South Africa:

Key Populations' Strategic Priorities

Introduction

South Africa is unique in the region because its HIV programme is largely domestically funded, although donor funds and partnerships support key components. In 2023, the last year for which complete expenditure data are available, PEPFAR accounted for 21% of South Africa's total HIV expenditure of $1.86 billion, and the Global Fund for another 3%[1].

However, this expenditure was unequally distributed across programme areas. For example, while the South African government (SAG) funded 86% of antiretroviral treatment (ART) in 2023, PEPFAR funded 50% of prevention services, including a substantial portion of the voluntary medical male circumcision (VMMC) and pre-exposure prophylaxis (PrEP) programmes. Additionally, PEPFAR supported substantial treatment retention activities by community-based healthcare workers, interventions for KPs, and health system strengthening, including investments and technical assistance in logistics, supply chain management, and data systems[2].

South Africa also has some of the most progressive legal protections for LGBTQIA+ people on the African continent. Unlike many other African countries, South Africa has decriminalised same-sex relationships, and does not criminalise transgender people. However, decriminalisation has only been extended to these KP communities; SWs and PWUDs remain criminalised.

Even with all this progress, KP groups are characterised by high HIV prevalence, social marginalisation, and stigmatisation that contribute to high rates of HIV transmission.

Some Key Population specific (KP) services, including HIV prevention and treatment, have been provided through PEPFAR supported drop-in centres (DICs) and mobile services. However these services were limited and the majority of KPs still utilised the public health system to access health services. Ritshidze data show that 83% of people surveyed in 2024 had not even heard of a DIC The accessibility of hormonal care and harm reduction services also varied depending on geographic location. When trans people are able to get a referral for hormonal care, often this means travelling long distances to a few hospitals in larger cities in the country. For those without the money to travel, or at the end of long waiting lists, it means hormonal care remains out of reach. Similarly, there is limited access to harm reduction services centred around a small handful of DICs and mobile services in limited locations across the country. Most facilities simply refer people to private rehabs and pharmacies to access harm reduction tools, putting them out of reach for those with little or no income.

To expand reach, the government and stakeholders recognised the need for expanded KP services in public health facilities and began to realign the former "High Transmission Area Programme" into the current KP programme. The Key Populations Health Implementation Plan and KP Centres of Excellence (KP CoE) became central to strengthening KP-friendly services in the public health sector[3]. However, after several years of implementation, at the end of 2024 while 33 CoEs had been "completed" across the country, being "completed" simply means that a training has taken place at the site. No additional staffing, expertise, or clinical services have been added to make this a place for KPs to come. Further, following the PEPFAR disruptions, PEPFAR's support of this work has paused.

The PEPFAR disruptions in South Africa threaten to undo a decade of progress unless services are taken over by other funders, including the South African Government (SAG). Between 2025 and 2028, discontinuing activities currently funded by PEPFAR in South Africa – without replacement by SAG – could result in an additional 150,000 to 296,000 new HIV infections (a 29–56% increase) and 56,000–65,000 additional AIDS-related deaths (a 33–38% increase).

Sustaining these services across the full programme would cost an additional $620 million to $1.4 billion between 2025 and 2028. Under a reduced budget, the most cost-effective interventions to prioritise are ART and PrEP for KPs[4].

[1] https://hivfinancial.unaids.org/hivfinancialdashboards.html [2] https://links.lww.com/QAD/D602 see Supplementary Table 1
[3] South Africa Country Operational Plan COP 2023

Geographic Distribution of PEPFAR SA Key Populations Sites[5]

District	FSW	MSM	TG	PWUD
EC: Buffalo City				
EC: Nelson Mandela Metro				
EC: OR Tambo				
GP: City of Johannesburg				
GP: City of Tshwane				
GP: Ekurhuleni				
KZ: eThekwini				
KZ: uMgungundlovu				
LP: Vhembe				
MP: Ehlanzeni				
MP: Gert Sibande				
MP: Nkangala				
NW: Dr Kenneth Kaunda				
NW: Ngaka Modiri Molema				
WC: Cape Town				

ec=Eastern Cape Province, gp=Gauteng Province, kz=KwaZulu-Natal Province, lp=Limpopo Province, mp=Mpumalanga Province, nw=NorthWest Province, wc=Western Cape Province. NB: PEPFAR also supports approximately 60 correctional centers in South Africa.

[4] https://journals.lww.com/aidsonline/fulltext/2025/08010/the_cost_of_the_plunge__the_impact_and_cost_of_a.20.aspx
[5] South Africa Country Operational Plan COP 2023 Strategic Direction Summary

While HIV services are fully available at all public health facilities across the country, the poor treatment of KPs is a cause of people either not accessing HIV prevention, or interrupting treatment or disengaging from care. Centres of Excellence (CoEs) are one solution to this. CoEs are public health facilities that are identified as places KPs can go to access services. To be workable, CoEs must be friendlier and more accessible than DICs and offer the clinical services, expertise, transport, and referral pathways that key populations need. Additional staffing is critical at these sites not only to provide the expertise and specialised clinical services required, but also to instill culture change and improve attitudes towards people who use drugs (PWUDs), sex workers (SWs), and the LGBTQIA+ community. The openly hostile treatment of KPs is prevalent and has been well documented by Ritshidze.

The country needs to establish at least two Centres of Excellence per district per population group that provide comprehensive health services, with full staff accountability measures, as well as full integration of harm reduction services, and provision of gender affirming care to ensure that KPs have access to services going forward.

A minimum package of services (minimum package of service section) must be made available at facilities serving as CoE, as well as the remaining PEPFAR supported DICs, so that they can provide comprehensive health services to PWUD, SWs and LGBTQIA+ communities.

KP Community Core Priorities

1. Antiretroviral Therapy (ART) and Service Continuity

Over the term of the current US administration, 2025–2028, the cessation of PEPFAR funding in South Africa without services being replaced by the South African Government (SAG) would increase AIDS-related deaths by 33–38%. This would return AIDS deaths to levels similar to those estimated in 2013 – undoing more than a decade of progress toward ending AIDS as a public health threat[6].

Ensuring access to ART is critical for KPs living with HIV. With the funding cuts, preserving ART is the most cost-effective support for PLHIV based on both cost per death averted or cost per life-year saved[7]. ART programs need to be designed in collaboration with KPs to ensure quality access to services.

