REPUBLIC OF MALAWI

MEETING TARGETS AND MAINTAINING EPIDEMIC CONTROL (EPIC) PROJECT

COOPERATIVE AGREEMENT NO.
7200AA19CA00002

Programmatic Mapping of Key Populations in Selected Districts in Malawi

SEPTEMBER 2021

USAID FROM THE AMERICAN PEOPLE

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EpiC Meeting Targets and Maintaining Epidemic Control

NATIONAL AIDS COMMISSION MALAWI

Suggested citation: Meeting Targets and Maintaining Epidemic Control (EpiC). Programmatic Mapping of Key Populations in Selected Districts of Malawi. Durham (NC): FHI 360; 2021.

This study was made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the US President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the EpiC project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government. EpiC is a global cooperative agreement (7200AA19CA00002) led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobee Group.

EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobee Group. For more information about EpiC, including the areas in which we offer technical assistance, click here.

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Acknowledgments

The Ministry of Health, through the National AIDS Commission, would like to acknowledge the efforts of the FHI 360 Meeting Targets and Maintaining Epidemic Control (EpiC) project on the design and implementation of the study and preparation of this report. This report would not have been possible without the involvement of multiple individuals and institutions in the design and implementation of this study. We want to express our deep gratitude to the following people and institutions:

- Dr. Andrew Gonani, Chimwemwe Mablekesi, and Afirima Barinaadaa of the National AIDS Commission
- Dr. Rose Nyirenda, Washington Ozituosauka, and Tadala Hamisi from the Department of HIV and AIDS
- The district health and social services directors, district research committees, and district councils for Blantyre, Phalombe, Zomba, Lilongwe, Machinga, Mangochi, and Mzimba North Districts
- The National Health Sciences Research Committee
- Staff of Pakachere; Community Health Rights Advocacy; Lesbians, Intersex, Transgender Persons, and Other Extensions; Rainbow, Rights, Education and Awareness; Female Sex Workers Association; Malawi AIDS Counselling and Resource Organization; Centre for People Development (CEDEP); Drug Fight Malawi; and Centre for Key Population Rights
- The FHI 360 Malawi team: Melchiade Ruberintwari, David Chilongozi, Allison Zakaliya, Elizabeth Mpunga, and Grace Phombeya
- Site principal investigator: David Chilongozi, FHI 360, Lilongwe, Malawi
- FHI 360 US-based team: Chris Akolo, Navindra Persaud, Virupax Ranebennur, Lillian Mugonyi-Nasser, Amy Gottlieb, and Elizabeth Eckard
- Consultants: Tobi Saidel, United States; and Dr. Nyanyiwe Mbeye of the Kamuzu University of Health Sciences, Malawi
- USAID Malawi: Erick Mlanga
- The study enumerators
- The respondents who gave freely of their time

Acronyms

ART	Antiretroviral therapy
CBO	Community-based organization
CI	Community informant
DHA	Department of HIV and AIDS – Ministry of Health
DIC	Drop-in center
EpiC	Meeting Targets and Maintaining Epidemic Control
FGD	Focus group discussion
FSW	Female sex worker
IDI	In-depth interview
KP	Key population
L1	Level 1
L2	Level 2
MOH	Ministry of Health
MSM	Men who have sex with men
MSW	Male sex worker
NAC	National AIDS Commission
NGO	Nongovernmental organization
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
TG	Transgender
TWG	Technical working group
UNAIDS	United Nations Joint Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Background: In May 2022, with funding from the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) for the EpiC project led by FHI 360, the National AIDS Commission (NAC) sanctioned key population (KP) programmatic study among female sex workers (FSWs), men who have sex with men (MSM), transgender (TG) people, and people who inject drugs (PWID) in Lilongwe, Blantyre, Mangochi, Machinga, Zomba, Phalombe, and Mzimba North. The objectives of the study were to (1) identify, map, and geocode venues where FSWs, MSM, and transgender people congregate to meet sexual partners, (2) validate venues and conduct KP counts of FSWs, MSM, and transgender people in the seven target districts, (3) determine the HIV-related services that KPs access at no cost in the seven districts, (4) determine the best times to reach KPs with relevant services at the various venues, and (5) assess the nature and extent of injecting drug use in the selected districts.

