Healthcare provider perspectives on clinic operations in Malawi following the 2025 funding cuts

KEY FINDINGS

- The 2025 funding cuts disrupted HIV clinic operations, increasing workloads, burnout, and uncertainty following the loss of implementing partner-supported staff.
- Facilities maintained ART and other essential services through rapid adaptation, including task shifting and staff reassignment, but providers perceived declines in service quality.
- Recovery has been uneven: many services resumed, but community outreach, counselling, prevention, and some differentiated service delivery models remain weakened.
- Providers emphasized the need for workforce development, knowledge transfer, and greater domestic ownership to improve resilience during future funding transitions.

WHAT IS THE ISSUE?

- In Malawi, adult HIV prevalence declined from >14% in the late 1990s to 7% in 2024 and AIDS-related deaths from 80,000 in 2003 to 14,000 in 2024.
- The HIV programme has been heavily dependent on external funding: in 2023, donors contributed 62% of HIV programme financing.
- In early 2025, U.S. funding cuts led to the loss of more than 4,500 HIV programme staff from implementing partner organizations (IPs).
- We examined the effects of the funding and staffing cuts on HIV service delivery.

WHAT DID WE DO?

- 23 in-depth interviews between Dec 2025 and Feb 2026 to explore provider perspectives on funding changes, facility-level impacts, and capacity to deliver services.
- 8 facilities in 3 districts:
  - Lilongwe District, Central Region: 4 sites (2 CDC-supported, 2 USAID-supported)
  - Blantyre District, Southern Region: 2 sites (all CDC-supported)
  - Chiradzulu District, Southern Region: 2 sites (all CDC-supported).
- We identified key themes in the interview responses and illustrated them using representative quotations.

WHAT DID WE FIND?

Workforce reductions

- Healthcare providers reported that the loss of IP staff led to discontinuation of services like tracing and community outreach.
- Uncertainty around future staffing and planning remains due to continually changing contracts.

> *"… we just heard that [IP-funded staff] contracts were being terminated on the spot… People who were helping us with the blood collection like HDAs, stopped working... Nurses and other expert clients, also stopped working. The following week, we had no one to turn to… It was really chaos because some of the work that they were doing, we weren't familiar with it, and there was no any transition on that."* - Blantyre

Adaptations

- Facilities responded by:
  - Task shifting
  - Multitasking
  - Reassigning staff from other departments to ART to fill gaps
- Staff who filled in gaps were not always trained for their reassigned tasks, leading to stress and a perceived reduction in quality of care

> *"The quality of care is not the same as it was in the beginning, because most of the people who are working, they're multitasking. They have to work in one department and then they have to come here to do [other] work. They are experiencing burnouts and tiredness... For instance, here we have just allocated one nurse, but she is not capable health-wise to work. So, I think that can also affect the quality."* - Blantyre

> *"It has made things worse because as I've said this facility has got about 27,000 plus clients who are alive in care. Cutting the number of staff will not make things better, it will make things worse because the impact will be felt by the ones who are working on the ground. They will have to shoulder the other duties that other staff were doing. They have to take it on board. So, exhaustion is there."* - Lilongwe

Return to work after initial USG stop-work order

- Many IP staff returned after the initial cuts, but uncertainty remains around contract length and sustainability.

> *"When [IP-funded staff] came back, we stayed for a while. We were told the budget was cut by 40%. They had to trim staff... Half of us left. Now we have increased workload, we have government staff. We are mentoring them—they are not yet fully in because HIV is complicated."* - Lilongwe

Logistics and supply chain challenges

- Facilities reported stock-outs or supply chain instability for a range of commodities, including:
  - Drugs: ART, TB drugs, Cotrimoxazole, Bactrim
  - Laboratory materials: CD4 test kits, CrAG test kits
  - Prevention commodities: Condoms, PrEP
- Layoffs of transport and outreach staff led to reductions in community-based service delivery.
- ART dispensing was sometimes shortened from a 6-month supply to shorter intervals.