Prior to the funding cuts, some KPs were able to access ART at DICs, while the majority were collecting through public health facilities. However, after the funding cuts, all the USAID KP DICs were closed. Now only 53% (15 out of 28) of PEPFAR funded DICs remain operational in June 2025, compared to December 2024. Further USAID supported healthcare workers and other support was terminated in 12 districts, further impacting the availability and quality of HIV services.

After the funding cuts, one critical task has been to refer KPs using now closed DICs back to public health facilities for continuation of care. It is imperative people can move between health facilities without barriers that can cause prolonged treatment interruptions. However, various challenges have arisen. First, not all DICs users have been provided with transfer letters. While PEPFAR partners attempted to ensure people received communication and referrals, there were reports of people not being provided with transfer letters in the rush and confusion of the stop work orders. While according to national guidelines transfer letters are not mandatory and people transferring without such documents should be immediately formally transferred and provided with a full supply of ART, many facilities still deny people access or only provide a buffer supply of ARVs before a transfer letter is provided. Second, due to the well documented challenges at public health facilities – unfriendliness, hostility, victimisation, lack of confidentiality, denial of services – some KPs who have been issued with transfer letters are scared to return. For those with income they can choose to go to private doctors, however for those with little or no income it means stopping treatment altogether.

[6] https://journals.lww.com/aidsonline/fulltext/2025/08010/the_cost_of_the_plunge__the_impact_and_cost_of_a.20.aspx
[7] Supplementary Table 2A, https://links.lww.com/QAD/D603

According to Ritshidze, many additional challenges are occurring at public health facilities too following the PEPFAR disruptions. For example, 22% of people surveyed by Ritshidze said that waiting times were longer in April to June 2025, compared to before the PEPFAR disruptions. For people living with HIV, either collecting refills through standard dispensing or at facility pick-up points, or returning to the facility for a rescript, spending an extended time at a facility increases the risk of that person interrupting treatment and/or disengaging from care. Further, forPWUDs, SWs, and the LGBTQIA+ community who often face discrimination and hostility at the clinic, the shorter the time spent in such an unsafe or uncomfortable environment the better. Data from 2024 show that 16% of gay, bisexual, and other men who have sex with men (GBMSM), 15% of trans people, 14% of sex workers, and 10% of PWUDs surveyed who no longer use public health facilities blamed the long waits.

Further while guidelines mandate the provision of 3 month supply of ARVs for most people living with HIV, and the Department of Health (DoH) is now rolling out 6 month supply from August 2025, Ritshidze data show that there has been an 8% increase in people living with HIV surveyed reporting getting a 1 month supply, a 9% decrease in 3 month supply, and no implementation of 6 month supply in ARV refill length. This was seen across all provinces monitored by Ritshidze, except for the Eastern Cape[8].

Additionally, there was an 8% reduction in people surveyed by Ritshidze who collected ART from external pick-up points – a strategy to make ART collection easier and quicker. This is likely due to PEPFAR funded service providers no longer being available to manage some pick-up points, and is forcing more people to return to the clinic to collect either through facility pick-up points which often operate inefficiently and cause longer delays, or through standard facility medicine dispensing through consult and rescript with a clinician. A diversity of external pick-up point providers is needed beyond private pharmacy networks largely only available in urban areas, and beyond services provided by PEPFAR partners that have been disrupted in multiple districts.Further, 35% of people surveyed said it took longer to collect ART after PEPFAR disruptions. There has also been a worsening in the friendliness of services – with 8% more people reporting that staff are only sometimes or never friendly after the PEPFAR disruptions.

Facility staff surveyed across 313 public health facilities also reported a negative impact on viral load testing (12% of sites), routine clinical consultations (20% of sites), and psychosocial support services (20% of sites) after the PEPFAR disruptions.

Key Population Progress Updates From the Health Department, June 2025.

- In Gauteng, a total of 6,882 patients from Wits RHI's FSW programme and OUT/Engage Men's Health sites were transferred. These sites serve MSM, FSWs, and TGWs. Of the total transferred, only 4,847 patients were successfully contacted for re-engagement, and of those, just 724 were registered at Department of Health (DoH) facilities.
- Among the 215 TGWs issued transfer letters in Johannesburg, only four were confirmed to have visited a DoH facility. This highlights a major challenge in tracking and converting client self-referrals, and highlights the fears some members of key populations have to return to the public health system.
- In the North West, CPC and TB HIV Care supported services for sex workers; however, no formal client files were reported as transferred between implementing partners and Department of Health (DoH) facilities in any district during the 30 July 2025 reporting cycle.
- All reported client re-engagement efforts (14 clients) were conducted solely by CPC in the Bojanala district. TB HIV Care, operating in Ngaka Modiri Molema and Dr Kenneth Kaunda districts, reported no clients contacted for re-engagement during this period.

[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

- In Bojanala, CPC successfully facilitated 143 new client registrations at DoH facilities. These included PrEP initiations, new HIV diagnoses, and re-initiations for clients previously lost to follow-up.
- In contrast, TB HIV Care reported receiving 265 client files and 50 client visits across Ngaka Modiri Molema and Dr Kenneth Kaunda districts. However, zero new registrations were reported pointing to a likely issue in data capture or reporting.
- In the Eastern Cape, a total of 281 patients were transferred from Wits RHI to DoH facilities.
- In Limpopo, although only 142 client transfers were recorded, DoH facilities reported 4,280 new client registrations, suggesting that the majority of new clients were not linked through formal transfer mechanisms.
- In the Free State, North Star Alliance's HTA programme continues to deliver comprehensive health services to key populations (KPs), including mobile unit operations and scheduled outreach activities within the district. To support service delivery, 199 peer educators have been appointed and deployed to various clinics.

What is the cost of inaction? If affected interventions do not return to current coverage levels, the number of additional AIDS-related deaths will increase. Providing friendly, high-quality, and comprehensive services is essential to retaining people in care. A reduction of PEPFAR funding by half, or a complete withdrawal, would result in an estimated increase of between 286,000 and 565,000 new HIV infections, respectively, over the next ten years[9].

Non-negotiable Priorities:

- Services specific to the needs of PWUDs, SWs, and LGBTQIA+ communities must be made available in public health facilities, beginning with the expansion of the CoE model.
- A minimum package of services (as outlined in the minimum package of services) must be made available at facilities serving as Centres of Excellence, as well as DICs, so that they can provide comprehensive health services to PWUDs, SWs, and LGBTQIA+ communities.

