Effects of Global HIV Funding Shifts on Prevention, Testing, and Treatment in Malawi

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BACKGROUND

- In many countries, national HIV programs are heavily dependent on donor funding and support from implementing partners (IPs).
- In January 2025, PEPFAR support was halted, triggering immediate disruptions to prevention, testing, and treatment services.
- Some PEPFAR support resumed (varied by service and location) by mid-2025, but restoration of personnel and services was gradual and uneven.
- The SHIFT study monitored changes in personnel and service delivery volumes at a sample of facilities in Malawi from Oct 2024 - Dec 2025.

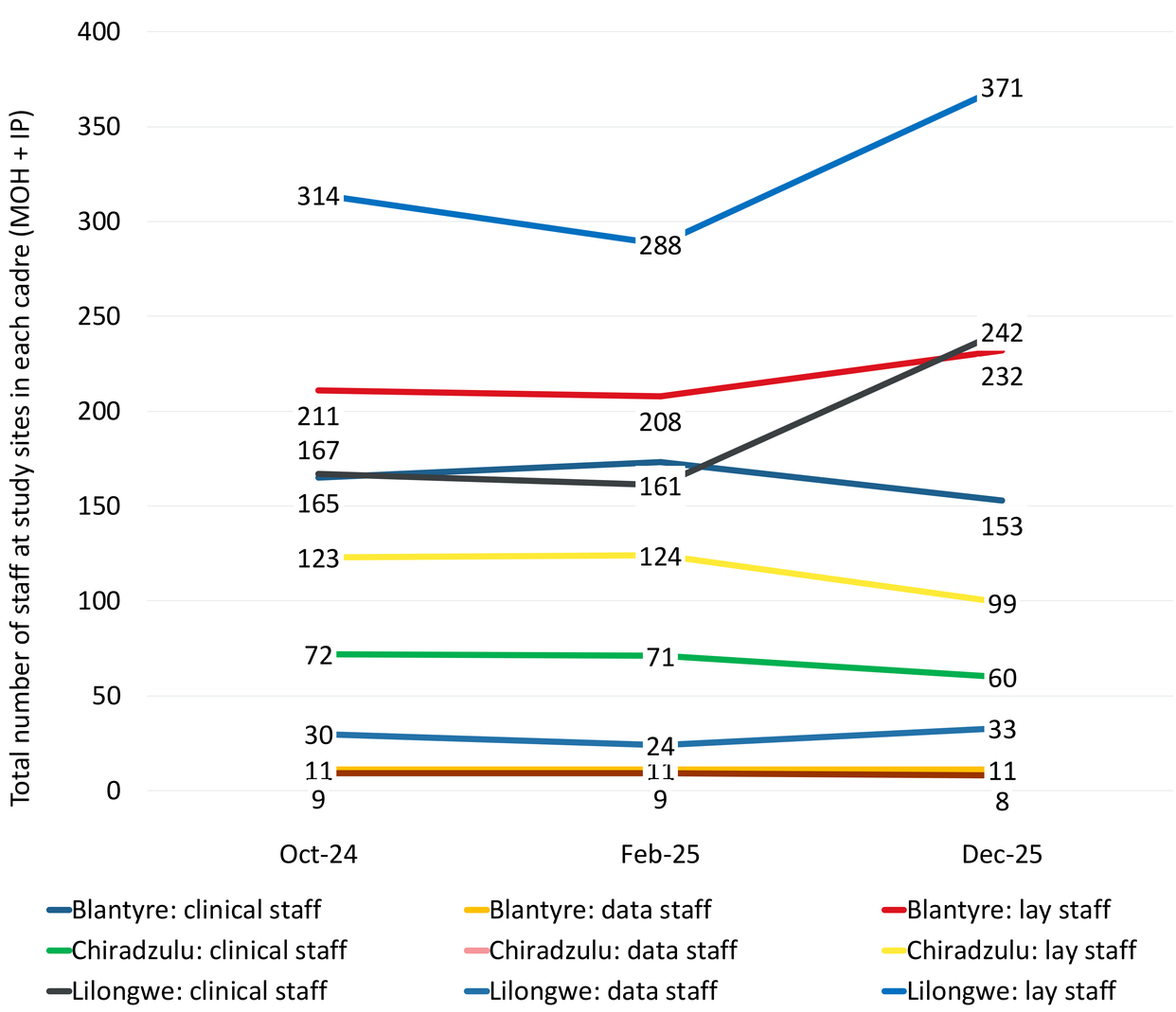
METHODS

- 16 healthcare clinics across 3 districts of Malawi:
  - Lilongwe: 8 sites; 4 USAID-supported, 2 CDC-supported, 2 unsupported
  - Blantyre: 4 sites; all CDC-supported
  - Chiradzulu: 4 sites; all CDC-supported
- Data were accessed from the Malawi Directorate of HIV, AIDS, STIs and Viral Hepatitis Management Information System, DHIS2, Laboratory Information Management System, and study site assessments for Oct 2024 to Dec 2025.
- Outcomes assessed included:
  - Staffing levels
  - HIV prevention services (PrEP, condom distribution)
  - HIV testing uptake, ART initiation and retention
  - Viral load testing and suppression rates
- We report total numbers of Ministry of Health (MOH) and IP staff and total service delivery volumes for the study sites in each district.

RESULTS

PEPFAR funding cuts caused immediate, widespread disruption to HIV services in Malawi - and a year later, recovery remains incomplete

Figure 1. Staffing changes by cadre and district (total MOH and IP staff at study)