"PrEP. It was supposed to be given to only pregnant women, because there were drug shortages… Some time we were having shortages of the viral load kits… We completely stopped offering Bactrim, these drugs completely run of stock… Sometimes you can send a client [to the lab], and you will be told services have been stopped because they do not have the cartridges." - Chiradzulu

"We used to have the PrEP drugs. But we had a stock out on the PrEP drugs for a very long time." - Lilongwe

Preparedness and capacity building (in the absence of IPs)

- Providers underscored the importance of local ownership of the ART program and described preparing for a future without IPs.

"... We need to have the other cadres from the government doing the same thing that the partners are doing, with the aim of taking over... So that whenever this IPs have gone, the government should be able to provide the services." - Chiradzulu

"... I'm doing all these activities with a partner... I make sure that I have an MOH counterpart beside me so that we are doing together. To transfer the knowledge and the skills that I have to the MOH counterpart. That's the major difference that is there." - Chiradzulu

Adaptation (no. of facilities reporting it)	Details of adaptation	Status
Viral load testing suspended (8)	Routine viral load testing paused; only targeted testing (pregnant/symptomatic); sample transport halted	Resumed with backlog
Task reallocation (8)	Health surveillance assistants (HSAs)/nurses reassigned to ART roles (HIV testing, filing, counselling) without formal training	Ongoing, fragile
Defaulter tracing suspended (8)	Active tracing stopped; limited ad hoc phone follow-up using personal airtime	Partially restored
Counselling reductions (8)	Structured adherence counselling reduced to brief dispensing interactions	Ongoing gap
Teen clubs dismantled (7)	Adolescent DSD models stopped; merged into general clinic; no incentives/support	Partially restored
PrEP restrictions (6)	PrEP limited to pregnant/breastfeeding women; key populations excluded	Partially lifted
Multi-month dispensing supply reduction (7)	6MMD reduced to 3- or 1-month dispensing; 1 site cut maximum ART supply for travellers from 12 to 6 months	Largely reversed
Manual data entry (5)	EMR disrupted; paper-based recording used; backlog in data systems	Ongoing gap
Community models stopped (4)	Community ART distribution stopped; clients shifted to facility pickup	Not reinstated
MOH-led pairing model added (5)	MOH staff paired with IP staff for mentorship and task transfer	Ongoing, fragile
Reduced clinic hours (3)	Shortened hours and fewer clinic days due to staffing constraints	Largely reversed
Paediatric clinic suspended (2)	Specialised paediatric/teen-mother clinics stopped; shifted to routine care	Partially restored
EID suspended (2)	Early infant diagnosis (EID) temporarily halted, later exempted and resumed	Reinstated
DREAMS program suspended (2)	AGYW community prevention programs and outreach stopped	Not reinstated
Family planning integration removed (2)	Family planning removed from ART clinics; clients referred to OPD	Not reinstated
Cervical cancer/STI services suspended (1)	Integrated cervical cancer/STI services halted; referral to OPD	Partially restored

Some facilities have returned to previous capacity:

- Return or re-hiring of staff
- Regular viral load testing for all clients
- Resource security
- Community-based care

Some facilities report continued challenges:

- Persistent feelings of "chaos" and uncertainty around the future of service delivery
- Lack of transportation and/or outreach staff precludes tracing and community-based care
- Teen clubs have returned, but have been restructured
- Some continuing commodity shortages
- Some staffing challenges, including reduced capacity of staff who need training on ART service delivery.

CONCLUSIONS

- The 2025 funding cuts caused immediate, system-wide disruptions to HIV service delivery.
- Recovery across facilities and service areas has been substantial but uneven.
- Workforce pressures and concerns about long-term sustainability remain.
- Sustained investment in the public health workforce and health systems is critical to strengthen resilience to future funding transitions.

Tchereni T, Msukuma M, Kachingwe E, Morgan A. J, Reeves D, Scott N, Macheso S, Gunda A, Birhanu F, Rosen S, Pascoe S, Huber A, & Mokhele I. Healthcare provider perspectives on clinic operations in Malawi following the 2025 funding cuts. SHIFT Policy Brief, June 29, 2026.