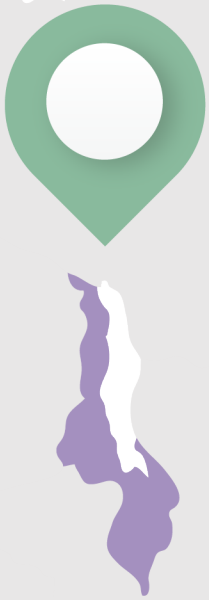
Malawi:

Key Populations' Strategic Priorities



Introduction

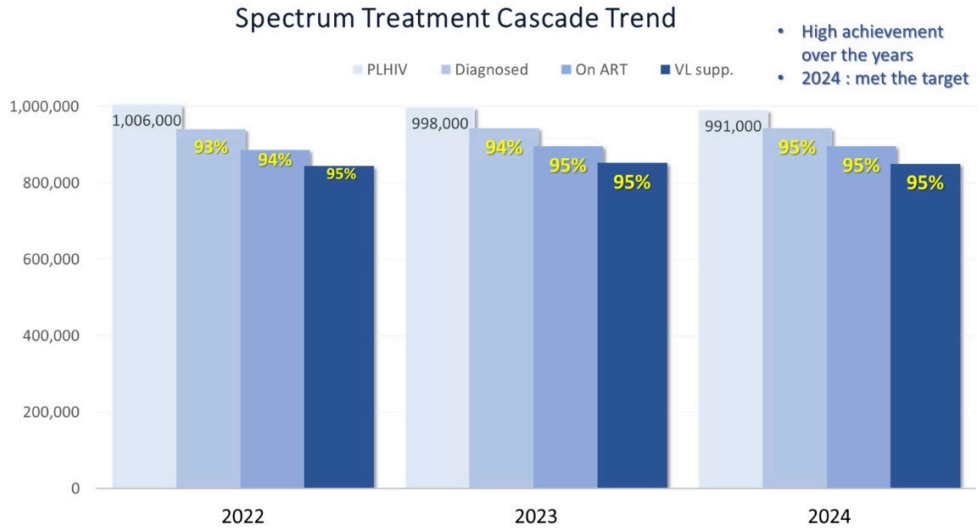
By the end of 2024, Malawi's Key Population (KP) programme had established a functioning service delivery framework through an estimated 18 Drop-in Centres (DICs) spread across Blantyre, Mangochi, Muzuzu and Lilongwe serving female sex workers (FSWs), men who have sex with men (MSM), transgender (TG) individuals, and people who use or inject drugs (PWUDs). The country had built a substantial community infrastructure with an estimated 13 KP-led organisations actively conducting advocacy and policy engagement, 6 organisations providing social support services, and 6 community-led monitoring programmes ensuring accountability in HIV service delivery.

While there was progress to reach KPs, especially MSM and FSWs, there were still gaps in service delivery that needed attention to improve the quality of services prior to January 2025, including reaching key populations (KPs) not based in urban areas, transgender communities, incarcerated KPs and PWUD. Structural barriers including criminalisation, stigma and discrimination also hindered access to life-saving health services. Whilst successful community-led models were supported, DICs and peer-led approaches remained underfunded, fragile, and limited to a few urban centres. A lack of robust policies especially for PWUDs and transgender community members, alongside challenges of integrating KP national databases to track and use KP data also persisted and undermined service delivery.

In the first half of 2025, Malawi experienced devastating losses in KP HIV programming marked by widespread service closures, massive staff disruptions, and the collapse of essential community systems. This increased the strain on the growing KP programme and on the cohort of 7,600 key population members living with HIV accessing HIV treatment and greatly impacted the 7,000 continuing Pre-Exposure Prophylaxis (PrEP) HIV prevention services including access to oral and injectable PrEP.