Methods: Between June and September 2021, EpiC carried out KP programmatic study among FSWs, MSM, and transgender people and a rapid qualitative assessment of PWID in the seven selected districts in Malawi. Programmatic mapping was conducted based on the standard USAID/LINKAGES (Linkages across the Continuum of HIV Services for Key Populations Affected by HIV) guidelines and included pre-mapping in all seven districts, followed by interviews with community informants to generate a list of possible venues where KPs congregate in Level 1; verification of the identified venues, geocoding of the venues, interviews with KP individuals, and collecting information for KP count in Level 2. In-depth interviews (IDIs) and focus group discussions (FGDs) for the rapid assessment of the use of injecting drugs in all seven districts were carried out separately. Data for programmatic mapping were cleaned, deduplicated, and imputed where appropriate. The number of KPs frequenting the venues weekly was calculated and adjusted for mobility (double counting) and those uncounted because they do not visit the venues and are less accessible. The geo-coordinates for each venue were imported into Power BI software and plotted on a map. All qualitative data were analyzed using NVivo 12 Software.

Results: A total of 2,743 venues where KPs congregate were reported by community informants in the seven districts. During site visits in Level 2, 58.2% (1,484/2,551) of the venues reportedly visited by FSWs, 90.8% (89/98) of those venues reportedly frequented by MSM, and 90.4% (85/94) of the venues where transgender people reportedly congregate were found to be operational and had members of the target population. The study team could not verify the presence of FSWs in 695 of the 2,551 (27.2%) venues identified by community informants as places where FSWs congregate despite being operational during the visit in Level 2. Interviews were conducted at 62.2% (923/1,484) of the FSW venues, 34.8% (31/89) of the MSM venues, and 90.5% of the transgender individuals venues. After adjusting for mobility and non-venue-based KPs, it was estimated that 11,966 FSWs, 360 MSM, and 1,131 transgender people frequented the venues weekly in the seven districts.

Findings from the PWID rapid assessment show that the number of people injecting drugs in Malawi is increasing, with decreased age at initiation. Drug injecting is increasing among girls and school-going youths. Opioids were the most identified injecting drug used, but the use of prescription drugs was also reported as common. Based on the information provided by study participants, it was estimated that there are 11,120 PWID in the seven districts.

Conclusions: Programmatic mapping directly captures the subset of KPs who patronize physical venues and is especially suited for FSWs. This study has established that MSM and transgender venues are usually fluid and has confirmed the previous belief that a large proportion of MSM and transgender people do not usually congregate at public venues. However, it provides information on the best time to reach KPs with services at the venues. The estimates generated by this study are significantly lower than what other studies have previously reported. Additional studies are required to fully understand their dynamics and the best approach for reaching MSM and transgender people with much-needed services.

Limitations: The study was conducted at the peak of COVID-19-associated movement restrictions, including limited operational hours of entertainment centers, with all closed by 10 p.m. This affected the availability of KPs in the venues and the time for conducting interviews with study respondents. This largely contributed to the lower KP count, as the study team could not reach a bigger number of venues. Additionally, the relatively shorter study implementation period affected the times the teams could visit the venues, resulting in most venues being visited only once and in a small proportion of venues from which data was collected. Despite these limitations, the study provides evidence to inform decision-making regarding targeting interventions and provides a basis on which other studies could be designed. The PWID rapid assessment is the first study in the country to explore the nature and extent of injecting drug use in Malawi, provides information for program planning, and generates hypotheses for more advanced studies.

1.0 Background

The World Health Organization (WHO) defines a key population (KP) as a population at higher risk for HIV irrespective of the epidemic type or local context and that faces social and legal challenges that increase their vulnerability to HIV acquisition [4]. These include female sex workers (FSWs), men who have sex with men (MSM), transgender (TG) people, people who inject drugs (PWID), and people in prisons and other closed settings [4]. Available data from 2018 suggest that, globally, the risk of HIV acquisition among gay men and other MSM was 22 times higher than it was among all other adult men, 22 times higher among PWID than compared to people who do not inject drugs, 21 times higher for sex workers (SWs) compared to all adults of sexual reproductive age 15–49, and 12 times higher among transgender women compared to adults of sexual reproductive age 15-49 [4]. In addition to their elevated HIV risk and burden and challenges with legal and social issues, KPs have not historically received adequate priority in response to the HIV epidemic, especially in countries with generalized HIV epidemics such as Malawi [5,6]. Members of KPs are hard to reach as their behaviors are often considered illegal and stigmatized. Designing and implementing effective KP programs requires a thorough understanding of the distribution, dynamics, and access to the minimum package of services by the different KP groups in different geographic areas. According to a recent United Nations Programme on HIV/AIDS (UNAIDS) report:

> *"Addressing the specific issues within local epidemics is crucial to a greatly improved HIV response. Focusing on the areas where the HIV epidemic is highly concentrated and identifying where services are lacking or not reaching the people needing prevention services, testing, treatment, and support are the first steps toward achieving more efficient and effective programs [9]."*

The estimated KP populations and the proportion with specific risk factors in different geographic areas are important components of HIV surveillance. Not only is size a critical determinant of the potential contribution of different KPs to new HIV infections, but it is also crucial for defining program resource needs and setting priorities and targets. Public health program planners need information on the number, distribution, and dynamics of KPs in different settings to determine the content and scale of the response required to prevent HIV transmission. Furthermore, robust estimates of KP distribution are important to inform policy, advocacy, and funding needs; and to measure the coverage, quality, and effectiveness of interventions targeting KPs.

The HIV/AIDS pandemic has remained a constant public health problem in Malawi. Malawi registered an estimated 9.2% of the adult population ages 15-49 living with HIV in 2019 and an estimated 33,000 new infections in the same year [1]. In 2018, 13,000 Malawians were estimated to have died from AIDS-related illnesses [1]. Malawi's HIV and AIDS epidemic is generalized, with transmission occurring across all population segments [2]. As a result, substantial prevention resources and the HIV surveillance system have been oriented toward the general population [2]. However, there has been growing awareness of the importance of the epidemic among KPs in Malawi. Although KPs makes up a small proportion of the population, they are at high risk of acquiring and transmitting HIV infection. According to UNAIDS, approximately 62% of all new HIV infections that occurred in 2019 globally were among KPs and their sex partners [3]. In Malawi, 55% of FSWs and

approximately 7% of MSM were estimated to be living with HIV [1]. There is no reliable data on HIV prevalence among transgender people and PWID in Malawi.

Through the 2015–2020 and 2020–2025 National HIV Strategic Plans and 2018–2020 HIV prevention strategy, Malawi has prioritized KP programming with an emphasis on differentiated HIV prevention interventions targeting the populations most at risk of acquiring and transmitting HIV [7]. For this to be achieved, HIV services such as testing need to be available around the settings and populations where the most HIV-positive individuals can be identified and linked to treatment. The Malawi Government prioritized a massive scale-up of routine testing for HIV in health facilities, in community settings, and among KPs. Similarly, the country's National Condom Strategy 2015-2020 recognizes the importance of ensuring access to condoms and lubricants for KPs, including FSWs, MSM, and their clients. [8].

Malawi has no national consensus on the size of the KP groups in different districts. However, several studies have been conducted in the past few years to generate national and subnational KP estimates. Very little is known about the PWID in Malawi. There have been few — or no — attempts to characterize injecting drug users in Malawi or implement programs to help prevent or discourage injecting. Moreover, the number and location of venues where KPs can be found are typically hidden and known only to programs or individual service providers and not always shared widely. As a result of these data limitations, setting targets and assigning resources for KP programs is not based on a thorough understanding of the population size and geographical distribution.

Against this backdrop, with funding from USAID and PEPFAR through FHI 360, the National AIDS Commission sanctioned a KP programmatic mapping and PWID assessment study in May 2021.

2.0 Study Goal

2.1 Study Aim

This study was designed to provide high-quality data that stakeholders providing services for key populations can use to design interventions aimed at reducing HIV risk; and monitor the reach, coverage, and effect of interventions targeting KPs and PWID.

2.2 Study Objectives

The objectives of the study were to:

1. Identify, map, and geocode venues where FSWs, MSM, and transgender people congregate to meet sexual partners
2. Conduct KP counts for FSWs, MSM, and transgender people in the seven target districts
3. Determine the HIV-related services that KPs access at no cost in the seven districts
4. Determine the best times to reach KPs with relevant services at the various venues
5. Assess the nature and extent of injecting drug use in the selected districts

3.0 STUDY DESIGN AND METHODOLOGY

3.1 Study Design

Two prospective approaches were used to collect data for this study. During programmatic mapping, we identified, mapped, and geocoded the location of venues where FSWs, MSM, and TG people congregated and counted the number of KP individuals at the venues. PWID and other key informants were assessed on the nature and extent of injecting drug use. Both assessments were conducted in seven USAID/PEPFAR-funded districts under FHI 360 in Blantyre, Zomba, Machinga, Mangochi, Phalombe, Lilongwe, and Mzimba North in Malawi (Figure 1). The details of the methodology and results of the programmatic mapping conducted among FSWs, MSM, and TG people are included in Section 2, while the methodology and results of the rapid assessment conducted among PWID are presented in Section 3.

