Zambia:

Key Populations' Strategic Priorities

Introduction

By the end of 2024, Zambia's Key Population (KP) program had made substantial progress reaching KP communities with prevention options such as Pre-Exposure Prophylaxis (PrEP), antiretroviral treatment (ART), and comprehensive structural HIV prevention activities particularly with funding by PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). The country had established a service delivery framework for KPs delivering quality interventions through differentiated service delivery (DSD) models, with specific emphasis on community-led and community-based care, complemented by facility-level integration in urban and rural hotspots. KP-friendly clinical services provided through Wellness Centers largely targeted female sex workers (FSWs), men who have sex with men (MSM), transgender individuals (TGs), and people who inject drugs (PWID).

As of late 2024, Zambia had approximately 30–35 functional Wellness Centers, supported by PEPFAR, Global Fund, and KP-led CSOs. Zambia's Wellness Centers are dedicated service points for KPs, offering integrated HIV prevention, treatment, sexual and reproductive health (SRH), and psychosocial support under one roof delivered holistically in a confidential, non-judgmental setting, tailored to the needs of marginalised groups.

ART access for KPs had improved, with multi-month dispensing (MMD) scaled to all stable clients, contributing to retention in care, particularly among FSWs and MSM. As a result, Zambia improved KP treatment scale up, reaching an estimated 22,866 KPs with HIV treatment. Viral load coverage for KPs lagged at 83%, but of those, 97% reported suppressed viral load[1].

Programmatic gaps remained among TG and PWID, with consistently lower rates of viral load suppression and worse treatment retention outcomes noted in program data from FY24 Q3. Despite this important progress, however, criminalization, stigma, and discrimination still undermine KP-led efforts to reach 95-95-95 for all KP sub-sectors.

Projected PEPFAR budgets for KP programs for US fiscal year 2025 (FY2025) had been $15.8 million, a 5% increase over the FY2024 PEPFAR KP program budget, despite a 6% decrease in the overall program budget (a reduction of $23.4 million between FY2024-FY2025). Of that, an estimated $3.7 million was intended for KP PrEP, with a target of reaching 46,585 new people with PrEP (PrEP_NEW)[2].

But over the past six months (January to June 2025), Zambia has experienced significant reversals in KP programming due to abrupt funding reductions, donor reprioritization, and systemic integration without adequate safeguards. These massive setbacks have not only weakened access to life-saving HIV services for KPs, but also eroded essential community systems that were foundational to sustainability. Zambia has lost critical ground in KP HIV programming marked by clinic closures, stockouts, reduced trust, and declining community engagement.

32 Wellness Centres in 7 out of 10 provinces have either been closed or significantly scaled down following US government HIV funding freezes; these centres had reached more than 20,000 KPs with ART. Across urban Lusaka, Copperbelt, and Central Province mobile outreach services were reduced or discontinued, limiting access for highly mobile FSWs and underserved PWID populations, particularly in border towns like Nakonde.

KP ART re-engagement (return-to-care) rates dropped from 63% in FY24 Q3 to 41% in FY25 Q2 across monitored CHEKUP II and Key Population Investment Fund (KPIF) sites. TG were among the most negatively affected, with a 25% increase in reported treatment interruptions compared to the previous period.

These losses underscore an urgent need for strategic recommitment to funding KP Wellness Centres, safe spaces, and other KP-specific programs, short-term emergency planning, long-term integration of KP services into resilient, stigma-free public health systems together with continued funding for complementary programs alongside mainstream public health clinics.

[1] PEPFAR: Zambia FY2024 Q4 Program Performance, slide 6 [2] PEPFAR. "Slides for 4-4-24 CSO Budget Discussion." Resource available on request

The Heart of Zambia's KP-led Service Delivery Model: Wellness Centers and Safe Spaces

As of end-2024, Zambia had multiple functional KP-focused Wellness Centres (WCs) and safe spaces, supported by USAID, Global Fund, and civil society partners. These centers provided comprehensive packages including HIV testing, STI screening, psychosocial support, condom and lubricant distribution, mental health services, and gender-based violence support. Notably, USAID CHEKUP I and II, CIHEB, CIDRZ, KPIF, among other IPs operated 49 DREAMS and KP Wellness Centers in Lusaka, Muchinga, Luapula, Central, Copperbelt, Southern, North Western Provinces. Civil society organizations such as LATU Human Rights Foundation, Sanity House, Key Population Alliance of Zambia, and Titandizane played a vital role in operating these spaces with a focus on stigma-free health service delivery. These CSOs received varying levels of donor support (e.g., KPIF, UNFPA, or USAID subgrants) to fund staff salaries, site rentals, peer stipends, and basic commodities. However, several CSO-run sites experienced funding reductions in 2024, leading to closures or partial operations.