What does the data say about HIV prevalence among KPs in Malawi[1]? 50% among sex workers , 12.7% among MSM, 4.3% among TGs, 27.45 among PWID

Where was Malawi on the 95/95/95[2] track? Malawi had achieved the 95/95/95 UNAIDS targets by 2024 for the general population; KP cascade data unavailable



[1] HIV Epidemiological Estimates for Malawi, HIV Prevention Technical Working Group Meeting,2025
[2] https://www.unaids.org/sites/default/files/media_asset/progress-towards-95-95-95_en.pdf

By June 2025, the KP response in Malawi found itself in crisis, marked by severe service coverage reductions, weakened peer networks, and the near-complete collapse of community-led monitoring and rights protection infrastructure. While some essential services such as ART and prevention including PrEP, remain partially operational, they are significantly limited in scope, reach, and quality, particularly following the disruption of an estimated 4,451 PEPFAR-funded staff across 10 implementing partner organisations and 18 DICs[3].

Malawi had also made gains through the Blantyre Prevention study (BPS), a joint programme between the Malawian government, NGOs, and local actors that was designed to apply quality improvement (QI) methodology to HIV prevention, but whose progress has stalled as the HIV programme faces staff lay-offs, reduced outreach capacity, supply chain challenges, reduced testing and DIC operations[4] [5] . While the BPS' systems-strengthening and coordination work remains, the funding shortfall has also threatened its ability to fully implement high-impact strategies, as community engagement, data-driven quality improvement, and integrated service delivery depend on stable partner capacity.

Malawi's KP HIV response is currently surviving on the fragmented remains of what was once a comprehensive system providing a package of core clinical and behavioural services necessary to identify people at risk of HIV infection and link them and their partners with biomedical and structural prevention services, and identify people living with HIV and link them with life-saving treatment and care. The few remaining DICs are operating with sharply reduced services, challenges in commodity distribution to the community members due to lack of support for peer community workers to facilitate distribution and an overstretched health system lacking KP-competent providers. The near-total erosion of community infrastructure, combined with the exclusion of KP voices from ongoing district and national planning and coordination processes, signals a critical need for emergency intervention and systematic rebuilding.

With massive organisational closures and funding uncertainties, KP-led CSOs have largely lost their voice in national HIV planning forums. Community feedback loops, peer-led monitoring, and inclusion in planning processes have diminished significantly, especially at district level.

The Ministry of Health lacks comprehensive data tools to track KP-specific outcomes as comprehensively and accurately as PEPFAR systems did. This has affected data quality and programme monitoring at both district and national levels. Community-led monitoring (CLM) has collapsed, creating critical blind spots in understanding service access and quality during a time of crisis. The only remaining CLM programme is funded by the Global Fund; it is not KP-led and is restricted to Malawi's 9 Global Fund implementation districts; PEPFAR-supported districts are excluded.

The Malawi Consortium of KP Organisations under the Diversity Forum undertook this assessment to identify the key non-negotiable priorities needed to rebuild and maintain a quality life-saving key population programme. We assessed the disruptions created by new funding gaps created by the US retreat, defined community priorities and shared costed essential elements of KP programmes endorsed by the KP coalition and designed to coordinate emergency response and systematic reconstruction.

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[3] https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250327_Malawi_fs [4] https://oneill.law.georgetown.edu/projects/blantyre-prevention-strategy/ [5] https://www.frontiersin.org/journals/reproductive-health/articles/10.3389/frph.2025.1558630/full

What was the investment profile as of the last SDS?

Total Investment Profile for HIV Programmes, 2022[6]					
Area	**Total $**	**Domestic Government**	**Global Fund**	**PEPFAR**	**Other Funders**
Care and treatment	$230,610,828	0%	64%	36%	0%
HIV testing services	$14,011,855	0%	59%	41%	0%
Prevention	$39,196,957	0%	21%	79%	0%
Socio economic (including ovc)	$8,174,954	0%	5%	95%	0%
Above site	$26,621,658	0%	41%	59%	0%
Programme management	$32,356,760	0%	10%	90%	0%
Total including commodities	$355,535,005	1%	51%	48%	0%
Commodities only	$164,124,928	0%	98%	2%	0%

[6] https://www.dropbox.com/scl/fo/sozw9ixydjlx7phe3tfwn/ANP9xk2d7iQMOS2xcqqj3Ew/SDS/2022?dl=0&preview=Malawi.pdf&rlkey=73df8y19t1azhi6b9gixhl4j7&subfold-

PEPFAR FY2025 Budget Breakdown

The information below reflects the planned allocations prior to grant cancellations, stop work orders and other shifts in the PEPFAR programme.