Figure 1

3.1 KP Programmatic Mapping for FSWs, MSM, and TG People

3.1.1 STUDY POPULATION

FSW: A female 18 years or older who received money or goods in exchange for sexual services with a man either regularly or occasionally.

MSM: Men who engaged in sexual and/or romantic relations with other men during the past 12 months.

TG people: According to the 2015 UNAIDS terminology guidelines, transgender is an umbrella term used to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth [12]. TG people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g., hormone therapy), and individuals who identify as having no gender, multiple genders, or alternative genders. TG people may self-identify as transgender, female, male, trans woman or trans man, transsexual, or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine, and/or androgynous ways.

3.1.2 Data collection

We selected programmatic mapping methods for this study among FSWs, MSM, and TG people because it provides locally relevant program data for determining the resources required and planning implementation strategies [16, 17]. Programmatic mapping was justified by the understanding that many KP individuals engaged in high-risk activities solicit sexual partners by visiting physical venues. This is especially true for FSWs [15]. It may be less true for MSM except for a more visible subset that includes male sex workers (MSWs) and TG people. However, given that other size estimation studies using other methods (e.g., RDS multiplier) were being conducted in Malawi around the same time in some of the same districts as this one, and acknowledging that the situation is fluid, we opted to do programmatic mapping for all KP groups including FSWs, MSM, MSWs, and TG people and to include an approach for estimating the proportion of KP who may not visit physical venues. It is envisaged that the results from this study will be triangulated with other studies to further the understanding of plausible size estimates of KP.

KP programmatic mapping was conducted based on the USAID LINKAGES guidelines [14]. It was implemented in sequential steps beginning with pre-mapping in all seven districts, then generating a list of possible venues (Level 1), verification of venues, and data collection for KP count during site visits (Level 2). The **pre-mapping exercise** includes obtaining approval from the district research committees and consultations with representatives of the KP community, community members, NAC, the Department of HIV and AIDS (DHA) in the Ministry of Health (MOH), and District AIDS Coordination Committees to garner support for the assessment. At these meetings, the study protocol and implementation plans were reviewed and discussed, and guidance was sought from district teams on the best approach for geographically dividing the districts into manageable units for study implementation. Each study unit was given a unique identification code.

Level 1: Identification of Venues: The study team visited geographical areas in the selected districts and conducted interviews with a wide range of community informants (CIs). They were knowledgeable about the local context and KPs and able to identify and generate a comprehensive list of venues where FSWs, MSM, and TG people congregate. CIs were identified and selected through purposive sampling among participants ages 18 and older who were voluntarily willing to participate. Verbal informed consent was obtained from each

CI before the interview commenced. Table 1 lists the main categories of CIs interviewed for this study.

Table 1. Community informants interviewed in Level 1

Taxi driver	Youth out of school
Truck driver	Military/police
Bar owner/worker	Community-based organization/nongovernmental organization
Individual socializing at a venue	Peer educator
Security guard	Community health worker
Transgender person	Trader/businessperson
A person who injects drugs	Hawker/street vendor
A man who has sex with men	Fuel attendant
A woman who exchanges sex for money	Individual loitering
A community leader	Fisherfolk
A hairdresser	Minibus driver, bicycle, or motorcycle rider
Youth in school	

At Level 1 (L1), a structured questionnaire (Annex B) was used to collect information from consented CIs. Data collected from each venue include name, location, and important nearby landmarks; type of venue including a public place, brothel, nightclub, bars, and guesthouses; days when the venue was busiest; busiest times of the day; count of KPs who visit the venue; and the estimated number of and type of KPs who visit the venue. At the end of each day, the completed L1 forms were reviewed by the field team for completeness, after which the data were entered into a password-protected MS Excel database. The number of L1 interviews that were needed in each district was dependent on the geographical size of the area as well as the population density. Approximately one L1 interview for every 1,000 population in an area was planned. After the L1 data collection was completed, the data were cleaned to produce a de-duplicated list of venues for each district in preparation for Level 2 mapping.

