Act%2C%202023.pdf [2] https://cquin.icap.columbia.edu/wp-content/uploads/2021/08/SOP-Drop-In-Centre-DIC-Final-June-2020.pdf [3] Uganda AIDS Commission's Annual Joint AIDS Review Report 2023/24 [4] Uganda Ministry of Health report. (CQUIN Differentiated Testing & Linkage meeting | March 13-16, 2023) [5] https://www.unaids.org/sites/default/files/media_asset/progress-towards-95-95-95_en.pdf [6, 7, 8, 10] Uganda AIDS Commission. (2024). Annual Joint AIDS Review Report 2023/24. Kampala: Uganda AIDS Commission [9] Stigma and discrimination make it highly challenging to collect high quality, comprehensive data on the size of key population groups, and on HIV treatment and prevention cascades for these individuals, who may not disclose their KP identities while accessing services. We report these estimates with those caveats.

Because of this dependence, Uganda's HIV services were severely disrupted by the shifts in US Government and other foreign aid support that began in January 2025. No Time to Wait, a survey conducted between February and March 2025 of 72 key population (KP) serving organisations by the Uganda Key Population Consortium (UKPC), found catastrophic disruption in primary prevention services with restricted or loss of access to PrEP/PEP service reported by 73% (53 out of 72) of respondents, loss of access to condoms and lubricants reported by 70.8% (51 out of 72), and disruptions in HIV testing for 62.5% (45 out of 72).[11] More than two-thirds of respondents reported increased stigma; more than half said that they had dropped out of antiretroviral treatment and were experiencing major mental health challenges, and had lost access to services supporting sexual and reproductive health and rights, such as lubricants, family planning, and STI treatment and counselling.

A staggering 97% of community organisations in Uganda report financial constraints as follows: 66% of the organisations were supported by the CDC and 33% by USAID, with 43% relying on US funding supporting 76% to 100% of their budgets. The No Time to Waste survey found an 87% drop in client engagement, severing crucial community connections and threatening the health of Uganda's most vulnerable populations. Across the country, drop-in centres and safe spaces are no longer functioning due to a lack of financial support for organisational operations.

The erosion of access to prevention, treatment, and community infrastructure, which ensures continuity of care, along with increased stigma and marginalisation of KP voices, requires urgent investment in emergency restoration of services, renewed investment in peer-led structures, and strategic support for essential high-impact elements of KP programming.

The Uganda Key Population Consortium has 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, ART access for KPs had improved significantly under the Test and Treat policy, with KP-led organisations supporting their communities through differentiated service delivery (DSD) models. KP-friendly clinics and peer-led ART distribution models were scaled up, resulting in improved ART retention and reduced treatment interruptions.

In the September 2023 review period, 83% of 502,342 KPs were reached with testing, of whom 1.5% (4811) were HIV-positive. Among KPs diagnosed with HIV, 89% were initiated on HIV treatment, bringing ART coverage to an estimated 54% (37314/69559). Among KPs on ART who had a viral load test, 90% were virally suppressed[12].

However, after the funding cuts, only an estimated 70% (46 out of 66) of sites or facilities including those serving the general population attended by KPs, providing or supporting treatment for KPs living with HIV, remained operational in June 2025 compared to December 2024; 30% had closed down due to the funding freeze. In some areas, such as Buikwe and Ibanda, there is a complete closure of DICs, while urban centres like Kampala retain more operational sites limiting access to KPs mostly based in urban areas.

According to the KP survey,[13] after the funding cuts, access dropped by 62.5% for HIV testing. Measures to maintain KPs on treatment are currently inadequate, particularly given challenges like poor treatment outcomes and loss to follow-up. Other key barriers faced by KPs include the closure of community-run KP centres, which pushed many clients into mainstream health facilities where discrimination, fear of exposure, and poor treatment became

[11, 13] Uganda Key Populations Consortium. "No Time to Wait 2: Funding Cuts, Threatening Uganda's HIV Services and Community Health." Uganda Key Populations Consortium, 2025 [12] Uganda AIDS Commission. (2024). Annual Joint AIDS Review Report 2023/24. Kampala: Uganda AIDS Commission, Pg. 8

barriers to continued care. There was also a 67% increase in stigma as KPs were forced to seek care in general population facilities that lacked KP-specific training and safe spaces, and a 53% rise in mental health challenges among KPs. As reported in early 2025, safety and security for KVPs has also been compromised. Peer-based support, vital for treatment continuation, has weakened, with peer staff numbers dropping by 58% (from 12 to 5 per organisation).