Figures 2-5. Prevention and treatment volumes from January 2024 to December 2025

Fig 2: Proportion change of total PrEP initiations

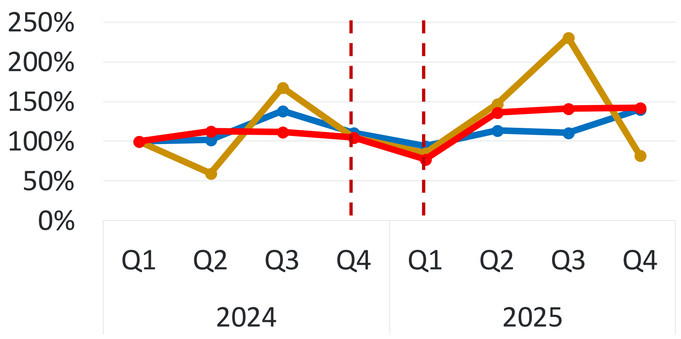


Fig 3: Proportion change of total HIV tests

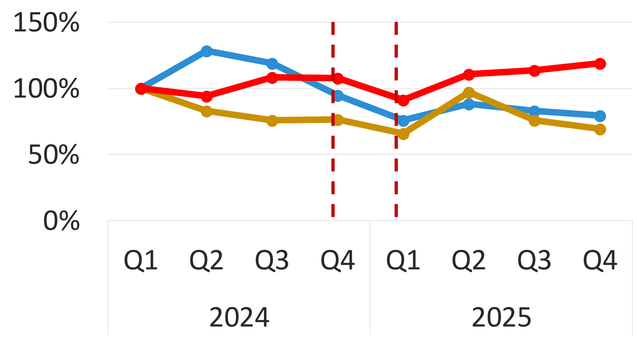


Fig 4: Proportion change of total ART initiations

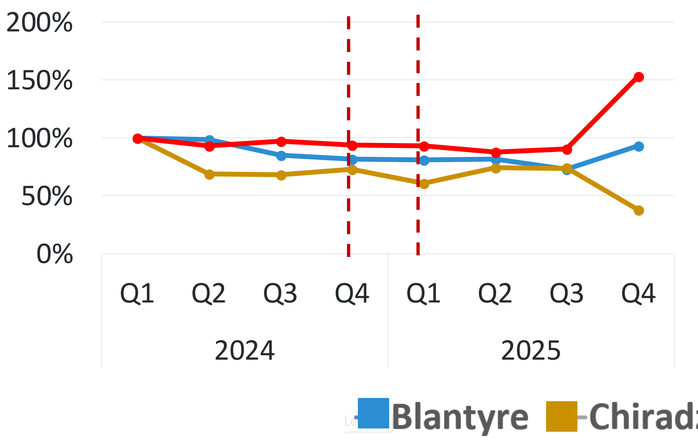
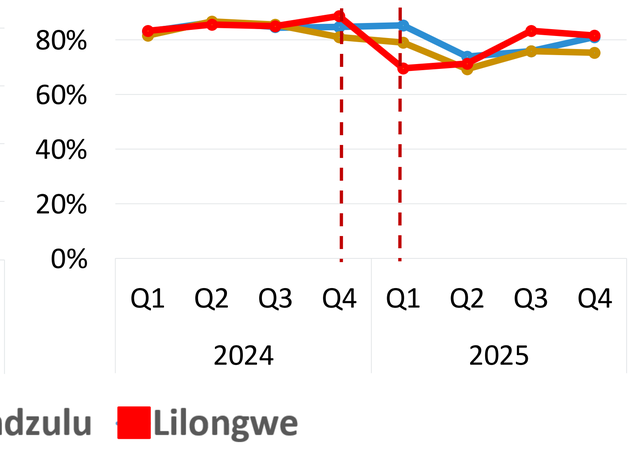


Fig 5: Viral suppression rates



Blantyre Chiradzulu Lilongwe

Staffing changes (Figure 1)

- ❑ Staff declined across all districts, with clinical cadres in Chiradzulu experiencing the greatest proportional losses (~17% reduction by Dec 25)
- ❑ Lay health workers increased in Lilongwe and Blantyre by Dec 25
- ❑ Staffing recovery was uneven across districts: Lilongwe showed the strongest rebound in lay workers, while Chiradzulu's lay staff also declined
- ❑ Despite partial restoration of funding by mid-25, clinical staff counts had not returned to pre-cut levels in any district by Dec 25

Prevention and treatment volumes from Q4 2024 to Q4 2025 (Figures 2-5)

- ❑ **PrEP initiations**: Declined in Lilongwe; recovered above baseline levels , Chiradzulu and Blantyre was stable
- ❑ **HIV testing:** Declined; recovered in Lilongwe (+16%) and Chiradzulu (+27%); Blantyre remained below baseline
- ❑ **ART initiations:** Remained relatively stable across all districts
- ❑ **Viral suppression:** Declined; recovered but remained below baseline

Table 1. Impact of funding cuts on service delivery

Impacted Service	Disruption	Mitigation Measures	Status (Jun 2025)	Status (Dec 2025)
Viral load (VL) testing	Paused in early 2025 and halted sample transport	Shift to targeted VL testing to manage limited capacity	Routine VL testing had resumed, but backlogs and delays persisted	Routine VL testing ongoing; backlog reduced but not fully resolved