Category	Programme Area	PEPFAR FY2025 Amount	% of KP Budget
Care & treatment	HIV Clinical Services	$3,266,330	48.8%
HIV testing Services	Community-based testing	$932,335	13.9%
Prevention	PrEP	$1,480,903	22.1%
	Non-Biomedical HIV Prevention	$683,880	10.2%
	Not Disaggregated	$251,142	3.8%
	Condom & Lubricant Programming	$76,017	1.1%
TOTAL	**All KP Programmes**	**$6,690,607**	**100.0%**

KP Community Core Priorities

1. Antiretroviral Therapy (ART) and Service Continuity

The KP coalition's strategic vision for ART programming acknowledges that while commodities remain available through Ministry of Health (MoH) systems, the collapse of peer cadres and KP-friendly service delivery has severely compromised access, retention in care, and access to crucial monitoring tools such as viral load testing and advanced HIV disease screening. Multi-month dispensing and referrals to public health facilities have been inconsistently applied and often lack KP sensitivity approaches, leading to treatment interruptions and poor adherence outcomes.

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
ART new initiations for KPs	62.5% reduction	New ART initiations dropped from 400 to 150 per quarter due to outreach suspension and centre closures
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.
- Maintain and key population KP peer cadres to **find, mobilise, link and maintain KPs in care,** with suppressed viral loads.
- **Maintain the current KP-specific ART sites** to ensure that there are safe spaces for KP service provision.
- **Scale up** KP-friendly integrated sites that have service providers trained to provide key population-friendly services.
- **Restart and maintain TB diagnosis**, prevention and treatment services as most services were terminated.
- **Restart and maintain mobile clinics** and community viral load sample collections which were terminated.

Strategic Element	Current Status	Annual Funding Gap	Key notes
ART commodities	Available through MoH	MoH continues support	Ensure consistent supply chain to designated KP service areas
Peer cadres	Most peer workers stopped	$360,000	Essential for community mobilisation and linkage to services. 60 peer staff needed to provide minimum coverage.
KP-specific ART sites	Some closed (6 of 18 closed, and remaining DICs providing very minimal services	$480,000	DICs provide critical safe spaces and comprehensive, life saving services requiring urgent support
KP-friendly public sites	Not reliable	$180,000	Need intensive mentorship and training for providers on KP-friendly services
TB diagnosis & treatment	Most sites stopped/closed	$150,000	Previously donor-dependent, requires sustainable funding
Viral load access	Mobile VL collection stopped	$120,000	Community VL sample collection was critical for client retention

ART Funding Gap: Approximately **$1,290,000** million annually to restore comprehensive, peer-supported ART services for KPs in Malawi.

What is the cost of inaction? Malawi has made great strides in reaching the 95/95/95 targets, and if supported, can maintain momentum in reducingHIV infections. However, this will not be possible unless the programme responds to the ART needs of KPs by finding and offering ART services in places where communities feel safest and respected. The success of the three 95s will only be realised if the programme restores and supports a robust ART programme that targets KPs who need access to treatment and support to remain in care and achieve viral suppression.