Wellness Centers offer integrated clinical services and psychosocial support, with some MoH or IP technical involvement. safe spaces offer non-clinical services via community hubs providing psychosocial support, peer navigation, GBV referrals, condom/lube access in a stigma-free environment.

Wellness Centers offer a comprehensive package of services, including:

- **Direct services:** HIV testing, ART and PrEP initiation (in selected WCs), STI screening and syndromic management, psychosocial support, mental health counseling, condom and lubricant distribution, and GBV case identification and first-line support (LIVES).

- **Referral services:** Clients needing specialised GBV care, advanced STI treatment, psychiatric care, or legal aid were referred to partner facilities or public sector services, with some accompaniment provided by peer navigators.

Staffing norms are: 1–2 clinical officers or nurses (where medical services were provided directly), 1–2 professional counselors, 2–4 peer navigators, 1 center coordinator, and 1 community liaison officer or outreach lead. Staffing patterns varied depending on whether the site offered onsite clinical services or functioned more as a safe space (i.e., offering psychosocial support and linkage to health facilities).

What does the data say about HIV prevalence among KPs in Zambia? Men who have sex with men are at 21%, Female sex workers are at 40%, people who inject drugs are at 15%, Transgender people are at 22%[6].

Where was Zambia on the 95/95/95[7] track?

- 98% of people living with HIV know their status
- 99% of those who know their status are on treatment
- 98% of those on treatment have achieved viral load suppression

[6] Zambia Country Operational Plan COP 2023 Strategic Direction Summary
[7] https://www.facebook.com/mohzambia/posts/pfbid0nTHzTaknd375eNmHqthLv1TshnzcVuKfCXPUyH7piXJrTNAx4bJsDU5LyN6qehtGl?rdid=0xSlLXwSzNLTEqou

As of June 2025, the KP response in Zambia is in a crisis. Service delivery is in a precarious state marked by funding cuts, reduced service coverage, weakened peer and community systems, and a sharp decline in structured engagement in planning and coordination processes. PEPFAR KP program budget gaps created by US funding cuts and freezes for Zambia are estimated to be $19.1 million[8]. Zambia has lost nearly half of its legal and violence prevention infrastructure supporting KPs in just six months. The remaining programs are deteriorating under the strain, often relying on unpaid peer workers or minimal donor carryover.

While some essential services such as ART and PrEP remain operational, they are sharply limited in scope, reach, and quality compared with 2024 service delivery levels, especially in areas that previously relied on donor-funded, community-led KP service delivery points.

As a result, Zambia's KP HIV response is currently barely surviving amidst fragmented and fragile service delivery, driven by a few remaining centres, overstretched volunteers, and overburdened health systems. Whereas KPs originally planned major strides during FY2025 in expanding KP HIV case finding and linkage to treatment, KP focused HIV self testing, expanded investment in fighting stigma and discrimination as well as expansion of access to oral and injectable PrEP, now KP progress is rapidly deteriorating[9]. The erosion of community infrastructure, along with the marginalisation of KP voices in critical national planning and funding decisions, signals a critical need for renewed investment, restoration of peer-led stand alone structures, and strategic integration of KP services into national systems with clear accountability mechanisms to ensure stigma free service delivery. Without targeted investment, further degradation of rights-based services is expected, putting KPs at elevated risk of abuse, impunity, and systemic exclusion.

KP Community Core Priorities

1. Antiretroviral Therapy (ART) and Service Continuity

The KP Coalition's strategic vision reflects the reality that massive disruptions since January 2025 in provision of continuous ART for KPs have resulted in grave setbacks to Zambia's public health goal ending HIV as a public health threat and achieving 95-95-95 UNAIDS targets[10] for KPs and for all Zambians.

Reliance on donor-funded stand-alone KP service provision sites is unsustainable unless paired with ambitious and accountable capacity-building to make public health infrastructure deliver quality, stigma free HIV services to KPs. Over time, the number of standalone sites providing KP clinical, behavioral and social services can be reduced to a core set in high priority areas offering comprehensive treatment and prevention services. However, this is only possible with re-investment in peer cadres, which are the backbone of successful linkage, adherence, and re-engagement. Funding for this cadre was severely impacted in 2025, with more than half cut from deployment because of U.S. funding cuts. Restoration of this cadre is a high priority and integral to the success of KP-safe integration into MoH future integration efforts, which must be accompanied by scaled up training and support supervision for KP-competent government health workers, and introduction of KP safe spaces in government sites. As the Table below illustrates, there is a $10-11 million annual funding gap for comprehensive ART services.

For example, KP ART re-engagement (return-to-care) rates dropped from 63% in FY24 Q3 to 41% in FY25 Q2 across monitored CHEKUP II and KPIF sites. TG populations were the most affected, with a 25% increase in reported treatment interruptions.