[9] Gandhi AR, Bekker L-G, Paltiel AD, Hyle EP, Ciaranello AL, Pillay Y, et al. Potential clinical and economic impacts of cutbacks in the President's Emergency Plan for AIDS Relief Program in South Africa: a modeling analysis. Ann Intern Med 2025

Service Area	Current Status	Target Coverage	Annual Cost (USD)	Notes
HIV Minimum package of services	TK	Available at all public health facilities	$750,000	HIV Treatment and support services for KPs

ART Funding Gap: $4,041,954 million per year

2. Prevention

Prior to the funding cuts, some KPs were able to access HIV prevention at PEPFAR supported DICs and mobile services. Again others were accessing through public health facilities.

Ritshidze data show that there has been a drop in facilities offering external and internal condoms and lubricant following the PEPFAR disruptions. Of 322 facilities monitored, 9% of sites did not offer external condoms and 27% did not offer internal condoms. This is unacceptable as the provision of condoms is known to be the cheapest, easiest and biggest impact HIV prevention intervention. 14% less sites (just 49% in total) had lubricants available despite 80% saying they do provide them for HIV prevention.

While only 13% of sites reported challenges with PrEP services following the PEPFAR withdrawal – of PrEP users surveyed, 45% said it took longer than usual to collect PrEP, 9% said they were given a smaller supply, and 4% said there was no PrEP available. Fast track systems are urgently required to reduce workload on overstretched staff and ensure people do not discontinue PrEP. Unnecessary discontinuations put people vulnerable to HIV acquisition at risk, and waste intensive work done to find, test, and start people benefitting from PrEP.

Long-acting injectable PrEP in the form of two-monthly CAB-LA was approved by the South African Health Products Regulatory Authority (SAHPRA) in 2022, as well as the dapivirine vaginal ring, and pilot implementation began in 2024 through both public sector and donor-supported platforms, largely with PEPFAR support. While urban rollout has advanced, rural coverage remains limited. The government has emphasised reaching adolescent girls and young women (AGYW) and MSM as key priorities. UNITAID-funded introduction projects are continuing to inform scale-up, but the USAID-funded projects were terminated with no notice. Additionally, Gilead has submitted a regulatory filing for six-monthly lenacapavir (LEN) to SAPHRA, and rollout is expected early in 2026. Continued expansion of access will be largely determined by budget and resources, as well as regulation allowing for differentiated service delivery. Currently, there continues to be limitations in policy and regulations on service delivery points which restrict access (e.g. limited access through pharmacies).

The South Africa harm reduction programme was funded by PEPFAR (2 districts in City of Tshwane and Ehlanzeni), the Global Fund (8 districts in City of Cape Town, City of Johannesburg, Ekurhuleni, eThekwini, Sedibeng, uMgungundlovu, Nelson Mandela Bay, West Rand), with the only domestic funding from the City of Tshwane. While harm reduction including information on safer drug use, sterile needles and syringes, safe disposal of used injecting equipment, naloxone, methadone, and psychosocial support is life-saving, they were almost entirely unavailable in primary health facilities in the public sector. The South African country submission to the Global Fund in September of 2021 reported a 96% funding gap for HIV interventions for PWUDs[10]. PEPFAR on the other hand provided medication for opioid use disorder; drug dependence counselling and support; harm reduction information; wound and abscess care; and access to sterile injecting equipment.

[10] https://hri.global/publications/impact-of-pepfar-funding-cuts-in-harm-reduction-in-south-africa/

After the funding cuts, the PEPFAR/CDC funded harm reduction service centres in the City of Tshwane and Ehlanzeni districts stopped providing services for a period of 15 days, from 29 January 2025 to 14 February 2025. One thousand PWUDs from Mpumalanga (Ehlanzeni district) and 4,000 people from Gauteng (City of Tshwane district) faced disruption in accessing OST and NSP. Clients were encouraged to utilise the public health care facilities near them, however, none of them offered OST or NSP, except for in the City of Tshwane where University of Pretoria provide services through COSUP (Community Oriented Substance Use Programme[11]). TB HIV Care, the implementing organisation for PEPFAR, received instruction to resume limited waived HIV interventions, including harm reduction, from CDC on 13 February 2025. While these services have since resumed, no new clients are being initiated on methadone or in structural programmes.

However these two DICs were always too few to meet the needs of most of the PWUDs across the country. Harm reduction services must be made available in public health facilities to be useful. However, according to Ritshidze data, while 52% of facilities said they provide information about needle safety and where to get sterile needles – however only 9% of PWUDs surveyed in 2024 were actually given information on where to get sterile needles from. This was not surveyed in 2025 yet, but is unlikely to have improved.[12]

Only 7% of people were given information about where they could get methadone from clinic staff. The 31% of sites that said they refer people, referred them to hospitals – where methadone is only available for withdrawal management on a short term basis – or to buy methadone themselves at a pharmacy or go to private rehabs – putting it out of reach of most people with little or no income. Ultimately, even clinics that do want to provide information and care have nowhere to refer people onwards. National guidelines and policies must be amended to ensure that OST is made available in clinics, starting with CoEs.

Hepatitis C (HCV) prevalence is estimated to be at 83% among PWUDS in South Africa – yet only 22% of PWUDs even knew what hepatitis C was. Only 4% said a healthcare worker in the public health system had talked to them about screening – and only 3% of those surveyed had been screened.[13]

In terms of gender affirming care – all four USAID funded DICs for trans women were closed after the PEPFAR disruptions, reducing access to hormonal care. According to Ritshidze, 50% of trans people surveyed wanted to access hormones at the facility in the last year – yet hormonal care is not available in primary health facilities currently. While 35% of sites said they provide trans people with information on hormonal care – 21% of trans people we surveyed were confronted with a staff member that did not know anything about hormones or where to get them. A change in national policy is critical to ensure that hormones could be prescribed by doctors at primary level, just like they are by private GPs. This would expand access to many more trans and gender diverse people in need.[14]

In addition HIV testing services have also been impacted. No HIV testing means it is not possible to identify people who are living with HIV who need to start or restart treatment – or identify people for prevention services. Yet 20% of facilities reported challenges with HIV testing following the PEPFAR disruptions, and only 47% of people not on ART reported being offered HIV tests at a health facility visit in this reporting period. Missing an easy opportunity to test people who are coming to our health facilities either sick, with an STI, or for either family planning or ante/post-natal services which may indicate unprotected sex.[15]