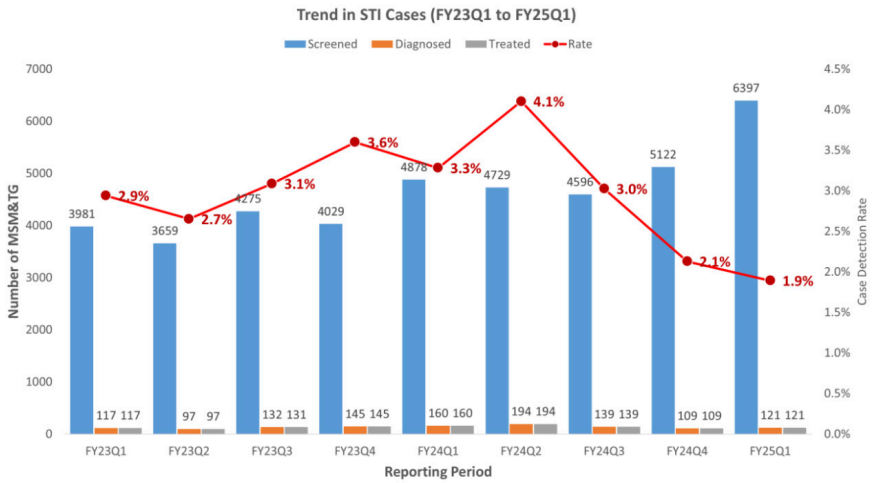
2. Primary Prevention

Prevention is the cornerstone of KP programming. Ensuring that KP communities at high risk of acquiring HIV have access to quality HIV prevention options is key to reducing new infections. While some commodities remain available, the systematic collapse of trained PrEP providers and peer distribution networks has severely compromised prevention access, particularly for oral and injectable PrEP services. KP DICs were the primary site for PrEP initiation and refills; by dismantling these sites, Malawi's PrEP ambition for vulnerable communities has been brought to a standstill.

After the funding cuts, PrEP stockouts became widespread as most trained providers stopped operating. Access to prevention options such as cabotegravir long-acting (CAB-LA) injectable PrEP has been greatly curtailed by the scale-up of injectable PrEP only among people continuing PrEP and only recruiting new pregnant and lactating women.[7] Condom and lubricant distribution continues at reduced levels only in the few remaining operational DICs. HIV self-testing kit availability has been severely limited.

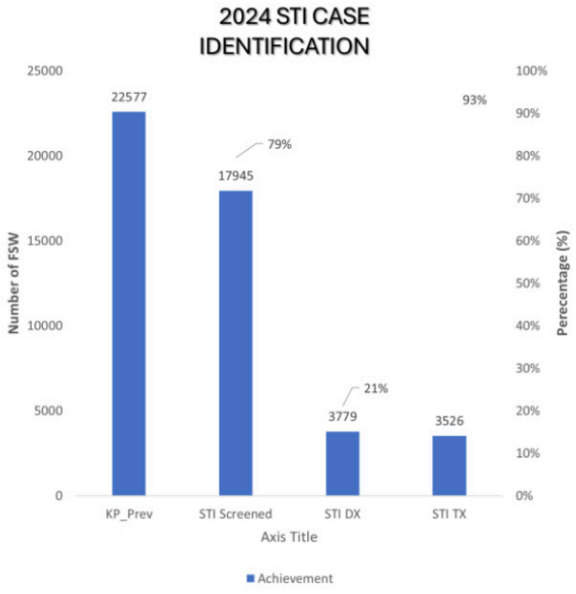
KPs, particularly MSM, often experience fear and actual incidents of involuntary disclosure when seeking STI services, largely due to negative attitudes and stigma from some healthcare providers. This discourages care-seeking for sensitive conditions such as anorectal STIs. As a result, most KPs prefer to access screening and treatment through KP-specific outreach programmes, which are known to be more friendly and non-judgmental. Female sex workers operate within environments shaped by poverty, gender inequality, and cultural norms that heighten both STI risk and barriers to accessing care. For some, traditional healers are preferred due to lower costs, greater privacy, and ease of access though this often results in delays in seeking biomedical treatment or receiving suboptimal care.

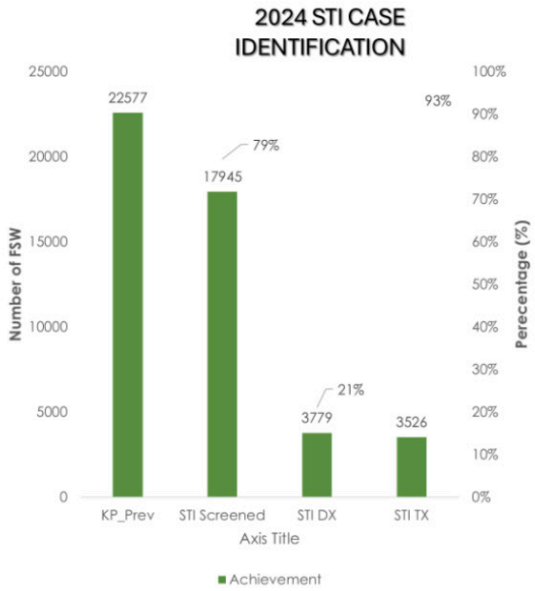
The figures below highlight examples of trends in the number of clients being screened in the 4 DIC for MSM and TGS and among FSWs.