[9] Zambia had received 4000 doses of CAB-LA, enough for a year of protection for just 1000 people
[10] https://www.unaids.org/sites/default/files/media_asset/progress-towards-95-95-95_en.pdf

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Operational KP ART sites	35–40%	Of the more than 32 KP-friendly or standalone ART sites, an estimated 15 were scaled down, closed, or absorbed into MoH facilities without KP-specific adaptations.
Peer navigators/ Outreach workers	50%	From approximately 150 active staff in 2024, fewer than 75 remain deployed nationally due to loss of stipends and support systems.
Community-based volunteers	45%	Volunteer engagement has sharply declined, especially where CSOs lost operational grants (CHEKUP II, KPIF bridge funding lapses).
CSOs operating safe spaces	35%	Several community-led safe spaces in Lusaka, Central, and Muchinga suspended services or restricted hours due to lack of rent, staff, or commodities.
CSOs operating Wellness Centers	90%	23 out of 32 wellness centres shut down in 7 out of 10 provinces , the remaining operational wellness centers are under CDC.

Non-negotiable Priorities:

Restoration of Wellness Centres, safe spaces, and peer cadres are top priority interventions, not only to reverse losses in the ART cascade but to deliver on a vision for KP-safe integration into the Ministry of Health's (MoH) public facilities. This restoration must be supported by:

- **Recruitment or secondmen**t of at least 150–200 peer cadres, budgeted at $600/month, totaling $1.2–1.4 million annually, supported by CSOs or embedded within Wellness Centers and KP-friendly public sites.
- **Scale-up of KP-competent government healthcare worker training**, reaching at least 400 MoH providers across 60+ priority sites, with ongoing mentorship and supervision.
- **Introduction of designated KP safe spaces within public facilities** (converted rooms or containers offering private peer support, psychosocial services, and navigation).
- **Deployment of an interoperable ART tracking system**, linking KP clients across facility and community points to reduce silent transfers and lost to follow-up.
- **Restore prioritised KP-focused sites** to ensure continuity on treatment and continued expansion of enrollment, with a particular attention to PWID and TG communities who were already experiencing disproportionately poor clinical outcomes as reported in 2024.

[8] Ritshidze National State of Health Update, August 2025: https://ritshidze.org.za/wp-content/uploads/2025/08/Ritshidze-National-State-of-Health-August-2025.pdf

Strategic Element	Current Status (June 2025)	Target Vision	Annual Funding Required (USD)	Key Notes
Peer cadres (Navigators & Outreach workers)	~70–80 active (reduced >50% from 2024)	Restore to 150–200 nationally	$1,260,000	Essential for linkage, retention & return to care
		Expand peer support model with formal funding, supervision, and career pathway	$1,200,000	For 210+ peer cadres nationally at ~$300/month (incl. salary, training, mentorship, and supportive supervision). Cadres support ART, PrEP, re-engagement, case management, STI/GBV referrals. Highly cost-efficient frontline workforce across all KP typologies.
Return to Care Rates	from 63% to 41% nationally	Restore to >65% across all typologies	Included in peer cadre & supervision costs	TGs most affected by dropouts
Standalone KP Wellness Centers	~15–20 partially or fully functional	Rationalise to 10–12 high-burden districts	$900,000	Core hubs for integrated KP-friendly services
		Maintain high-volume urban Wellness Centers (e.g., Lusaka, Kitwe); phase out duplicative small sites in favor of KP-friendly public	$600,000	Covers operating costs of core Wellness Centers: staff, rent, outreach, integrated services (ART, PrEP, STI, GBV, mental health). Rural KP sites will be absorbed into nearby MoH facilities with dedicated peer staff and support.

MoH Facility Integration	Ongoing but inconsistent	60+ public sites with KP-trained staff & safe spaces	$150,000	Needs joint MoH-CSO rollout & SOPs
		Train and deploy KP-competent providers, establish dedicated service hours and private spaces in MoH facilities	$150,000	For training 400+ MoH providers on KP sensitivity, setting up confidential service rooms, adapting flow and hours, and assigning peer navigators to MoH-run ART rooms. This enables safe, stigma-free integration of KP care into public facilities.
Training & Supervision (MoH & CSO sites)	Ad hoc or donor-funded	Annual structured training, quarterly supportive supervision	$200,000	Aligns with NASF & KP Action Plan
ART Commodity Security (for KPs)	Partial coverage (risk of gaps)	Full coverage, including MMD & refill tracking	Included in national ART cost	Advocacy to ensure no KP-specific exclusion
		Maintain full ART availability through MoH + strengthen decentralised access for KPs	$300,000	This cost is for service delivery support, not procurement. It covers decentralised ART access for KPs (e.g., MMD logistics, distribution support to rural sites, buffer stock at KP-friendly centers, transport subsidies, and differentiated delivery at community level).
Tracking & Client Management System	Fragmented/ siloed	Interoperable system linking community & facility	$400,000 (setup and integration)	Needed to reduce silent transfers and LTFU