The funding freeze and stop-work also resulted in stalled procurement & distribution. PEPFAR/USAID payments were paused and stop-work orders issued, forcing implementers to halt field operations and lay off logistics staff—disrupting routine deliveries of ARVs, PrEP, test kits, and lab supplies. A partial "life-saving" waiver was issued on Jan 28, but ambiguity and delays persisted[14]. Because of the stalled procurement and distribution, Uganda experienced ARV shortages—mainly in private not-for-profit facilities—with emergency redistribution and shipments expected from April 2025 to stabilise supply[15]. Supply chains for viral-load test kits and other diagnostics—and the sample referral network—were disrupted, undermining treatment monitoring and delaying clinical decisions[16].

The KP coalition's strategic vision recognises that the collapse of donor-funded standalone service provision requires immediate emergency response while building toward sustainable integration with public health infrastructure. The dramatic 51% drop from 5,446 in October-December 2024 to 2,661 in April-June 2025 in KPs accessing ART services and ART discontinuations that nearly doubled, rising by 94% from 3,077 to 5,983 individuals demand urgent restoration of peer support systems and KP-safe service delivery points.

Area of Impact	Estimated Reduction	Narrative Explanation
ART new initiations for KPs	55.8% reduction	New ART initiations dropped from 1315 to 581[17] per quarter due to outreach suspension and centre closures
ART retention	51.1% reduction	Estimated number of KP living with HIV who accessed ART (total) during the prior 3 months dropped from 5446[18] to 2661.
ART disruptions	94.4% increase	Estimated number of KP living with HIV who discontinued ART during the last 6 months increased from 3077 to 5983
PEPFAR staff impact	4,451 staff disrupted	Clinical staff, medical assistants, and HDAs across 10 implementing organisations affected

Non-negotiable Priorities:

- **Maintain and scale up access to ART commodities for KPs** living with HIV by stabilising financing and procurement, and bridging the gap domestically. Fast-track a supplementary allocation (e.g., Uganda AIDS Commission's (UAC) call for approximately UGX 300 billion) to cover ARVs, PrEP, VL reagents, condoms, and lab inputs while donor flows normalise[19].

- **Leverage Global Fund & pooled purchases.** Use emergency reprogramming and pooled procurement to backstop PEPFAR gaps; prioritise high-risk stock lines (second-/third-line ARVs, VL reagents)[20].

[14] https://www.wsj.com/politics/policy/state-department-reverses-near-full-stop-of-foreign-aid-70784f05? [15] https://www.unaids.org/sites/default/files/2025-05/UNAIDS_focused-analysis_HIV-commodities_en.pdf? [16] https://www.unaids.org/sites/default/files/2025-03/20250305-USstop-Sitrep.pdf [17, 18] Source (KP TRUCKER) [19] https://parliamentwatch.ug/news-amp-updates/uac-seeks-ugx-300-billion-to-offset-us-aid-freeze/ [20] https://www.unaids.org/sites/default/files/2025-03/20250305-USstop-Sitrep.pdf

- **Grant tax/clearance waivers and greenlane imports for HIV commodities during the emergency window**[21]. This recommendation is based on best practice and aligns with UNAIDS calls for predictability.
- **Issue clear standard operating procedures on the U.S. waiver**. Translate the 28 January "life-saving" exemptions into Ministry of Health (MoH) circulars so partners resume allowed distributions immediately[22]
- **Surge deliveries via National Medical Stores (NMS)/ joint medical stores (JMS)**. Use temporary weekend/ after-hours runs and cross-docking to clear backlogs; continue inter-facility redistribution while new consignments arrive[23].
- **Multi-Month Dispensing (MMD).** Where stock allows, move stable clients to 3–6-month refills to decongest facilities and cushion future shocks[24].
- **Ring-fence viral load (VL) early and infant diagnostic (EID) reagents and sample transport.** Restore the national sample-referral network first (drivers, fuel, couriers) to prevent silent treatment failure[25] and scale up and maintain viral load access at DIC.
- **Review and scale up sustainable models** (e.g., KP corners, DICs mobile clinics) and remove consolidated triage and drug dispensary stations
- **Scale up KP-friendly general population ART sites by training health service providers on KP service delivery** and create KP spaces to bridge DIC closures and to enhance human rights-based HIV services delivery approach to key populations.
- **Maintain opportunistic infection (OI) diagnosis and treatment**
- **Scale up and maintain and integrate TB diagnosis, prevention and treatment at DICs.**