[7] https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250327_Malawi_fs

FY23 &FY24 STI Screening for against among female sex workers





Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
PrEP access points for KPs	70% reduction	Only 30% of previous PrEP sites remain functional; most providers stopped operations, affecting oral PrEP continuation rates
PrEP new initiations	71.4% reduction	New PrEP starts declined from 700 to 200 per quarter as trained providers were laid off

Non-negotiable Priorities:

- **Maintain commodities** to support scale-up of oral PrEP and lowest costing injectable options for all populations
- **Maintain continued access** for those currently using PrEP.
- Maintain **free standing PrEP sites**
- **Scale up** KP friendly general population PrEP sites
- **Scale up** male condoms and lubricants for all populations
- **Expand availability** of condoms/lube in informal sites (e.g., bars, brothels, vending machines) managed by local actors.
- **Support harm reduction** effort for PWUD such as safe injecting equipment (needles and syringes)

Strategic Element	Current Status	Annual Funding Gap	Key notes
PrEP commodities (Oral & Injectable)	Severely restricted availability	$240,000	Includes PrEP medication, both oral and injectable
PrEP sites (Free-standing)	Few operational	Already Included in DIC costs	DICs and mobile clinics essential for KP access
KP-friendly public PrEP sites	Limited capacity	$120,000	Train more providers and support interface meetings
Condoms & lubricants	Distribution reduced	$80,000	Includes condoms and lubricants
HIV test kits	Distribution limited	$100,000	Include HIV self-test kits, train peer cadres for distribution for 7,000+ clients
Safe injecting equipment	Policy development stage	$50,000	MoH coordinating finalisation of PWID service guidelines
PEP (Post-Exposure Prophylaxis)	Limited availability	$40,000	Emergency access critical for violence survivors
Demand creation and awareness building	Limited activities	$200,000	Need for support to peer workers to support mobilisation and awareness in communities for the services available and access points.

Primary Prevention Funding Gap: Approximately **$830,000** annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? Failing to ensure adequate access to PrEP for KPs in Malawi would carry significant public health, economic, and social costs. Without timely scale-up, new HIV infections among high-risk groups such as MSM, TGs, FSWs, and PWUDs are likely to increase, driving transmission in both KPs and the general community. This would reverse recent gains in epidemic control, leading to higher lifetime treatment costs for the health system, which are substantially greater than the preventive costs of providing PrEP. For example, the annual cost of ART for one person can exceed the cost of providing PrEP to multiple individuals for a year, making prevention far more cost-effective.

3. Community Infrastructure

Community infrastructure is a central part of the success of the key population programme. Community-led organisations have greatly contributed to finding and linking and maintaining KPs. These community organisations are also key to ensuring that key population data is collected, disaggregated and used for future programming and funding.

In Malawi, KP-led organisations play a critical role in advancing inclusive, rights-based health and social systems. Their primary roles include amplifying the voices of KP communities to influence national HIV policies, health budgets, and legal reforms. They engage in lobbying for decriminalisation, stigma reduction, and KP inclusion in national frameworks as they participate in different forums including, technical working groups, diversity forums, district health structures and Global Fund meetings. The shutdown, however, reveals catastrophic losses requiring systematic rebuilding of advocacy, monitoring, and protection systems that form the foundation of sustainable KP programming.

The level of KP engagement in national HIV planning by December 2024 was moderate to strong, with KP representation in national Technical Working Groups (TWGs), diversity forums, and district health structures. However, this engagement was heavily dependent on donor-funded coordination capacity and organisational support.

Drop-in Centres and Safe Spaces

As of the end of 2024, Malawi operated 18 DICs providing comprehensive packages. These DICs decreased to 12; 11 serving FSWs and 2 serving the MSM and TG community members by June 2025. These centres served as the primary platform for reaching FSWs, MSM, TGs, and PWUDs across urban and peri-urban areas.