Patient tracing & follow-up	Loss of phones/internet and reduced tracing capacity	Task shifting to Health surveillance assistants, nurses, clinicians	Reduced efficiency with ongoing gaps in tracing and follow-up	Gaps remain, though some tracing functions continue
Facility operations	Increased congestion and longer waiting times	Transition to facility-based care; task redistribution	Congestion and long waiting times reported at several facilities	Congestion improved, but high workload continues
DSD models (community-based)	Discontinuation of Nurse led community ART programme, Saturday clinics, Community ART distribution, youth-friendly models	Expansion of mother–infant pairs and 3/6MMD	Partial replacement of discontinued models; gaps remained	Facility-based models in place; discontinued outreach models largely not resumed
Workforce capacity	Increased workload due to staff losses	Task shifting to MOH staff (HSAs, nurses, clinicians)	Ongoing strain due to staff losses and task shifting	System remains under strain, though more stable
Service delivery model	System-wide shift from outreach to facility-based care	Consolidation of services at facility level	Shift from outreach to facility-based care largely implemented	Facility-based model sustained with reduced outreach capacity

CONCLUSIONS

- Funding cuts disrupted frontline cadres disproportionately, especially IP-supported lay counsellors.
- Urban facilities showed resilience, but rural and lower-volume areas lagged and risk being left behind.
- HIV services can decline rapidly when funding shifts - impacts are measurable quickly.
- Routine facility monitoring is essential to detect disruptions, guide recovery, and protect programme gains

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