Strategic Element	Current Status	Funding Gap	Key notes
ART commodities		$240,000	Ensure consistent supply of commodities to designated KP service areas and fix the supply chain issues
KP-specific ART sites	70% (46 out of 66) operational. 20 closed	$200,000	Review and scale up sustainable models (e.g., KP corners, DICs mobile clinics)
KP-friendly public sites	Limited KP sensitivity	$390,928	Need intensive mentorship and training for providers on KP-friendly services and create the KP spaces to bridge DIC closures
TB diagnosis & treatment	Severely limited	$190,000	Addresses co-infection; needs integrated TB/HIV services
Viral load access	Significantly reduced	$100,000	

[21] https://www.eatg.org/hiv-news/unaids-and-hiv-sector-struggle-amid-funding-cuts/ [22] https://www.wsj.com/politics/policy/state-department-reverses-near-full-stop-of-foreign-aid-70784f05 [23, 24] https://www.unaids.org/sites/default/files/2025-05/UNAIDS_focused-analysis_HIV-commodities_en.pdf [25] https://www.unaids.org/sites/default/files/2025-03/20250305-USstop-Sitrep.pdf

ART Funding Gap: Approximately **$1,120,928** annually to restore comprehensive, peer-supported ART services for KPs.

What is the cost of inaction? The drastic decline in the number of those initiating and accessing ART is alarming. This trend will only continue if urgent measures are not taken to curb and reduce the loss of KPs living with HIV from care. A lack of access will increase the risk of HIV acquisition among those not living with HIV as their partners may no longer be able to access ARVs.

2. Primary Prevention

The USG funding cuts triggered a severe funding shortfall, leading to stockouts of essential commodities like condoms and lubricants, PrEP, MAT for PWUD, and is preventing the introduction of the highly efficacious new, long-acting prevention products. Prior to the cuts, the National HIV prevention strategy had officially incorporated PrEP as part of HIV prevention approving PrEP options such as the dapivirine vaginal ring, daily oral PrEP pill, and the first long-acting injectable (cabotegravir) and making the policy widely available for KPs in government health facilities and DICs with peer-delivered services. In 2023, community-based pharmacy delivery of oral PrEP and PEP was initiated as part of a multi-country project in order to broaden and improve access to multiple populations, including KPs and other vulnerable groups. This was vital to increasing access to PrEP for KPs in the Kampala, Kabaale and Iganga districts. In fiscal year 2025, the PEPFAR Uganda team had planned to expand this initiative to other districts. However, overall, there were some challenges with little to no demand creation/awareness building for prevention options, especially PrEP and services for adolescent girls and young women (AGYW) were still controversial, which affected young women working in informal sex work.

After the funding cuts, stop-work orders stalled PrEP service delivery and product introductions across Africa, including Uganda, with large numbers losing access to prevention[26]. 73% of organisations reported limited access to PrEP and PEP due to a shortage of commodities and discontinuation of collection by clients. HIV testing dropped by 62.5%, and condom distribution also dropped by 70%, affecting 51 out of 72 surveyed organisations[27]. Clinics and drop-in centre (DIC) closures also severed vital care pathways for KPs to access prevention options. The supply partners, facing uncertainties about the viability of contracts, scaled back or delayed deliveries, leading to immediate stockouts of essential commodities including PrEP, ARVs, STI drugs, lubricants, condoms, and HIV test kits and potential future stockouts. In some regions, organisations can no longer schedule testing outreaches[28].

The drastic decline of PrEP and PEP access and the reduction in condom and lubricant distribution represent catastrophic losses in HIV prevention infrastructure. The collapse of community-led distribution networks, combined with the closure of 30% of DICs, has left massive prevention gaps that require immediate intervention.

Prior to the cuts, a second Medically Assisted Therapy (MAT0Centre was opened at Mbale Hospital to complement the Butabika centre in supporting PWUD, however, the stop-work directives led to MAT clinic shutdowns and syringe shortages—fueling overdose risk and interrupting services for people who use/inject drugs[29].

The Uganda HIV prevention demand creation plan and needs to include community-led approaches (peer educator networks, community dialogues, safe space outreach), multi-channel communication campaigns (mass media, digital & social Media, print & outdoor media), integration into existing platforms (health facilities, schools & universities and the workplaces), service delivery innovations (mobile outreach & community ART distribution points, pharmacy delivery models and informal distribution points), ensuring advocacy and an enabling environment (law & policy reform and sensitisation of service providers) and most importantly funding to reach people.