Tracking & Client Management System	Fragmented/ siloed	Interoperable system linking community & facility	$400,000 (setup and integration)	Needed to reduce silent transfers and LTFU
Annual ART/PrEP Cascade Report with KP Disaggregates	Not consistently produced	Institutionalised reporting in NASF reviews	$150,000	Facilitates accountability and planning
OI diagnosis and treatment	STI management gaps persist across public sites and Wellness Centers; frequent stockouts of drugs like doxycycline, fluconazole	Ensure STI screening/treatment at all KP access points, with supply chain security	$200,000	To cover essential STI and OI meds (e.g., doxycycline, fluconazole), diagnostics, and provider training in 9–10 districts. Includes demand forecasting and logistics for consistent stock.
TB diagnosis, prevention and treatment	TB services exist but often disconnected from KP service points; IPT not consistently offered	Continue TB screening at ART initiation and integrate preventive therapy at KP sites	$ 100,000	Includes cost of IPT procurement, peer-supported referrals, and data tools to screen and treat 15,000 KP clients across urban and peri-urban sites.
Viral load	VL testing is technically available, but major issues exist in result return, tracking, and suppression follow-up	Ensure timely VL testing for all KP clients, with turnaround < 30 days and access to results	$100,000	To fund sample transport, turnaround improvement tools, VL registers, digital reminders, and training for timely suppression follow-up in KP sites and KP-friendly MoH facilities.

ART Funding Gap: $5,710,000 million per year

What is the cost of inaction? Unless peer cadres, prioritised stand alone Wellness Centers, KP clinical tracking, and high-impact training programs for front line clinical staff are restored and scaled, KPs will continue to be pushed out of care, with losses disproportionately affecting FSWs, TG, and PWID, who rely more heavily on tailored outreach and standalone services in Zambia. The current deteriorated level of community service availability is wholly insufficient to sustain gains in new PrEP enrollment (PrEP_NEW), people maintained on treatment (TX_CURR), and viral load (VL) suppression. Without urgent reinvestment, KPs in Zambia will be unable to gain access to KP-friendly, rights-based HIV service delivery.

2. Primary Prevention

Restoring and expanding KP primary prevention is critically important if Zambia will rebuild and recover in response to donor retreats. This is particularly the case for highly effective prevention interventions such as oral and injectable PrEP. Zambia has been anticipating introduction of long-acting Lenacapavir (LEN) for PrEP since 2024, before the U.S. government retreated from its position as the main funder of PrEP programs.

At the end of 2024, Zambia had an estimated 32 KP-specific PrEP roll-out service delivery points, spread across Lusaka, Copperbelt, Central, Muchinga, and Southern Provinces. Nakonde was among the districts introducing long-acting injectable CAB-LA for PrEP through the USAID CHEKUP II Activity.

PrEP service disruption (oral PrEP and CAB-LA) were reported in several KP service delivery points, particularly in Lusaka and Northern Province, due to closure of wellness centres disrupting continuity for newly initiated clients[11]. Shortages of water-based lubricants, STI treatment drugs, and HIV self-test kits have further eroded trust in service reliability, disproportionately affecting MSM and TG populations.

The closure or downscaling of KP-operated safe spaces and Wellness Centers—sites typically managed by KP-led civil society organizations and staffed by trained peers and KP-competent providers—has pushed many clients back into mainstream health facilities, where stigma, discriminatory attitudes, and fear of being outed remain high.

According to peer navigators (client advisors and community health workers) and community-led monitoring reports (Q2 FY25), clients increasingly avoid or delay care due to anticipated mistreatment or lack of confidentiality in general public health settings. This has led to interruptions in ART and PrEP, missed STI treatment, and reduced uptake of prevention commodities, particularly among MSM, TG persons, and FSWs.

[11] Zambia Key Populations Programmatic Update, Quarter 2 FY2025 (USAID CHEKUP II and CIDRZ internal site-level reporting), and Key Population Supply Chain Briefing Note, April 2025 – compiled by Zambia Ministry of Health and UNFPA, with partner inputs from CIDRZ, ZHECT, and LATU.