Level 2: Verification of venues: Using the de-duplicated list of venues generated during Level 1, field teams visited the venues identified in L1 and used the Level 2 (L2) form (Annex C) to verify the existence of the venue and collect more in-depth information for each venue. Four respondents, including KP and non-KP members, were purposively selected for an interview at each operational venue. Data for L2 were collected using pre-programmed electronic devices. Data that were collected for each site during this phase included: location, venue geocoding, type of venue, the estimated number of KP on a typical day, days and times of the week when the most KP members could be found, use of the internet to work or meet sexual clients, the estimated number of KPs who frequent the venue over the course of a typical week, and the name of other nearby venues where KPs could be found. New venues identified during L2 were added to the comprehensive list generated from L1 interviews and were visited for L2 data collection. Venues that were not found, closed temporarily or permanently, determined to be places where KPs do not congregate, or inactive at the time of the visit were noted accordingly and excluded from further data collection.

Training of study staff: A comprehensive four-day training for all study team members, including research assistants and supervisors, was conducted in June 2021. The team was trained on the mapping process, study tools, research ethics, interviewing techniques, and study expectations, among other topics. The training included simulations during which research assistants practiced how to introduce themselves, ask questions, and record information using role-plays and demonstrations. KP-led organizations were invited to orient the study team on acceptable conduct and language when interacting with KP members.

Pre-testing and piloting of survey activities: Pre-testing of the questionnaires and piloting of the study procedures were carried out during the training. For this, the research team conducted the pre-testing by interviewing volunteers ages 18 years and older at Mponela Trading Centre, which represented the semi-urban setting, and Dowa district, which represented the rural setting. After the activity, the team converged at the training venue to review the process and experience using the data collection tools. Based on this, the data collection tools, as well as some approaches for the recruitment of study participants, were refined.

Management of fieldwork: For the programmatic mapping of FSWs, MSM, and transgender people, each district was divided into smaller geographic areas during the stakeholder engagement meetings. Each geographic area reflected either an administrative or a health catchment area. The purpose of dividing a district into smaller geographical areas was to monitor fieldwork effectively and to ensure that all areas in each district were covered. Each area was assigned a unique three-digit identification number known as the area code. Venues were numbered consecutively within each area, and each was assigned a unique code comprised of the district code and the area code.

3.1.3 Data Management and Analysis

At the end of each day, all Level 1 forms were reviewed by the field team for completeness, after which the data were entered into a password-protected MS Excel database. After the Level 1 data collection, the data were cleaned to produce a de-duplicated list of venues for each district. After Level 2 data collection, the data were cleaned and prepared for analysis using the following procedures:

- Identifying and deleting duplicate records
- Checking for internal inconsistency
- Range checks to ensure values were within a valid range
- Review of missing data and imputing values as appropriate
- Checking to ensure that the number of records in the dataset equaled the number of interviews conducted, as reported in the fieldwork reports

Data imputation: The following imputations were made during the data cleaning process. For those variables for which respondents provided only minimum and maximum values, the point estimate was derived by calculating an average of the minimum and maximum values given by respondents. For venues with multiple respondents, the final value for each variable was developed by taking the mean (or the mode in case of categorical variables) across all respondents for the selected variable at that venue. If the value for Q11 (number of KPs who visit other sites) in any record was greater than the value for Q10 (weekly size) for that record, the Q11 value was replaced with the Q10 value. For records that were missing weekly size (Q10) estimates, the mean value from the other respondents at the same venue was substituted for the one that was missing. However, if values for Q10 were missing from

all records for a given venue, that venue was excluded from the calculation of the size estimates. If the values for Q11 (mobility) and/or Q12 (number of venues visited) were missing for all respondents from a given venue, but the weekly size estimates (Q10) were available for that venue, then the district level average values for Q11 and Q12 were used for these venues.

Calculating the number of KPs: The crude number of KP that can be found in each district during any given week was first calculated by summing the average number of KP individuals across all operational venues where at least one respondent was interviewed. These estimates were then adjusted for two factors: mobility across sites to account for double counting and those KP members who never visit physical venues. The crude number of KP visiting venues during a normal week was derived using the responses for Q10 of the L2 data collection form (Figure 2).