[26] https://www.prepwatch.org/pepfar-stop-work [27] Uganda Key Populations Consortium. "No Time to Wait 2: Funding Cuts, Threatening Uganda's HIV Services and Community Health." Uganda Key Populations Consortium, 2025 [28] https://ugandakpc.org/reports/no-time-to-wait/ [29] https://hri.global/publications/impact-of-pepfar-funding-cuts-in-harm-reduction-in-uganda/

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
PrEP access	63.4% reduction	Estimated number of KP who accessed PrEP during the last 3 months (total). Reduced from 55,415(Oct-Dec) to 20,287[30](Apr-Jun)
PrEP new initiations	60% reduction	New PrEP starts declined from 38,203 (Oct-Dec) /15,461(Apr-Jun)[31]

Non-negotiable Priorities:

- **Increase investment in condoms and lubricants and critical HIV prevention tools** that have a strong impact on reduction of HIV infection and TG populations.
- **Maintain oral PrEP, introduce and scale up injectable options** such a CAB LA and Lenacapavir and sustain current users and expand access for those without PrEP[32].
- **Maintain free standing PrEP/ differentiated service delivery (DSD) sites** as they are critical access points for KPs.
- **Consider innovative outreach and explore and invest in community-developed models** / mobile/pharmacy delivery models and virtual client support options/telehealth services.
- **Scale up KP sensitisation and training at general population PrEP sites** to build KP-specific service capacity.
- **Expand informal (e.g., bars, brothels, vending machines) and peer-led distribution models for condoms and lubricants.**
- **Reopen and scale up needle exchange programmes** which are essential for HIV prevention among PWUD[33].
- **Reopen and expand MAT services to support dependence reduction and lower HIV transmission risk[34].**
- **Ensure emergency procurement and rapid distribution of commodities for PEP (post-exposure prophylaxis).**
- **Invest in interventions that address structural barriers such as violence against TG people** which is a driver of HIV risk and a barrier to seeking HIV prevention among TG populations.

[30, 31] Source (KP TRUCKER) [32] https://www.prepwatch.org/wp-content/uploads/2025/04/Impact-of-Stop-Work-Order-110425.pdf [33, 34] https://hri.global/publications/impact-of-pepfar-funding-cuts-in-harm-reduction-in-uganda

Strategic Element	Current Status	Annual Funding Gap/Need	Key notes
Oral and injectable PrEP	Significant gap	$6,218,598	Maintain current, scale up injectable and expand access. Injectable options reduce stigma to PrEP use.
PrEP sites (free-standing)	High gap	$2,574,477	Maintain current sites (the number before the cuts) as critical access points for KPs; explore mobile and community-based models
PrEP community mobile pharmacy models	Non-existent	$2,574,477	Introduce mobile clinics to improve access
KP-friendly general population PrEP sites	Moderate gap	$2,674,477	Scale up KP sensitisation as general health facilities require KP-specific service capacity and training
Prevention policy and national guidance	Moderate gap	$100,000	Essential for the introduction of new prevention options
Building demand creation and awareness on PrEP	Moderate gap	$204,800	Needed for the demand of PrEP options at the community level
Condoms and lubricants	High gap	$20,400	Expand informal and peer-led distribution to the last mile to Increase reach through non-traditional KP-friendly channels; community vending and hotspot distribution

Service delivery, including safe injecting equipment	Significant gap	$312,600	Maintain and scale up.safe injecting equipments for essential for HIV prevention among PWUD
Methadone, buprenorphine or other opioid agonist maintenance therapy (OAMT	Significant gap	$92,000	Maintain and expand OAMT services to support dependence reduction and lower HIV transmission risk
Post exposure prophylaxis	Significant gap	$100,000	Scale up emergency procurement and rapid distribution for commodities for PEP