A complete cessation of PEPFAR-funded activities without take-over by SAG would increase new HIV infections in adults and children over the next 4 years (2025–2028) by between 29% (677,158 new infections[16]) to 56% (822,797 new infections). HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP, and harm reduction services must be easily available at all public health facilities. Sustaining full coverage of PrEP among KPs is the most cost-effective option based on cost per infection averted.[17]

[11] https://hri.global/publications/impact-of-pepfar-funding-cuts-in-harm-reduction-in-south-africa/ [12, 13, 14, 15] https://ritshidze.org.za/wp-content/uploads/2025/08/Ritshidze-National-State-of-Health-August-2025.pdf [16] https://journals.lww.com/aidsonline/fulltext/2025/08010/the_cost_of_the_plunge___the_impact_and_cost_of_a.20.aspx [17] https://links.lww.com/QAD/D603 Supplementary Table 2A

Non-negotiable Priorities:

- **Condoms and lubricants:** The provision of condoms is known to be the cheapest, easiest and biggest impact HIV prevention intervention. Condoms and lubricants should be available in all facilities in a range of spaces across the facility (including in the toilets, at the gate, in quiet areas out of sight) so people can freely and easily collect them without fear or judgement.
- **PrEP:** While PrEP is available in all sites, it is important that PrEP is actively offered to KPs, and that people are actually made aware of its benefits in order to make an informed decision about starting. Ensuring a safe environment is particularly important, so that people feel comfortable to disclose this and subsequently request or be offered PrEP services. This shows the critical role that CoEs could play in providing a safe space for KPs to disclose this, allowing for more people to be actively offered PrEP. PrEP should be offered to all KPs who are not living with an HIV negative test for HIV, with information shared on its benefits. Passive ways to inform people about PrEP must be used including the distribution of PrEP posters to be put up in all facilities informing people about PrEP, and PrEP information being provided in daily health talks.
- **PEP:** PEP should be made available to anyone following an HIV exposure without judgement.
- **Harm reduction:** The National Department of Health's guidelines and policies must be amended to allow for the roll out of harm reduction services at public health facilities in South Africa – including but not limited to provision of sterile needles/syringes, safe disposal of injecting equipment, methadone, naloxone, and psychosocial support. National Department of Health guidelines and policies should also be amended to ensure that naloxone is not only nurse initiated, but can be initiated by community members themselves. People who use drugs must be able to access these life-saving harm reduction tools closer to where they stay – including in public health facilities and correctional service facilities. Harm reduction services must also be made available to SWs and LGBTQIA+ community members who use drugs. The Department of Health must commit to providing sterile needles/syringes, safe disposal of injecting equipment, methadone, naloxone, and psychosocial support in public health facilities, beginning with the expansion of CoEs. The Department of Health should social contract this work to organisations competent in providing these services already.
- **Differentiated service delivery for prevention options:** As part of the standard of care, including through pharmacies which would be able to allow for non-stigmatised services even in rural settings.
- **Gender Affirming care:** Clinicians must understand the health needs of trans and gender diverse people and be able to offer appropriate services e.g. appropriate sexual and reproductive health services, or cancer screening. A healthcare provider wanting to prescribe hormone therapy should not require a letter from a mental health provider[18]. A change to national policy is urgently required so that hormones could be prescribed by doctors at primary level, just like they are by private GPs, expanding access to many more trans and gender diverse people in need. CoEs must have access to medical support networks, mentorship, and tele-support to assist in consultations on the use of hormone therapy for trans people. Further, all facilities must provide gender affirming services including:
    - Using trans people's correct name and pronouns
    - Providing a gender neutral toilet for trans people
    - Removing coloured folders that mark people's (perceived) gender
    - Ensuring that trans women are not made to use service points for men (including Men's Corners or men only clinic days)
    - Protecting privacy by ensuring that additional staff members are not called into consultation rooms, and that staff knock before entering, allowing consultations to pause until the person has vacated the room

[18] https://sahivsoc.org/Files/SAHCS%20GAHC%20guidelines-expanded%20version_Oct%202021(3).pdf

Service Area	Current Status	Target Coverage	Annual Cost (USD)	Notes
Prevention minimum package of services	Available but limited	Available at all public health facilities	$1,500,000	HIV Prevention and support services for KPs.
Condoms & lubricants	Available but limited	Available at all public health facilities	$150,000	Lubricants, external/internal condoms.
PrEP services	Available in all sites but with implement ation challenges	Ensure no unnecessary PrEP discontinuations. Ensure everyone with negative HIV test is offered PrEP at all public health facilities. Ensure PrEP literacy through active and passive measures.	$6,728,168	Include MMD, community refill, offer all those eligible PrEP, PrEP literacy education through consultations, after HIV test, posters, health talks.
Injectable PrEP	Not available	Offered to all KPs who test HIV negative	$27,719,067	Scale up injectable and expand access.

Ensure KP engagement in guideline amendments for new prevention products	Regulatory barriers	Guideline for long acting prEP, amendments to ensure access to gender affirming services		Ensure policy preparation to absorb new prevention product coming into the market
Demand creation and awareness building for prevention options	Moderate knowledge about prevention options available	Demand creation on PrEP, oral and long acting, harm reduction, gender affirming services		
Harm Reduction Supplies	Extremely limited access	Sterile needles/syringes , safe disposal, methadone, naloxone, psychosocial support	$262,400	Ensure rollout of sterile needles/syringes, safe disposal of injecting equipment, methadone or other OST, naloxone, and psychosocial support in public health facilities, beginning with the expansion of COEs, to support dependence reduction and lower HIV transmission risk
Harm Reduction policy	PWUDs are criminalised and safe stigma	All PWUDs across the country	$100,000	The Department of Health's guidelines and policies must be amended to allow for the roll out of harm reduction services at public health facilities in South Africa e.g. methadone and naloxone.

Hormonal Care	Limited access	Trans and gender diverse people	$312,600	A change in national policy is critical to ensure that hormones could be prescribed by doctors at primary level, just like they are by private GPs. This would expand access to many more trans and gender diverse people in need.
Post-Violence Services	Limited access	Rapid HIV testing, PEP, STI treatment, emergency contraceptive, J88 forms, rape kits, counselling, DV shelter referrals	$538,000	Comprehensive response for all populations
Total prevention services			**$37,310,235**	Complete service package transformation

Primary Prevention Funding Gap: Approximately $37,310,235 annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? There will be a continued high rate of HIV transmission among KPs, who are already disproportionately affected. Without targeted prevention, these communities remain at risk of both acquiring and transmitting HIV, undermining South Africa's progress. The country will also miss opportunities for cost-effective prevention—allowing new infections to rise, which increases the long-term burden on the health system. When KPs cannot access essential services and commodities, the health system is forced to carry the greater financial and human cost of treating preventable infections.