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
PrEP access points for KPs	30–50%	Both injectable and oral PrEP rollout were impacted due to site closures and reduced peer outreach support. • Oral PrEP: Access declined significantly following the closure of several DREAMS and KP Wellness Centers in Lusaka, Central, and Northern Provinces. Reduced peer outreach, stockouts, and lack of refills for mobile populations contributed to poor continuation rates—especially among FSWs, MSM, and AGYW. • Injectable PrEP (CAB-LA): Rollout has been severely disrupted by a combination of programmatic instability, funding cuts, and reduced site functionality, especially in Nakonde, the initial PrEP CAB-LA pilot district. Additional barriers include: o Rumors and misconceptions about CAB-LA's side effects and long-term impact, particularly among TG and MSM populations. o A program shift without adequate community sensitization, leading to confusion about eligibility and scheduling. o U.S. retreat from funding CAB-LA roll out has led to fear and uncertainty within the KP community, undermining trust in the CAB-LA program reliability and continuity. o As of mid-2025, fewer than 10 sites nationally were equipped to offer CAB-LA, primarily in urban centers, with minimal demand-creation activities in place.
Condom and lubricant distribution to KPs	40%	Monthly distribution dropped significantly due to logistics gaps and reduced outreach, especially in border and peri-urban areas.

Non-negotiable priorities:

- **Support the minimum package for primary prevention:** The KP coalition assesses that it is essential for the Government of Zambia and partners to ensure continued provision of a standard primary prevention package for all KPs as defined by the National AIDS Council (NAC) and national KP frameworks (including the NASF 2022–2026 and the National KP Strategy). This minimum package for primary prevention for all KPs (FSWs, MSM, TG, PWID, and AGYW in high-risk settings) includes:
  - HIV Testing Services (HTS) – routine and targeted, including index testing and self-testing.
  - Condoms and Water-Based Lubricants – distributed via peer outreach and Wellness Centers.
  - Oral PrEP and CAB-LA PrEP – for eligible individuals at substantial risk of HIV infection.
  - STI Screening and Treatment – syndromic management and referrals for lab diagnosis.
  - Harm Reduction Support (PWID) – including safe injecting information and linkage to care.
  - Psychosocial Support & GBV Referrals – basic mental health screening and referrals.
  - Behavioral Interventions – risk reduction counseling, community empowerment, and peer navigation
  - Sexual and Reproductive Health (SRH) – particularly for cis-women and transgender sex workers.
  - TB Screening and Preventive Therapy – at ART and PrEP initiation points.
- **Deliver prevention services through Wellness Centres:** These services should be delivered via the Wellness centre model which has been the main delivery platform for the KP primary prevention package in Zambia. These centres are typically KP-focused or KP-led, offering a safe, stigma-free space with integrated clinical and psychosocial services.
- **Ensure Wellness Centres are well staffed:** Wellness Centres are staffed by trained healthcare workers, peer navigators, and community outreach staff, and provide HTS, ART, PrEP (oral and injectable), STI treatment, condom/lube distribution, psychosocial support, and referrals for GBV and mental health.
- **Continue the roll out of Medication-Assisted Treatment (MAT):** Zambia's ongoing roll out of Medication-Assisted Treatment (MAT) for PWID, an essential component of the harm reduction package, through dedicated clinics operating at the University Teaching Hospitals (UTH) in Lusaka, Ndola, and Livingstone will integrate with Wellness Centres with possible expansion to other districts. These clinics aim to reduce opioid dependence, improve retention in HIV care, and support holistic recovery. Alongside Wellness Centres, MAT clinics serve as an important component of the service delivery infrastructure for PWID. These clinics are expected to integrate efforts with Wellness Centres and community-based outreach to support case management, improve continuity of care, and reduce stigma. Additionally, service delivery access could be improved by leveraging more innovative, differentiated service delivery mechanisms such as through pharmacies and virtual platforms which are still in nascent phases of use in Zambia.
- **Maintain the "Zambia Ending AIDS" communication campaigns:** Finally, Zambia has had one of the most effective HIV public health communication campaigns in "Zambia Ending AIDS". Going forward, HIV prevention will need to maintain support from this effort, in particular for new product introduction and program budgeting should take this into account.

Strategic Element	Current Status	Annual Funding Gap/Need	Key notes
Oral and injectable PrEP	Significant gap	3,697,765	Maintain current, scale up injectable and expand access. Injectable options reduce stigma to PrEP use.
PrEP sites Standalone KP Wellness Centers	High gap	600,000	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	600,000	Introduce mobile clinics to improve access
KP-friendly general population PrEP sites	Moderate gap	230,000	Scale up KP sensitisation as general health facilities require KP-specific service capacity and training
Prevention policy and national guidance	Moderate gap	95,000	Essential for the introduction of new prevention options
Building demand creation and awareness on PrEP	Moderate gap	$120,000	Needed for the demand of PrEP options at the community level
Condoms and lubricants	High gap	65,000	Expand informal and peer-led distribution to the last mile to Increase reach through non-traditional KP-friendly channels; community vending and hotspot distribution

STI screening, Lab monitoring and service delivery		572,000	
Methadone, buprenorphine or other opioid agonist maintenance therapy (OAMT	Significant gap	305,000	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 **$6,714,765** annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? Unless we rebuild KP-led prevention service provision, Zambia's HIV programme will crumble. HIV prevention is the gateway for KPs to access services. Access to key services such as HIV testing and PrEP allow people to begin the journey of maintaining their HIV negative status or access ART. The need for prevention is irrefutable and the key link between the demand and access to these services and KP communities is community organisations and Wellness Centres.