Primary Prevention Funding Gap: Approximately **$14,871,829** annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? Despite serious challenges in the legal landscape, reaching KPs with combination prevention interventions remains an important goal. Despite the Anti homosexuality Act, partners like PEPFAR and the Global Fund continued to support accelerated progress by supporting KP-led service delivery of high-quality prevention especially through KP-led drop-in-centres (DICs). A lack of action to reverse the effects of the cuts will lead to even more people losing access to life-saving prevention. Access to testing is key to prevention, access to condoms and lubricants significantly reduces HIV risk. Uganda is one of the countries that was ahead of the curve with the approval of PrEP options such as the Dapivirine vaginal ring and the long-acting injectable (cabotegravir). All these critical gains will be lost as more people are at risk due to lack of access to these lifesaving options. These interventions are the difference between life and death, between controlling the epidemic and watching it spiral out of reach. Sustaining oral PrEP and scaling up injectable options keeps those most at risk HIV-negative, while freestanding PrEP sites, mobile outreach, and community-led delivery ensure that no one is left behind by fear, stigma, or distance. Training and sensitising providers turns hostile spaces into safe havens, and peer-led condom, lubricant, and needle exchange programmes put prevention directly into the hands of those who need it most. Opioid agonist maintenance therapy reduces dependency and slashes transmission risk, while rapid, reliable PEP access stops new infections in their tracks. Together, these measures are a proven shield for KPs—and a vital engine for Uganda's epidemic control—cutting new infections, preserving human potential, and protecting the hard-won progress your investment has made possible.

3. Community Infrastructure

Community-based service delivery remains the cornerstone of Uganda's KP response. Approximately 150 KP-led civil society organisations operated across the country; including 103 DIC, providing essential services ranging from health care delivery to advocacy and rights protection, community interaction points, drop-in centres, safe houses, and other safe spaces.

The reach of community organisations to peers bridges a critical gap that the general service delivery sites are unable to, especially with the Anti-Homosexuality Act which marks its second anniversary.These organisations also play vital roles in service delivery, community mobilisation, and representation in district-level forums such as District AIDS Committees (DACs) and Sub-county AIDS Committees (SACs).

KPs also gained improved services access due to the investment in peers. Peer-based support is a critical factor in improving adherence and retention. These community members bring essential services closer to the KP community. Initiatives such as peer navigation programmes, peer-led support groups, and integration of peer educators into healthcare teams have shown promise in building trust and supporting continuity of care.

With the funding cuts only 130, KP-led community organisations across the country remain operational. Standalone HIV/TB clinics were phased into general outpatient departments (OPD)/chronic care[35] fewer convenient pick-up points and increased stigma barriers—especially for KPs. The KP community lost vital spaces for social connection, friendly health services, and peer support. For organisations, the loss of office spaces hinders advocacy efforts, coordination, and service delivery, disrupting essential work and diminishing visibility in policy dialogues.

Drop-In Centres and Safe Spaces

At the end of 2024, Uganda had established a comprehensive network of KP services through drop-in centres (DICs) and health facility-based programmes. The country had developed Guidelines for Establishing and Operating Drop-in Centres for Key and Priority Populations[36], leading to the establishment of 103 DICs across the nation. This infrastructure enabled implementing partners and KP-led organisations to provide KP-friendly services, creating an enabling environment for quality service delivery at both facility and community levels.

As of the end of2024, Uganda had approximately 103 functional DICs distributed across regions: CDC Regions (50), USAID Regions (40), DOD Regions (5), and Others (8). These centres provided comprehensive packages including HIV testing, ART services, PrEP delivery, psychosocial support, and community mobilisation. The centres served as critical access points for KPs, offering specialised services that addressed the unique needs of different KP groups while providing safe spaces for community interaction and peer support.

The funding freeze led to a 60% closure rate of DICs, with particularly severe impacts in USAID-supported regions where all DICs operations were stopped. Staffing declined by 46% overall, with peer support workers experiencing a 58% reduction (from 12 to 5 per organisation).

The Central Region of Uganda, which accounts for 46% of all KP-serving organisations (33 out of 72), with services concentrated around urban hubs such as Kampala, has experienced uneven disruptions; Buikwe District, for instance, experienced a 100% closure of its three DICs. Kawolo Hospital reported a 99% decline in client engagement. In the Northern Region, Gulu District had a 90% drop in client engagement, while partner-run ART clinics in Lira became nearly non-functional, with a 99% decline. The Eastern Region also faced significant challenges, as Malaba HCIV saw an 80% drop in client numbers, potentially reducing capacity below 70%. Ibanda's only DIC closed entirely in the Western Region, indicating near-zero operational capacity. While 70% of DICs/clinics remain operational nationally, regional data show highly variable impacts, with service capacity ranging from almost zero in the most affected districts to relatively stable levels in less-disrupted urban centres[37].