3. Staff Accountability

Commonly PWUDs, SWs and the LGBTQIA+ community face particularly uncaring, uncompassionate, and sometimes cruel treatment at clinics. This makes it even more difficult to access health services including HIV testing/ prevention services, or ART collection for members of key populations living with HIV. Without making services friendlier and safer for PWUDs, SWs and the LGBTQIA+ community, the health department will never get everyone on ARVs and address the retention crisis, or prevent more people getting HIV. Some of the key challenges KPs have at public health facilities include:

- **Facility staff are still not friendly:** Ritshidze data collected in 2024 shows only a minority of people reported that facility staff were always friendly. This includes 44% of GBMSM and trans people, 33% of sex workers, and 25% of PWUDs. Many people reported that staff treated them worse after they found out they were a member of a KP including: 26% of GBMSM, 38% of trans people, 52% of sex workers, and 58% of PWUDs[19]. Staff being unfriendly was the main reason people reported for not using public health facilities, including those who have disengaged from care altogether. Since the closure of the USAID DICs, those people previously accessing those services have had to return to the clinic in order to get their ARVs, HIV prevention, and other health services. There have been numerous reports of people being treated poorly and humiliated upon return.

- **Confidentiality violations are abundant at the facility:** Ritshidze data from 2024 show that 47% of GBMSM, 52% of trans people, 57% of sex workers, and 63% of PWUDs did not think privacy was well respected at the facility. These privacy violations include people's HIV status being disclosed, or people's sexuality or gender being revealed, or the fact that someone uses drugs or engages in sex work. It also includes other medical issues being shared either indirectly through more than one person being consulted.[20]

- **Some facilities deny people ARVs or health services entirely:** People across all KP groups have been refused health services at the facility because of being queer or trans, using drugs, or engaging in sex work. Ritshidze data from 2024 reveal that 10% of GBMSM, 18% of sex workers, 18% of trans people, and 30% of PWUDs surveyed had been denied services in the last year. While other returned to the facility to try again and other went to a different facility, others never got the services they needed – including 48% of GBMSM, 51% of sex workers, 64% of trans people, and 66% of PWUDs surveyed – and others stopped using the public health system or were pushed out of care altogether.[21]

After the funding cuts, PEPFAR support was terminated in 12 districts across South Africa with additional districts reporting further disruptions. Ritshidze data from 310 sites show that 51% reported reduced capacity, and overall 21% of sites blamed staffing shortages on PEPFAR implementing partners no longer working or working at reduced capacity at the facility. PEPFAR implementing partner staff no longer working or working at a reduced capacity only adds to the pressures on already overburdened staff. The knock on effect of this staffing crisis, as well as unnecessarily frequent clinic appointments or medicine collections, and reduction of community-based key population services, is that people wait for longer to receive services or receive a reduced quality of services.

It also impacts staff friendliness. Clinic staff being unfriendly is a common reason for people disengaging from care or interrupting treatment. Yet people reporting to Ritshidze that staff are always friendly dropped down to 59% in this reporting period. Without addressing this – including ensuring adequate staffing and longer ARV refills (3MMD to 6MMD) to reduce the stress for those working in facilities – the government will continue to lose people from care at unacceptable rates and will never create the welcoming, safe and non-judgemental environment needed to encourage people back into care who have interrupted treatment. On top of that, the improvement of services for KPs requires the addition of staff and expertise at key clinics that would become CoEs in every district. Additional staffing is critical at these sites not only to provide the expertise and specialised clinical services required, but also to instill culture change and improve attitudes towards PWUDs, SWs, and the LGBTQIA+ community.

[19, 20, 21] https://ritshidze.org.za/wp-content/uploads/2025/08/Ritshidze-National-State-of-Health-August-2025.pdf

Non-negotiable Priorities:

- All facility staff (including clinical staff, non-clinical staff, lay staff, and security guards) who treat people poorly, violate people's privacy, or verbally or physically abuse or harass people must be held accountable and face consequences.
- To address unfriendliness, lack of confidentiality, and routine denial of services, CoEs need additional staffing to instil culture change within the facility. At least 2 CoEs per district per population group must be established.
- Clinicians must understand the health needs of KPs and be able to offer appropriate services. For example offering the appropriate sexual and reproductive health services, or cancer screening for trans and gender diverse people, or offering harm reduction services and psychosocial support for PWUDs.
- Further clinicians must understand the intersectional health needs of people with more than one KP identity.

Service Area	Current Status	Target Coverage	Annual Cost (USD)	Notes
Staff assessment and accountability	Refer to CoE section	Refer to CoE section	$100,000 Refer to CoE section	Refer to CoE section
Staff training	Refer to CoE section	Refer to CoE section	$100,000 Refer to CoE section	Refer to CoE section

Staff accountability Funding Gap: Approximately **$37,310,235** annually to restore comprehensive prevention services with peer support networks.

Community infrastructure

Most KPs use the public health system to access their health services. However, for those lucky enough to live or stay close enough to DICs or mobile services, these options are preferred due to the challenges faced at public health facilities. Before the PEPFAR disruptions there were 28 DICs across the country, and various other mobile services running. Unfortunately though, the country is vast, and there are just too few DICs across the country to meet the needs of KPs. According to Ritshidze 83% of people surveyed in 2024 did not even know about them. They are nice, but absolutely cannot provide healthcare for everyone who is queer or trans, uses drugs, or engages in sex work.

Drop-in Centres

PEPFAR SA's DICs provided high quality and tailored packages of prevention including PrEP (including MMD and community collection), post-exposure prophylaxis (PEP), both external and internal condom-compatible lubricants, and harm reduction, care and treatment interventions, STI screening and treatment; viral hepatitis, TB screening and referral and other primary health services, including sexual and reproductive health, psychosocial support; mental health services; and gender-based violence services on site or by referral targeted to SWs, MSM, TG women, PWID, and people in prisons. The programme also offered peer-led outreach and mobilisation that supported targeted strategic communication and demand creation.

While drop-in-centres remain friendlier and offer more appropriate services, there were just too few to meet the needs of all the KPs across the country. For KPs who do not live or work close by, or have money to cover transport/ accommodation to travel to different districts or even provinces to access services at the DICs, these services remained completely out of reach[22].