3. Community Infrastructure

With donor transitions underway and funding uncertain, KP-led CSOs and community-based groups have reported a loss of voice in national HIV planning forums, such as the KP Technical Working Groups (TWGs). Community feedback loops, peer-led monitoring, and inclusion in planning processes have diminished, especially at district level, weakening the foundation for sustained, community-centered programming.

The momentum built around integrating KP services into MoH systems—such as through seconded staff and joint supervision—has slowed considerably. Efforts to transition donor-supported KP services into government budgets or Global Fund country co-financing commitments remain minimal, with no concrete roadmap for sustaining service delivery beyond 2026. Civil society participation in sustainability dialogues has waned due to both resource fatigue and lack of clear leadership, threatening long-term ownership.

Community-based service delivery has been a cornerstone of the KP response in Zambia. Approximately 100–150 community-based volunteers and peer navigators were actively engaged across PEPFAR-supported sites. KP-led civil society organisations (CSOs) received limited but crucial funding (e.g., USAID CHEKUP II allocated $400,000 for KP CSO grants in FY25) to strengthen service delivery, advocacy, and policy dialogue. However, sustainability remained fragile, as many of these organizations were highly dependent on external funding and lacked robust core support making them highly vulnerable to donor shifts and programmatic instability. Sustaining and scaling this community networks will require dedicated investment in infrastructure, institutional capacity, and leadership development within KP-led organizations.

Core Components of the KP Community-Based Response:

- **Peer-Led Services:** Peer educators, navigators, and outreach workers providing risk reduction education, linkage to care, re-engagement, and client follow-up.
- **Safe and Stigma-Free Service Delivery Points**: safe spaces, and Wellness Centres operated by or in partnership with KP-led organizations.
- **Structural Interventions:** Community-led monitoring (CLM), GBV case support, legal literacy, rights education, and violence prevention mechanisms.
- **CSO Engagement in Governance:** Inclusion of KP-led CSOs in national and sub-national HIV planning, resource allocation, and policy development forums (e.g., KP TWG, NAC).
- **Advocacy and Policy Dialogue:** Community-driven advocacy to address criminalization, policy gaps (e.g., for TG and PWUD rights), and equitable resource distribution.
- **Data Systems:** Community data collection for KP cascade indicators (testing, ART, PrEP, VL suppression, GBV), used to inform service quality and access barriers.

Engagement in National HIV Planning

The level of KP engagement in national HIV planning by December 2024 was moderate: KPs had representation in the National HIV TWG and Key Population Technical Working Group, but not consistently across all sub-national structures. The MoH and the National AIDS Council (NAC) had shown increasing openness to KP inclusion, evidenced by joint site supervision and technical support in DREAMS/KP centres. However, KP voices were often underrepresented in budgeting, procurement planning, and M&E review forums.

Sustainability Roadmaps and Action Plans

By December 31, 2024, Zambia had developed two important guiding documents to strengthen and sustain Key Population (KP) programming: The National Key Population Strategic Framework (NKPSF) 2021–2026, and The National AIDS Strategic Framework (NASF) 2022–2026, both of which recognised the need for inclusive, rights-based, and sustainable KP interventions.

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Legal & GBV Support Infrastructure	~50%	Peer paralegal programs, safe reporting channels, and GBV survivor assistance collapsed in at least 6 of 10 districts.
KP Participation in HIV Planning Forums	60%	KP-led CSOs were excluded or absent from 3 out of 5 provincial reviews and no longer have funded coordination capacity in several districts.

Non-negotiable Priorities:

- **Support** legal and GBV support infrastructure to address rights violations that hinder access to healthcare
- **Strengthen** community-led monitoring to ensure that KP communities are able to monitor the quality of services offered to peers and support the government with the data needed to make informed programming decisions.
- **Support** institutional support systems for CSOs to ensure continued critical participation in governance and HIV planning spaces

Strategic Element	Annual Funding Required	Key notes
Legal & GBV support infrastructure	$147,000	Essential for providing legal support to communities
Community led monitoring	$840,000	Key to evaluate and ensure quality service delivery is retained
CSO engagement in governance	$75,000	Critical for community participation in decision making spaces
KP participation in HIV planning forums	$100,000	Critical for community participation in decision making spaces

Community Infrastructure Funding Gap: $1,162,000 per year

What is the cost of inaction? Meaningful engagement of key populations is critical to the success of the HIV program. Communities need to be at the centre of the discussion and to have their voices had. The cost of the funding cut is that the voice of the communities have diminished due to incapacity to participate in meetings due to loss of funding and the lack of government ability to fund the organisations to continue with advocacy work. Inaction will mean less community voices which will have negative effects on the program as government will no longer hear directly from those receiving the service about the quality of services and the key approaches government should take to ensure maximum returns on investments.