The DIC that are still open operate with severely reduced services due to inability to pay staff salaries and rent. The remaining centres (CEDEP Lilongwe, CHeRA Lilongwe Ivy foundation, NRA Blantyre, FSWA Zomba, Social Justice Foundation Blantyre, and Pakachere Blantyre) continue with minimal services, while organisations like Gender Collective Mzuzu, CKPOR Blantyre, and ASKE, OPTIMUM foundation, The VOICE sites have ceased operations entirely.

The DIC model provided:

Direct and referral services: Condom and lubricant distribution, HIV testing, ART initiation and refills, PrEP services, STI screening and treatment, psychosocial support,, and Gender-Based Violence (GBV) case identification and response mental health services, and legal aid and peer navigation support for linkage among others.

Typical staffing included:

- 1-2 clinical officers or nurses (where medical services were provided directly)
- 1-2 professional counsellors
- 2-4 peer navigators
- 1 centre coordinator
- 1 community liaison officer or outreach lead

Community-Based Services and Organisations

Community-based service delivery formed the cornerstone of Malawi's KP response. At the end of 2024, the country had:

- **An estimated 13** KP-led organisations actively conducting advocacy, accountability work, and government engagement through TWGs, diversity forums, and district health structures
- **An estimated 6** organisations providing social and material support including shelter, food, safe spaces, and psychosocial support
- **An estimated 6** community-led monitoring programmes ensuring service quality and collecting real-time data on access barriers
- **An estimated 6** organisations offering legal and rights protection services supporting KPs
- **An estimated 6** organisations offering violence prevention and response services supporting KPs
- **13 active DICs**, of which 11 were serving FSWs and 2 were only serving the MSM community

Core Components of Malawi's KP Community-Based Response included:

- **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:** DICs operated by or in partnership with KP-led organisations.
- **Structural interventions:** Community-led monitoring, 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 and policy development forums.
- **Advocacy and policy dialogue:** Community-driven advocacy addressing criminalisation, policy gaps, and equitable resource distribution.
- **Data systems:** Community data collection for KP cascade indicators used to inform service quality and access barriers.

Key Estimates of Reductions (January-June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Operational drop-in centres	22.2% reduction	Of the 18 DICs, 4 have completely closed and 10 are operating with severely reduced services due to funding cuts
Peer navigators/Outreach Workers	Complete suspension	All outreach activities for ART suspended; peer navigation networks collapsed due to funding cuts
KP organisations conducting advocacy	46.2% reduction	From 13 to 7 active organisations due to inability to pay staff and rent
Social support organisations	83.3% reduction	From 6 to 1 organisation providing shelter, food, and psychosocial support
Community-led monitoring programmes	83.3% reduction	From 6 to 1 active CLM programme due to loss of training, tools, and coordination support
Legal protection services	75% reduction	From 20 to 5 services; paralegal programmes and legal aid capacity severely impacted
Violence prevention services	100% elimination	All 6 violence prevention and response services ceased operations

Non-negotiable Priorities:

- **Maintain a national KP coalition** or network with capacity to convene, consult and mobilise communities.
- **Maintain KP advocacy** and accountability organisations with coverage in all priority geographic areas and for all KP population groups.
- **Scale up** legal and rights protection services for KPs.
- **Scale up** violence prevention services.
- **Scale up** methadone, buprenorphine or other opioid agonist maintenance therapy (OAMT) programmes.

Strategic Element	Current Status	Annual Funding Required	Implementation Notes
National KP coalition/network	CEDEP, Diversity Forums, CSAF available	$80,000	Strengthen coordination and convening capacity
KP advocacy organisations	13 → 7 active organisations	$280,000	Core support for advocacy and accountability across geographic areas
Legal & rights protection	Limited support available	$150,000	Essential for violence prevention and case response at the national and district levels
Violence prevention services	Very limited capacity	$120,000	Critical protective services for at-risk community members targeting key stakeholders,police, law enforcers, KPs, service providers and community gate keepers
Community-led monitoring	6 → 1 active programme	$150,000	Restoration of accountability mechanisms across all sites
Social support organisations	6 → 1 operational	$120,000	Shelter, food assistance, psychosocial support restoration

Data systems	KP disaggregation eliminated	$126,800	System upgrades and technical assistance for KP-specific indicators
Structural interventions including GBV	Funding terminated	$228,245	Violence prevention, legal aid, and law enforcement engagement programmes
Human rights & legal protection	Restore structural intervention programmes	$180,400	Violence prevention and response, legal aid, law enforcement engagement, and human rights monitoring across priority counties.
KP Consortium	Support and coordinate KP programing	$280,400	Coordination of KP organisation and KP programmes.