Prior to the funding cuts, there were only 28 PEPFAR funded DICs across the entire country (15 run by CDC and 13 run by USAID). This broke down to 9 sites for GBMSM, 2 sites for people who inject drugs, 13 sites for SWs (8 just for female sex workers), and 4 sites for trans people.

After the funding cuts, only 15 PEPFAR funded DICs remain open – 5 sites for GBMSM, 2 sites for people who inject drugs, and 8 sites for female sex workers. The USAID funded sites closed down, forcing DIC users to re-enter the public health system to get their health services. Some of the KPs re-entering the public health system without transfer letters have however been denied entry and others have been treated badly by staff members upon their re-entry into the public system.

To ensure better health services for people using drugs, sex workers, and the LGBTQIA+ community across the country, in all provinces and districts, in both rural and urban areas, communities of KPs require the building of accessible, acceptable, and quality services – with real accountability metrics – that meet the needs of populations within the public health system.

Centres of Excellence (CoEs)

By the start of COP 24 planning, 25 KP CoEs had been established in four provinces, and 93 district managers, 95 clinicians, and 87 support staff had been trained and mentored and the programme planned to increase resource support for a more rapid scale up with at least four KP CoEs established per district, equating to approximately 200 KP-friendly clinics and training nearly 3,000 health workers by the end of COP24[23]. CoEs are public health facilities that are identified as places members of KPs can go to access services.

By the end of 2024, 33 CoEs had been "completed" across 13 districts, in 6 provinces of the country. The progress has been slow and being "completed" simply meant that a training had taken place at the site but the site received no additional staffing, expertise, or clinical services to make the CoEs a place for KPs to come.

As the donor funding challenges persist, CoEs must be workable. In order to be workable, they have to be more accessible than DICs and offer the clinical services, expertise, transport, and referral pathways that KPs need. Additional staffing and redistribution of staff should also be considered and CoE staff must also provide services equitably across all populations.

[22] https://ritshidze.org.za/wp-content/uploads/2025/08/Ritshidze-National-State-of-Health-August-2025.pdf
[23] South Africa Country Operational Plan COP 2023

Community-Led Monitoring

To more consistently gather evidence on the dysfunction in South African clinics and how this causes people to stop going for health services including KPs — in 2018, the world's largest community-led monitoring system was developed by HIV activists, known as "Ritshidze[24]". Ritshidze was developed and designed in response to the crisis in South African clinics, and has also won awards including PEPFAR's Civil Society Partnership award in 2022. Ritshidze gives communities the tools and techniques to monitor the quality of health services provided at clinics — including HIV and TB services, and services for KPs — and escalate challenges to duty bearers. For the last 7 years on a quarterly cycle Ritshidze has been systematically collecting data at more than 450 clinics (up to 560 during 2024), across 25 PEPFAR priority districts, in 8 provinces.

Since inception in 2018, Ritshidze has surveyed 333,507 public healthcare users, 191,893 people living with HIV, and 44,942 KPs about the state of services, and carried out 462 in depth interviews. There is clear and detailed evidence about the challenges people face that cause them to stop going to the clinic — issues like KPs and people living with HIV being shouted at or turned away at clinics, slow progress on multi-month dispensing of ARVs, people living with HIV not being offered the option of using quicker ART collection points, shortages of healthcare workers, long waiting times, or stockouts of medicines. Much more on this can be seen in the 60 district, provincial and national State of Health reports and countless presentations produced. 4,794 feedback meetings with facilities have been held to date, with 3,509 sets of commitments being made by clinic staff. Where challenges cannot be addressed at a facility level, or there is failure to address concerns, or resistance from facilities to make progress, Ritshidze teams escalate the issues to duty bearers at higher levels, also on a quarterly basis. This consistent feedback is a core part of the community-led monitoring cycle, to hold duty bearers accountable.

Community accountability meetings are also held with national, provincial, and district duty bearers. At the meetings Ritshidze presents detailed findings of community-led monitoring, comparing results to past reporting periods. 53 community accountability meetings have been held to date. It is also critical to hear the voices of communities at the community accountability meetings. This is an opportunity for communities to talk directly to those in power, telling duty bearers their first hand experiences of the challenges they face. It cannot be ignored. Since Ritshidze's inception, they have recruited 1,193 community members to come and testify at the meetings and filmed a further 773 videos of people's stories and written up an additional 296 stories and countless quotes. This is not just about data gathering, but accountability to communities, where health department officials, PEPFAR agencies, and PEPFAR-funded implementing partners must explain their plans to address the problems.

Where no changes are made to the problems community-led monitoring uncovers, campaigns are organised in order to demand improvements. Recently, for example, there was a campaign to pressure several poor performing district health departments to increase ARV refill length. This led to 77% more people getting a 3-month supply of ARVs in the Thabo Mofutsanyana district. A further campaign led to a public commitment by the Minister and Deputy President on World AIDS Day 2024 to roll out 6-month supply of ARVs.

Since community-led monitoring began, the data shows many wins[25]. Among these, but not limited to them, are:

- **Staffing:** In 2021, 89% of Facility Managers said that their facility did not have enough staff - this number dropped by 7% in 2024.
- **Waiting times:** Average waiting times have dropped from a high of 5 hours 47 minutes in 2020 to 3 hours 12 minutes in 2024.
- **ARV collection:** People living with HIV getting a 3 month supply of ARVs has increased from 18% in 2021 to 60% in 2024. In 2024, there was a higher proportion of people collecting ARVs from pick-up points (that make ART collection quicker and easier) up from 25% in 2020 to 72% in 2024 — and people living with HIV wanting to collect ARVs closer to home (pointing to a lack of external pick-up points) has reduced from 44% in 2022, to 38% in 2024.

[24] Ritshidze: https://ritshidze.org.za/ [25] Ritshidze Impact Report 2025:https://ritshidze.org.za/wp-content/uploads/2025/01/Ritshidze-Impact-2025.pdf

- **ART continuity:** People living with HIV getting shouted at for missing appointments has dropped from 10% in 2021 to 5% in 2024. Staff sending people to the back of the queue as punishment for missing an appointment reduced from 12% in 2021 to 7% in 2024. People living with HIV who thought staff were always friendly increased to 64% by 2024.
- **Psychosocial support:** More people living with HIV report psychosocial services being available (up from 61% in 2020 to 79% in 2024).
- **Treatment literacy:** The percent of people living with HIV who understand that an undetectable viral load means you cannot transmit HIV has increased from 55% in 2020 to 77% in 2024.
- **PrEP availability:** Increased from a low of 44% in 2020 to 99% of facilities in 2024.
- **Facility Conditions:** There was an increase in the number of public healthcare users reporting toilets in good condition, from 35% in 2020 to 50% in 2024.