Summary of proposed cost of the Zambia Key Population Plan

Methodology

In Zambia, 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 Zambia budget, Zambia will focus on 30% of treatment and 20% 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: Zambia Targeting and Costing.

Category	Activity/Item	Annual Cost Estimate	Budget Narrative	Funding Sources + Needs
Staff	Train and embed KP-competent health workers within public clinics and Wellness Center settings to provide stigma-free, inclusive care national rollout and supportive supervision budgeted at $250,000. $600 per peer/month, or $360,000 annually for national coverage.	$645,875 (Year 1)	Covers adaptation of existing MoH training materials (not a new cadre); training & refresher for ~100 MoH clinical staff and facility managers; includes TA support & quality standards toolkit. Supports integration of KP-friendly service in 40–50 MoH sites.	PEPFAR (partial, limited); Funding gap: $150,000
	Reinstate peer navigators and outreach workers attached to Wellness Centers to ensure community linkage, adherence, re-engagement in care approx and KP participation in HIV planning forums	$360,000	$600/month x 50 peer staff across 10 high-burden districts. Covers stipends, supervision, job aides, and performance monitoring. Links to reengagement, PrEP continuity, and community ART support.	USAID CHEKUP II (prior support, now over); Funding gap: $360,000
Commodities Oral PrEP, CAB-LA and LEN-PrEP	Expansion of CAB-LA reach and starting LEN PrEP	$4,697,765		

Commodities	Restore supply chains for PrEP (oral and injectable), condoms, lubricants, and HIV self-testing kits to ensure uninterrupted prevention services	$300,000	Inclusive of procurement and distribution for: - ~12,000 PrEP users - ~2M condoms, 400,000 lube sachets - ~20,000 HIVST kits LEN is not included – consider separate harm reduction line	ZAMMSA (partial), CHEKUP II (was support); Funding gap: $300,000
Sites	Reopen and sustain KP-focused Wellness Centers in high-burden districts to offer integrated ART, PrEP (including CAB-LA), STI treatment, mental health, and GBV support estimated at $200,000–$300,000 per center annually.[12] Consistent with PEPFAR COP23 cost benchmarks ($200,000–$300,000 per KP Wellness Center annually), Zambia estimates the funding needs for sustaining 15 sites at approximately $2.4–$4.5 million per year."	$200,000 –$300,000 per site x 15 sites = ~$4.5M	Targeting 15 Wellness Centers across Lusaka, Kapiri Mposhi, Kabwe, Nakonde, and others. Includes rent, staffing, clinical supplies, utilities, and integrated KP services (ART, PrEP, STI, MH, GBV).	Previously CHEKUP II; Funding gap: $2.4M – 4.5M per year
	Expand KP Data Monitoring System and link with DHIS2	$1,470,205	Staffing, setting up networks and data systems, and purchases of servers and gadgets	
Systems	Updated KP Action Plan reflecting differentiated needs and sustainability targets under constrained budgets.	$600,000 (one-time)	Includes: - National & provincial validation workshops - Consultant and KP coalition-led drafting - KP priority typology-specific plans (TG, PWID, youth) - Integration costing with NASF review. Not covered in other systems costs.	NAC/UNAIDS (some support); Gap: $300,000

[12] PEPFAR. (2023). COP23 Guidance, p. 27.