Community Infrastructure Funding Gap: Approximately **$900,000** annually to rebuild essential community systems and protective mechanisms.

What is the cost of inaction? There will be no community organisations to mobilise and build solidarity among KPs to demand services, respond to human rights violations, and create safe spaces for engagement, peer education, crisis response, and mutual aid initiatives.There will be no space to assess the quality of the services offered to KPs to ensure access and retention of community members and access to quality services.

Safe houses and emergency shelters for GBV survivors and displaced KPs, especially transgender people, will shut down, leaving no protective options in times of crisis, and frontline defenders and rapid response teams will no longer be able to respond to human rights violations, emergency relocations, or legal aid needs.

The closure of KP-operated DICs will continue to force many clients back into mainstream health facilities where stigma, discriminatory attitudes, and fear of exposure remain high. Reports already indicate increased avoidance behaviour, where clients skip care or delay visits due to anticipated poor treatment. Most critically, there will be a reduction in access to HIV prevention, treatment, and psychosocial services for MSM, FSWs, PWIDs and TG people. Key population data collection will cease. This includes real-time data on access to services, human rights abuses, stigma in health facilities, and gaps in programme implementation.

4. Data and Monitoring Systems

By December 2024, Malawi maintained comprehensive KP-specific data collection systems through PEPFAR MER indicators and partner-led monitoring. A national bio-behavioural Surveillance (BBS) study targeting MSM, FSWs, TGs and PWIDs was completed in 2024, providing critical data on HIV prevalence, viral load, syphilis, and hepatitis B across all three regions.

Summary of proposed cost of the Malawi Key Population Plan

In Malawi, the methodology used the national population size estimates from PEPFAR, UNAIDS KP Atlas and the recent BBS 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 percentage of KP LHIV in need of treatment services (set initially at 100%). To meet the Malawi KP budget, the country will focus on 100% of both treatment and prevention as indicated below. Prisoners and clients of FSW are not included in the costing exercise. This covers the Malawi KPs Strategy Summary below with a programme cost total of $17,537,926, targeting 94,900 KPs. The itemised costing of each intervention is found on this link: Malawi Costed Budget and Targets

Malawi Key Populations Costed Strategy Summary

Category	Activity/Item	Annual Cost Estimate	Budget Narrative	Funding Sources + Needs
STAFF	Restore peer navigators and outreach workers essential for ART/PrEP continuity	$8,580,000	60 peer staff × $500/month across 12 operational DICs. Covers stipends, supervision, and performance monitoring. Critical for re-engagement and adherence support.	Previously PEPFAR-funded ; Current gap: $8,000,000
	Train and embed KP-competent staff within public health facilities	$180,000	Training and mentoring for 200 MoH staff in 30 priority facilities using KP sensitivity modules. Supports safe integration.	Limited MoH support; Gap: $150,000

COMMODITIES	Oral PrEP, CAB and Len PrEP procurement	$5,202,926	Procurement and last mile delivery of PrEP products	LEN PrEP will be provided by GF but sustainability of CAB-LA is still not clear
	Restore supply chains for PrEP, condoms, lubricants, and HIV self-testing kits	$240,000	Procurement and distribution for 7,000 KP clients across 12 centres: for lubricants.	Some MoH/GF support; Gap: $200,000
SITES	Reopen and sustain Drop-in Centres in priority districts	$480,000	Targeting 12 DICs (4 reopened, 8 enhanced): rent, staffing, clinical supplies, utilities, and integrated services (ART, PrEP, STI, MH, GBV). $40,000 per centre average.	Previously PEPFAR/GF; Gap: $80,000
SYSTEMS	Rebuild KP-specific data collection and monitoring systems	$150,000 (setup + annual)	Restore disaggregated data tools, training, dashboards, and quarterly validation. Critical for tracking recovery and informing advocacy.	No current support; Gap: $150,000