While there is still more to win, what is clear is that this system of community-led monitoring and advocacy at all levels is an essential tool to fix the public health system, get everyone tested and on treatment, and reduce HIV and TB deaths.

However, following the PEPFAR funding cuts, all funding was terminated. However it was critical to assess the immediate impact of the PEPFAR withdrawal, and conduct surveys to highlight the risks in our clinics that will lead to people being turned away, or stopping treatment. Following generous emergency support from one donor, community-led monitoring was able to temporarily resume from April to June 2025, in 320 sites across a reduced 17 districts:

- **6 PEPFAR priority districts:** OR Tambo (EC), Buffalo City (EC), City of Tshwane (GP), Ekurhuleni (GP), eThekwini (KZN), and uMgungundlovu (KZN).
- **8 previously PEPFAR supported districts** where contracts have now been terminated: Lejweleputswa (FS), Thabo Mofutsanyana (FS), Johannesburg (GP), Sedibeng (GP), King Cetshwayo (KZN), Capricorn (LP), Mopani (LP), and Ehlanzeni (MP).
- **2 non-PEPFAR priority districts:** Mangaung (FS), and Vhembe (LP).

Questions with regard to the impact of the PEPFAR funding withdrawal were added to existing tools[26] and a new tool was developed to survey patients as they exit the clinic to better understand the impact of the PEPFAR disruptions on clinics[27]. All data is currently being presented to the health department, and will be published in September 2025.

Non-negotiable Priorities:

- **At least two CoEs per district**, per population group must be established (this means up to 8 sites per district). They must offer the clinical services, expertise, transport, and referral pathways that KPs need. The sites must not be exclusive to one population group, but rather must have additional concentrated expertise, training, and recruitment strategies, based on the population group the site is most likely to be working with. Where people live too far away still to access services, resources (taxi fare, planned patient transport) must be made available so that people can actually get to them.

[26] Ritshidze tools: https://ritshidze.org.za/category/tools/
[27] Ritshidze Patient Exit Survey: https://ritshidze.org.za/wp-content/uploads/2025/05/Ritshidze-Patient-Exit-Survey-April-2025.pdf

- **CoEs need additional staffing** so that they can function effectively and to support and instil culture change within the facility:
  - For PEPFAR, this means District Support Partners (DSPs) that are still in operation that already employ significant healthcare workforces should redistribute staff to the CoEs, including specifically recruiting individuals and advertising positions that will have an emphasis on specific KPs within the context of general population services.
  - For the national, provincial, and district health departments, this means ensuring that all CoE staff recognise that their obligation is to provide services equitably across all populations, and not as unique cases to be handled by PEPFAR DSP staff.
- **Funding for community-led monitoring should be restored.** The ability to monitor the quality of services offered to KPs is even more critical with the reduction in foreign support.

Strategic Element	Current Status	Target Vision	Funding Required (USD)	Key Notes
Centres of Excellence per District	Available but limited	At least 2 CoEs per district per population group (up to 8 sites per district) with comprehensive health services with minimum package	$28,224,367	Must offer clinical services, expertise, transport, and referral pathways needed
Drop-in Centres	Available but limited	Maintain existing DICs with comprehensive health services minimum package	$6,803,755	Maintain CDC funded DICs
Transport and Access Support	Available but limited	Taxi fare, planned patient transport for distant populations	$100,000	Ensure access for those living far from services
Gender Neutral Infrastructure advocacy	Unavailable	Gender neutral toilets at all facilities	$100,000	Part of gender affirming services requirement
TOTAL SITES AND INFRASTRUCTURE	---	---	**$35,228,122**	**Fundamental facility transformation required**

Staffing and Human Resources: Workforce Development and Accountability

Strategic Element	Current Status	Target Vision	Funding Required (USD)	Key Notes
Additional CoE Staffing	TK	Redistribute DSP staff, recruit additional staff with expertise to provide specialised and friendly clinical services, and instill culture change in the site	$35,600,367	PEPFAR DSPs + health departments collaboration
Staff Accountability Systems	TK	Consequences for staff who ill-treat, violate privacy, or abuse people	$300,000	All facility staff including clinical, non-clinical, lay, security
Peer Educators/ Navigators both facilty and community	TK	At facility level for all populations	$1,038,240	Essential component of minimum package
Medical Support Networks	TK	Mentorship and tele-support for hormone therapy consultations	$100,000	Support CoEs in providing gender affirming care
TOTAL STAFFING	---	---	**$37,038,607**	**Comprehensive workforce transformation**

Community-Led Monitoring

Strategic Element	Current Status	Annual Funding Required	Implementation Notes
Community-Led Monitoring	The future of CLM is threatened with the loss of all PEPFAR funding. Currently work is taking place on a partial and ad hoc basis as funding is secured.	**$6,757,000**	Continued consistent monitoring of facilities and in the community to understand the impact of the PEPFAR withdrawal and the state of services provided for members of key populations. This includes the development/continual improvement of monitoring tools, collection of data in facilities and communities, the development and dissemination of reports in conjunction with KPs, engagement with duty bearers at all levels, and advocacy where no improvements are seen.

Community infrastructure Funding Gap: Approximately **$79,026,729**

What is the cost of inaction? Community-led monitoring is needed now more than ever to document the impact of the PEPFAR cuts on services for KPs. Already many additional challenges are being documented since the PEPFAR disruptions began. This is likely only to worsen. It is critical that community-led monitoring is able to continue to document the challenges KPs and people living with HIV face in our public health facilities, and lead engagement and advocacy to improve the service quality.