	All HIV service delivery points (including public and KP-run) should collect and report complete KP disaggregated data quarterly.	$1.1 million (Year 1 setup, $600K/year ongoing)	Covers national rollout of data tools, partner system alignment (SmartCare/DHIS2), training, data use dashboards, and validation events in 10 priority districts.	PEPFAR SI partners (limited); Gap: $1.1M
	A unified reporting module for supportive KP services (mental health, GBV, STI is needed for partner and MoH systems.	$850,000 (setup and rollout)	Fills gaps in current reporting platforms by adding partner-level data on non-HIV KP services. Includes developer costs, training, piloting in 5 provinces, and CSO-led M&E reviews.	Not currently funded; Gap: $850,000
	Structured MoH-CSO quarterly supportive supervision in every priority district	$745,000	Supports joint supervision, transport, tools, and district-level reviews	CHEKUP II (prior support); Gap: $600,000
	Produce national KP-specific HIV cascade report annually, endorsed by KP TWG and included in NASF mid-term reviews	$250,000	Institutionalise KP cascade reporting and convene stakeholder validation sessions. Including KP cascade reporting (PrEP, ART, VL, retention, STI, GBV); supports data analysis, KP TWG validation, dissemination via NASF/MoH.	NAC/PEPFAR partial; Gap: $250,000
Support	Fund KP-led CSOs to support Wellness Center operations through community-led monitoring, client feedback systems, and advocacy approx. $120,000–$150,000 per CSO annually, prioritizing at least 4 key CSOs, CSO engagement in governance -$75,000	$745,875	CSOs: WAFE, LATU, KPAZ, TBZ. Budget includes core admin support, rent, salaries, monitoring staff, CLM tools, and participation in district & national TWGs.	GF (partial prior support); Gap: $600,000
	Tailored services for underserved groups especially transgender persons and PWID	Integrated in above activities	Covered across staff (training), sites (DIC tailoring), and commodities (CAB-LA, PrEP options). Separate line for OAMT and needle exchange (LEN) would need costing if prioritised.	N/A; optional separate costing if OAMT is added

Total Estimated Investment Needed: $16,255,695

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.

Zambia's Methodological Guide:

The Zambia Consortium of Key Population Organizations developed a costed strategy of essential elements of KP programs endorsed by the Consortium. Undergirding these strategic priorities is a set of principles for rebuilding and sustaining effective programming in the context of funding cuts and donor retreat from HIV.

Guiding Principles for Rebuilding and Sustaining Effective KP Programming

- **Prioritise intersectionality of programming:** All KP services should support multiple overlapping identities (e.g., TG people who sell sex and use drugs).
  - Leverage digital tools and strategies:Consider lower-cost mobile solutions for legal help desks, case reporting, virtual convenings, and remote psychosocial support.
  - Use digital mapping to identify where rights and violence services have collapsed to prioritise support.
- **Consolidate and integrate:**
  - Where feasible, consolidate administrative structures of small KP NGOs under umbrella platforms for shared procurement, increased advocacy power, and training.
  - Consider bundling PEP, PrEP, and mental health into an integrated KP emergency care package.

This strategic planning process was undertaken by a civil society coalition with leadership from the Global Fund & PEPFAR Advocacy Network's Global Coalition on Key Population Priorities (GBGMC) and support from a range of stakeholders invested in the continuation of effective, rights-based HIV prevention, treatment and community-led responses for key populations.

Recognizing that programming for key populations is at particular risk of being eliminated or damaged in hasty efforts to define country-level integration of HIV services as a response to drastic funding shifts for HIV—particularly from the US government PEPFAR program—this coalition undertook collaborative work with countries to develop comprehensive plans for essential services that must be retained going forward.

The process involved extensive consultation with key population communities, civil society organizations, government representatives, technical experts, and advocacy allies to identify priority interventions, assess current gaps, and articulate community-endorsed approaches for sustainable service delivery. Following this community-driven assessment phase, the coalition worked with a range of subject matter experts to assign costs and coverage targets to the identified essential services, enabling the development of the detailed costed strategies presented in this document.

These strategies reflect the collective voice and priorities of key population communities while providing concrete frameworks for funders, governments, and implementing partners to maintain and strengthen life-saving HIV services. The approach ensures that decisions about service continuation, modification, or integration are informed by community needs and evidence-based programming rather than driven solely by funding constraints.

The Team

The Zambia team would like to acknowledge the contributions from Henry Sakala (Muzu Wandile) Director Latu Human Rights Foundation, Country lead for facilitating the survey and providing technical input into the document. Furthermore acknowledge the Zambia key populations and key stakeholders for their active participation in this process and for validating the content.

Key Populations Consortium

The lotus Identity

Women's Alliance for Equality

Deceive Minds

Sanity House

Ascending Youth Futures Foundation

Umotto Center for Culture

Key population Alliance of Zambia

Dignitate Zambia

Transbantu Association TBZ

Coalition for Health Zambia

Titandezeni Umoyo Network

Technical Team

Global Black Gay Men Connect (GBGMC): Maureen Milanga, Brian Kanyemba, Kingford Khanyiso, Micheal Ighodaro

Health Global Access Project: Brian Macharia, Asia Russell, Belinda Thibela

Partners

Partners: UNAIDS, KP-TNC, Kenya Key Population Consortium (KKPC), amfAR.

Contributors (research & preliminary drafting): Emily Bass, Brian White, William Miller

Technical contributors: Kent Klindera, Devynn Birx-Raybuck, Meg Densmore, Sarah Ekellogg, Sara Melillo, Ron Macinness and Brittany Parnel

Funders:

Elton John AIDS Foundation (EJAF)

UHAI-EASHRI

AidsFonds

Finally, 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.