[35] https://govinfohub.go.ug/index.php/2025/02/20/why-the-ministry-of-health-is-shutting-down-standalone-hiv-and-tuberculosis-clinics/ [36] https://cquin.icap.columbia.edu/wp-content/uploads/2021/08/SOP-Drop-In-Centre-DIC-Final-June-2020.pdf [37] Uganda Key Populations Consortium. "No Time to Wait 2: Funding Cuts, Threatening Uganda's HIV Services and Community Health." Uganda Key Populations Consortium, 2025

Peer Navigation Programmes

Peer cadres are the backbone of the three UNAIDS 95-95-95 targets and of successful linkage, adherence, and re-engagement services that lead to viral load suppression for KPs. The peer support network was robust, with organisations averaging 12 peer staff members per organisation, providing critical linkage, adherence support, and community outreach services. The 58% reduction in peer staff (from 12 to 5 per organisation[38]) directly correlates with the surge in treatment interruptions and discontinuations. Restoration of these cadres and community based initiatives is the highest priority for preventing further loss of life and is integral to successful integration into MoH systems.

Engagement in National HIV Planning

The level of KP engagement in national HIV planning by December 2024 was moderate to strong. KP organisations had representation in various decision-making spaces and participated actively in proposal development processes with partners across various grants. However, engagement was threatened by the legal landscape, particularly the Anti-Homosexuality Act (2023), which created challenges for sustained participation and advocacy efforts. With funding cuts, KP-led organisations' capacity for advocacy and accountability work was severely compromised. Organisations reduced from 150 to 90 active KP-led CSOs engaging in national planning, representing a 60% decline[39].

Community-led monitoring

Community-led monitoring programmes were active, including CLM under PEPFAR, Community Score Card under the Global Fund, and Uganda Health Activity monitoring systems. After the funding cuts, community-led monitoring programmes dropped from 3 active programmes to only 1 (Global Fund), representing a 67% reduction in monitoring capacity. The ability to participate in national HIV planning forums, represent communities in decision-making spaces, and conduct policy advocacy was significantly weakened.

[37] Uganda Key Populations Consortium. "No Time to Wait 2: Funding Cuts, Threatening Uganda's HIV Services and Community Health." Uganda Key Populations Consortium, 2025 [39] UKPC DIC database.

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Peer navigators/Outreach workers	58% reduction	Peer navigation networks reduced due to funding cuts
Drop-in centres	60% reduction	Some drop centres closed reduced due to funding cuts
KP organisations conducting advocacy	60% reduction	From 150 to 90 active organisations
Community-led monitoring programmes	67% reduction	From 6 to 1 active CLM programme due to loss of training, tools, and coordination support

Non-negotiable Priorities:

- **Scale up the peer cadres 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.
- **Establish selected DICs/private not-for-profit facilities** (PNFPs) as periodic, discreet refill hubs for stable KP clients to reduce stigma exposure[40].
- **Strengthen community-led monitoring and legal aid** to address rights violations that hinder access to healthcare.
- **Support institutional support systems for CSOs,** especially around registration, compliance, and navigating restrictive regulations.
- **Ensure that policy and implementation includes intersectional programming** that centres persons with disabilities, intersex individuals, transgender people and other underrepresented voices.
- **Strengthen community ART delivery models** for key populations through community-led and safe platforms.

[40] https://www.unaids.org/sites/default/files/2025-03/20250305-USstop-Sitrep.pdf

Strategic Element	Annual Funding Required	Key notes
National KP Coalition/Network	$133,120	Essential for community coalition and movement building
Peer cadres	$120,000	Essential for community mobilisation and linkage to services. 1 peer to 25 clients is recommended
Outreach workers	$62,200	Essential for community outreach, linkage and retention
Drop-in centres	$819,200	Essential for community- led service delivery
Community-led monitoring	$1,870,255	Essential for reviewing the quality of services offered to key populations

Community Infrastructure Funding Gap: Approximately **$3,004,575** annually to rebuild essential community systems and protective mechanisms.

What is the cost of inaction? Without community initiatives, the success of the KP HIV programme would be minimal. Communities need to be at the centre and be meaningfully engaged for the programme to be successful. Excluding community initiatives by fully integrating the HIV program will reduce the visibility that the programme has on key populations which will lead to worse outcomes for the already marginalised and criminalised populations. The country will not be able to ensure that key interventions such as PrEP and testing reach those who need them.