	Restore community-led	$150,000	Rebuild 6 CLM programmes with training,	GF (limited prior); Gap: $120,000
	monitoring programmes		tools, coordination mechanisms, and quarterly reviews in priority districts.	
	Emergency coordination and planning support	$80,000	Joint MoH-CSO planning, integration roadmaps, and coordination mechanisms with community safeguards.	Limited NAC support; Gap: $80,000
SUPPORT	Fund KP-led organisations for advocacy and service support	$2,000,000	Core support for 10 KP organisations at $500,000 each: operations, advocacy, community engagement, and service delivery support.	Some GF support; Gap: $2000,000

	Emergency social support services	$120,000	Restore 4 organisations providing shelter, food assistance, psychosocial support, and crisis response for displaced KPs KPs continue to face violations requiring support .	No current support; Gap: $120,000
HUMAN RIGHTS & LEGAL PROTECTION	Emergency violence prevention and response teams	$50,000	Crisis response capacity, safe houses, legal aid, and survivor support across 3 regions. Currently completely eliminated.	No current support; Gap: $50,000
	Restore legal protection services	$150,000	Paralegal training, legal representation, documentation systems for rights violations. Reduced from 20 to 1 services.	No current support; Gap: $150,000
	Coordination, monitoring & administration (8%)	$155,000	Programme oversight, joint reviews, emergency coordination, and learning mechanisms.	Distributed across above; Gap: $155,000

TOTAL ESTIMATED INVESTMENT NEEDED: $17,537,926 annually Across 11 strategic investment areas in emergency response, service restoration, systems rebuilding, and protection.

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
- tKP 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 mobilisation, and advocacy capacity).

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

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

In Malawi, the following steps were undertaken:

Consortium Coordination	The Malawi Planning Tool was developed through a participatory, evidence-informed process. Under the leadership of the Malawi Consortium of Key Population Organisations, a multidisciplinary TWG was established. This group included representatives from the Diversity Forum which represents KP-led organisations and CEDEP public health experts, and other stakeholders
Desk Review and Landscape Analysis	A review of national HIV programme documents, service delivery models, and recent policy shifts was conducted to understand the impact of the cuts. The team also examined global evidence on effective emergency response and recovery in similar contexts. This step helped identify existing resource gaps, bottlenecks, and key components of a resilient KP service package.
Data Collection and Stakeholder Engagement	Data were collected through: - Convening of the Rapid Response Meeting with KP-led senior staff representatives, in which two staff participated from each organisation. Each organisation was asked to share the impact and losses, current status, and what the plans included, including what they wanted to see in the KP space. - Roadmap development and reprioritisation of group discussions with members of the KP community to capture community-defined priorities, safety concerns, and access challenges. The team also proposed what they wanted to be done to ensure that the KPs continued to be safe. - Rapid Service Mapping across districts to determine availability, continuity, and quality of essential services during the funding crisis where organisations were operating.. - Costing and Prioritisation. CEDEP applied activity-based costing methods to estimate the financial needs associated with re-establishing and scaling essential KP services. Each intervention was analyzed for cost-efficiency, impact potential, and implementation feasibility.

The Team

We acknowledge the dedicated contributions of CEDEP staff whose leadership and coordination were instrumental throughout this process. Gift Trapence, Executive Director, provided strategic oversight and guidance; Maria Ngulube, Chief of Party, played a central role in coordinating inputs and ensuring coherence across the various components and expertly facilitated stakeholder engagement and supported the compilation of critical information. Dunker Kamba, The Diversity Forum Coordinator, for their commitment to advancing inclusive, rights-based approaches significantly enriched the final outputs.

Centre for the development of people - Gift Trapence

Pakachere Institute of Health and Development Communication

Angaza Foundation

Centre for Community Health and Awareness

Ivy Foundation in Lilongwe

Gender Collective in Mzuzu

Optimum Foundation in Salima

Social Justice Foundation

ASKE

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