Summary of proposed cost of the South Africa Key Population Plan

Targeting and Costing Methodology

In South Africa, 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 South Africa KP budget, the country will focus on 100% of treatment and prevention as indicated below. This covers the South Africa Key Populations Strategy Summary below with a programme cost total of $125,189,235 targeting 204,800 KPs. The itemised costing of each intervention is found on this link: South Africa Costed Budget

South Africa Key Populations Costed Strategy Summary

Category	Activity/Item	Cost Estimate	Budget Narrative	Funding Sources + Needs
Sites	Establish Centres of Excellence (CoEs) at existing public health facilities, with comprehensive services	$28,224,367 The amount above covers 33 CoEs with a cost of $855,284	At least 2 CoEs per district per population group (up to 8 sites per district). Provide comprehensive health services with minimum package	Department of Health + PEPFAR commitment required
	Existing PEPFAR supported DICs with comprehensive services and expansion	$6,803,755	Provide comprehensive health services with minimum package	
Staff	Additional staffing for COEs	$35,600,367	Redistribute DSP staff and recruit additional staff with expertise to provide specialised and friendly clinical services	PEPFAR DSPs + provincial/district health departments
	Staff accountability mechanisms	$500,000	Hold accountable facility staff who ill-treat, violate privacy, or abuse people	
	Train all facility staff on KP services	$500,000	Clinical, non-clinical, lay staff, and security guards	
	Peer educators/navigators at facility level	$519,120	All populations require peer support at facilities	
	Peer educators/navigators at the community level	$519,120	All populations require peer support at DICs	
Service Delivery	HIV prevention and HIV testing commodities easily available at all facilities, including service delivery	$8,378,167.80	Lubricants, external/internal condoms, PrEP, PEP at all public health facilities	Department of Health + PEPFAR

	HIV Treatment commodities and easily available at all facilities, including service delivery	$4,041,954		
	Oral PrEP, CAB-LA, LEN-PrEP	$32,719,067	Total Procurements and last-mile delivery. The separated cost is on the link above	
	Harm reduction supplies, including service delivery Social contracting for harm reduction	$362,400	Sterile needles/syringes, safe disposal, methadone, naloxone Contract organisations competent in providing harm reduction services	Department of Health commitment required
	Hormone therapy access	$312,600	For trans people at public health facilities locally	
	STI Service Delivery	$552,717.30	For STI service delivery	
	STI treatment, including commodities and lab monitoring	$5,405,600	STI commodities include lab monitoring	
Systems	Amend National Department of Health guidelines	$150,000	Enable harm reduction and gender affirming care services rollout in public facilities	Policy change required
	Gender affirming service protocols	$200,000	Correct names/pronouns, gender neutral toilets, remove gendered systems	

	Transport and access support	$200,000	Taxi fare, planned patient transport for those living/working far from services	
Support	Medical support networks for CoEs	$200,000	Mentorship and tele-support for hormone therapy consultations	
TOTAL ESTIMATED INVESTMENT NEEDED		**$125,189,235**	**Comprehensive transformation of public health system for KP services**	**Department of Health + PEPFAR coordination required**

Minimum Package of Services

Package of KP specific service provision:

Gay, Bi, and other MWSM

- Outreach services
- GBMSM outreach services
- Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
- Post-Exposure Prophylaxis (PEP)
- Lubricant
- xternal condoms
- GBMSM friendly HIV testing and counselling
- GBMSM friendly HIV care and treatment
- GBMSM focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), GBMSM adherence clubs and GBMSM friendly external pick-up points including at drop-in centres
- HIV support groups including PrEP/ART refill collection
- Psychosocial support
- Mental health services
- Sexual health services
- Information packages for sexual health services
- GBMSM friendly STI prevention, screening & treatment
- GBMSM friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
- GBMSM friendly hepatitis C (HCV) screening, diagnosis and treatment
- GBMSM friendly prostate cancer screening
- Harm reduction services for GBMSM who use drugs
- Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.
- Peer educators/navigators at the facility level

PWUD

- Outreach services for people who use drugs
- On site or referral to drug dependence initiation and treatment (e.g. methadone)
- On site or referral to drug-dependence counselling and support
- Resources to take up referred services (e.g. taxi fare, planned patient transport)
- Risk reduction information
- Wound and abscess care
- Sterile needles, syringes, or other injecting equipment
- Safe disposal of used needles, syringes, or other injecting equipment
- Overdose management and treatment (e.g. naloxone)
- Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
- Post-Exposure Prophylaxis (PEP)
- Lubricant
- External condoms
- Internal condoms
- Sexual and reproductive health services
- Information packages for sexual and reproductive health services
- Non barrier contraception (including the pill, IUD, implant, injection)
- Gender-based violence services on site or by referral
- PWUD friendly HIV testing and counselling
- PWUD friendly HIV care and treatment
- PWUD focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), PWUD adherence clubs and PWUD friendly external pick-up points including at drop-in centres
- HIV support groups including PrEP/ART refill collection
- Drug dependence support
- Psychosocial support
- Mental health services
- PWUD friendly STI prevention, screening & treatment
- PWUD friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
- PWUD friendly hepatitis C (HCV) screening, diagnosis and treatment
- PWUD friendly cervical cancer screening
- PWUD friendly prostate cancer screening
- Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.
- Peer educators/navigators at the facility level

Sex Workers

- Sex worker outreach services
- Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
- Post-Exposure Prophylaxis (PEP)
- Lubricant
- External condoms
- Internal condoms
- Sexual and reproductive health services
- Information packages for sexual and reproductive health services
- Non barrier contraception (including the pill, IUD, implant, injection)
- Sex worker friendly HIV testing and counselling
- Sex worker friendly HIV care and treatment
- Sex worker focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), sex worker adherence clubs and sex worker friendly external pick-up points including at drop-in centres
- HIV support groups including PrEP/ART refill collection
- Psychosocial support
- Mental health services
- Gender-based violence services on site or by referral
- Sex worker friendly STI prevention, screening & treatment
- Sex worker friendly cervical cancer screening
- Sex worker friendly prostate cancer screening
- Sex worker friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
- Sex worker friendly hepatitis C (HCV) screening, diagnosis and treatment
- Harm reduction services for sex workers who use drugs
- Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.
- Peer educators/navigators at the facility level

PWUD

- Transgender outreach services
- Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
- Post-Exposure Prophylaxis (PEP)
- Lubricant
- External condoms
- Internal condoms
- Sexual and reproductive health services
- Non barrier contraception (including the pill, IUD, implant, injection)
- Information packages for sexual and reproductive health services
- Trans friendly HIV testing and counselling
- Trans friendly HIV care and treatment
- Trans focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), Trans adherence clubs and Trans friendly external pick-up points including at drop-in centres
- HIV support groups including PrEP/ART refill collection
- Psychosocial support
- Mental health services
- Hormone therapy
- Gender-based violence services on site or by referral
- Trans friendly STI prevention, screening & treatment
- Trans friendly cervical cancer screening
- Trans friendly prostate cancer screening
- Trans friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
- Trans friendly hepatitis C (HCV) screening, diagnosis and treatment
- Harm reduction services for transgender people who use drugs
- Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.
- Peer educators/navigators at the facility level

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.

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