4. Data and Monitoring Systems

Uganda's data access system has been limited to donor partners and MoH and funding cuts further contributed to comprehensive KP-specific data collection systems gaps. Access to KP-specific data declined significantly due to service disruptions, staff losses, and weakened supply chains. 97% of organisations experienced adverse effects including impacts on data collection systems. Monitoring of PrEP continuation and ART retention became impaired, forcing organisations to rely on less precise aggregated MoH data.

Before the funding freeze, human resource capacity for data collection, analysis, and reporting was largely functional. PEPFAR-funded staff—including M&E officers, peer educators, and clinicians- enabled robust data flows through Drop-In Centres (DICs) and MoH systems. Reporting to both PEPFAR and the Ministry of Health was consistent, and supervision and data review processes ensured high-quality insights for programming. Access to up-to-date KP-specific data was intact through PEPFAR Monitoring, Evaluation, and Reporting (MER) Indicators and MoH systems, enabling robust monitoring and targeted interventions for PrEP and ART. PEPFAR also required KP-disaggregated data for HIV testing, antiretroviral therapy (ART) initiation, retention, virologic suppression, PrEP initiation, and continuation; the data currently collected no longer requires disaggregation.

The funding freeze led to a significant decline in human resource capacity for KP programmes, with a 46% overall staff reduction, 58% drop in peer staff, layoffs of peer educators that severely undermined outreach and data collection and the loss of M&E officers that limited analysis and reporting capacity.

Non-negotiable Priorities:

- **Maintain high-quality, disaggregated data for all populations** including TGs for an effective prevention and treatment programme for KPs by prioritising high-impact data reporting metrics can effectively guide interventions despite data constraints. There has been a systematic exclusion of TG HIV service data in MoH and Uganda Country Coordinating Mechanism (UCCM) reports with only SW and MSM data reported among key populations.
- **Increase digital tools and virtual platforms for service delivery and data collection** that offer safer, stigma-free alternatives.
- **Invest in research to generate the evidence base to inform HIV prevention programming** for the unique needs of transgender population,such as TG population size estimates, a TG HIV prevalence study and HIV stigma and discrimination index among the TG populations.

Strategic Element	Current Status	Funding Required	Key notes
Disaggregated data	Not collected	$70,000	Restore and maintain a high-quality, disaggregated data
Data reporting	Currently not funded	$70,000	Reports must remain practical given limited data availability. Currently, no confirmed funding sources support report production, which was previously funded by PEPFAR, resulting in significant funding gaps that threaten the sustainability of reporting efforts
Virtual options	Not active	$60,000	Introduce cheaper more efficient virtual reporting platforms that offer an opportunity to enhance confidentiality and safety for clients and community monitors.

Data and Monitoring Systems Gap: $200,000 annually to rebuild data and monitoring

What is the cost of inaction? By June 2025, the lack of PEPFAR funding for data systems will likely erode KP-specific data collection. Web sources indicate that 46% of countries, including Uganda, reported supply chain and data management issues, with patient-facing shortages undermining trust in data systems.

Summary of proposed cost of the Uganda Key Population Plan

Targeting and Costing Methodology

In Uganda, the methodology used the national population size estimates from PEPFAR, UNAIDS KP Atlas and the recent IBBS data. 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 the percentage of KP LHIV in need of treatment services (set initially at 100%). To meet the Uganda KP budget, the country will focus on 90% of treatment and 80% as indicated below. Prisoners and clients of FSW are not included in the costing exercise. This covers the Kenya Key Populations Strategy Summary below with a programme cost total of $28,209,606, targeting 204,800 KPs. The itemised costing of each intervention is found on this link: Uganda KP Budget and Costs

Uganda Priorities	Costs	Total	Cost per target	General costs	GBV	Testing	TX	Biomedical Prev	STI	MAT
Priorities	Costs	**$28,209,606**	$138	$3,543,040	$163,337	$2,056,767	$6,112,246	$14,242,029	$1,889,687	$202,500
	Percent of total			12.56%	0.58%	7.29%	21.67%	50.49%	6.70%	0.72%
		National Targets								
Targets	KP Treatment	**61,500**								
	KP Primary Prevention	**143,300**								
	Total	**204,800**								

What should a good core package for quality key population service delivery include?

- Outreach services
- Lubricant
- Male condoms
- KP friendly HIV testing and counselling, including HIV self testing
- KP friendly HIV care and treatment
- HIV and PrEP support groups to improve continuity in care
- Psycho-social support
- Pre-Exposure Prophylaxis (PrEP)
- Post-Exposure Prophylaxis (PEP)
- Mental health services
- Linkage to justice services
- Pmtct
- Information package for sexual health services
- KP friendly STI prevention, testing & treatment services
- Gender-based violence services on-site or by referral
- Peer educators/navigators at the facility
- Vaccination, diagnosis, and treatment of viral hepatitis (including HBV, HCV)
- Prevention, diagnosis, and treatment of tuberculosis
- Counselling and risk reduction information
- Anal health services
- Voluntary Medical Male Circumcision (VMMC)
- Prostate cancer screening
- Cervical cancer screening
- Screening and treatment for ano-genital warts
- On-site and referral for other SRHR services

PWUD specific:

- On-site and referral drug dependence initiation and treatment (e.g. methadone)
- On-site and referral drug-dependence counselling and support
- Resources to take up referred services (e.g. taxi fare)
- Wound and abscess care
- Unused needles, syringes, or other injecting equipment
- Overdose management and treatment (e.g. naloxone)
- Drug dependence support group

TG specific:

- Hormone Replacement Therapy (HRT)

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 KPsin 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.

Uganda's Methodological Guide: Grounded, Community-Led Priority Setting Amid Crisis

This priority-setting framework is not simply the result of research; it is a testament to the remarkable resilience, urgency, and inspiring community leadership in the face of adversity. Developed during a period of severe funding disruptions that jeopardised years of progress in Uganda's HIV response, this methodology was driven by key population (KP) communities themselves. It embodies a deliberate and inclusive process, built on evidence, lived realities, and a commitment to co-creation and sustainability.

Principles Guiding the Process

- **Community-Led:** KP communities were at the forefront of designing and steering the process.
- **Data-Informed:** Quantitative and qualitative data grounded the work in fact while amplifying lived experiences.
- **Participatory:** Stakeholders from grassroots to national partners were not just engaged, but integral to the process throughout, ensuring that every voice was heard and valued.
- **Strategic and Action-Oriented:** The process was designed not only to yield a practical roadmap for donor and programmatic investment but also to inspire action and motivate all involved to contribute to the community's recovery.

Step-by-Step Methodology

- **January 2025 | Comprehensive Desk Review:** A foundational review of national/government policies, strategic frameworks, health and HIV data, and donor investment trends provided a contextual landscape. This helped identify funding gaps, policy opportunities, and historical trends affecting KPs at national as well as international levels.

- **January–February 2025 | Nationwide Survey & Evidence Report:** UKPC launched a national survey to assess the impact of donor funding cuts. The resulting 'No Time to Wait' report highlighted disruptions in service delivery, employment loss, and community health consequences. It drew global attention and informed the broader priority-setting process.

- **February 2025 | Community Engagement/Consultations & Feedback Loops:** Consultations validated findings, contextualised experiences, and enabled co-creation of recovery priorities with KP networks and civil society groups.

- **March 2025 | National Network Convenings:** Heads of networks met to synthesise insights and establish thematic priorities, laying the foundation for the Roots Symposium.

- **March 4, 2025 | National Advocacy & Public Mobilisation:** A high-profile press conference united civil society in calling for accountability and KP inclusion in the national recovery framework. It elevated visibility and catalysed support.

- **March 2025 | Resource Mobilisation and Coordination:** KP networks led the planning and funding of the Roots Symposium, demonstrating ownership and collective coordination. **Roots Symposium:** Culmination of a Community Centred Process. The Roots Symposium consolidated all data and dialogue into a five-year strategic direction. It offered a safe space for consensus-building and priority alignment.

- **Conclusion | A Model Rooted in Lived Experience:** This methodology represents a powerful model for prioritising in fragile funding environments. It delivers a clear donor roadmap grounded in community wisdom and data. It is bold, necessary, and actionable.

The Team

This country planning journey was powered by the unwavering spirit and vision of communities who believe HIV responses must be led by those most impacted. At the heart of this process were the visionary leadership of Mr Richard Lusimbo, Dr Micah Kulubya, and Ms Stellah Nassuna, with coordination from the Uganda Key Population Consortium (UKPC), community leaders, networks, and Civil Society Organisations (CSOs); these voices became the heartbeat of this plan. In close partnership with courageous community leaders, resilient KP networks, UKPC convened the Roots Symposium, which laid the foundation for this transformative work.

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