Figure 2. Questions from Level 2 mapping used for crude size estimates

10	During a normal week, how many female sex workers usually come to this venue to look for clients? *(Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively.)*	☐☐☐ MIN	☐☐☐ MAX

Adjustment for mobility (double counting): This was done by using the data reported in Q11 and Q12 in the L2 form (Figure 2) and applying them in the formula below.

Mobility Adjusted Size = N – [N*P* (1-1/S)]

- N = Number of KPs mapped at each venue from Q10, summed across all venues in the district
- P = Percent of KPs who are mobile at each venue averaged across all venues in the district (Q11/Q10)
- S = Average number of other venues in the district visited by the people at each venue averaged across all venues in the district (Q12)

Figure 3. Questions from Level 2 mapping used for mobility-adjusted size estimates

11	During a normal week, how many of the FSWs who come to this venue *(please refer to Q10)* also go to other venues in this district to look for clients? (*Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively.)*	☐☐☐ MIN	☐☐☐ MAX
12	Among those FSWs who also go to other venues in this district *(please refer to 11)*, on average, how many venues in the district do you think they go to during the week, including this one? (*Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively.)*	☐☐☐ MIN	☐☐☐ MAX

Adjusting for the less visible (hidden) portion of the population: This was done by applying the response derived from Q14 and Q15 in the L2 form (Figure 3) to the below formula:

Mobility and Hidden Population Adjusted Size = Mobility adjusted size/1 – mean proportion not accessible at venues

Where:

- Mobility adjusted size = Mobility adjusted size (from a previous calculation)
- Mean percent not accessible at venues = mean of individual responses for proportion not accessible at venues as described below:
    - For each KP informant, divide the number of people who never visit venues (mean of min and max for Q15) by the number of KPs known to the respondent (mean of min and max for Q14). This gives % not accessible at venues for each respondent.

Figure 4. Questions from Level 2 mapping used for "hidden population" adjusted size estimates

14	How many FSWs do you know who live or work in this district? (*Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively.)*	☐☐☐ MIN	☐☐☐ MAX
15	How many of the FSWs that you know who live or work in this district do not EVER come to ANY venues to look for clients? (*Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively.)*	☐☐☐ MIN	☐☐☐ MAX

Identifying the location of venues on a map: The geo coordinates collected for each of the venues were imported into Power BI software and plotted on a map module available in the Power BI software to show the specific location of the venues relative to each other

3.1.4 Ethical considerations

This study was reviewed and approved by the Protection of Human Subjects Research Committee at FHI 360 and the National Health Sciences Research Committee in Malawi. Verbal Informed consent was obtained from all CIs, FGD, and IDI respondents, while written informed consent was obtained from all key populations. No name or other identifying information was collected for the study participants. All paper-based data were stored in a locked metal cabinet in the office of the principal investigator at FHI 360 offices in Lilongwe. Electronic data were stored using double password protection. Study participants reported no physical or psychological harm incidents. All interviews were conducted at sites where participants felt comfortable and were identified by members of the KPs during the study planning. All study staff were trained in human subject protection to ensure that the study was conducted ethically. Each research assistant signed a confidentiality pledge that stated penalties for any breach of confidentiality. No incentive was provided, but information, education, and communication materials; condoms; and lubricants were made available free of charge to all study participants.

3.1.5 Results of programmatic mapping for FSWs, MSM, and transgender people

3.1.5.1 Level 1 results – listing of venue

A total of 7,558 CI interviews were conducted across seven districts during Level 1 mapping. Respondents were asked to list up to 10 venues where FSWs, MSM, and TG people meet sexual partners. Table 2 shows the type and number of CIs by district. Interviews were uniformly spread across each locality where L1 mapping took place. About 20% of CIs were bar owners/workers, minibus drivers, motorbike riders, and bicycle riders; 12.4% were members of KP groups; and the rest encompassed a range of categories. There were more CI interviews in the three cities than other districts.

Table 2. Distribution of community informants interviewed during Level 1 by district

Type of community informant	Blantyre	Lilongwe	Machinga	Mangochi	Mzuzu	Phalombe	Zomba	TOTAL
Bar owner or worker	167	393	16	20	32	25	134	**787**
Minibus driver, motorcycle, & bicycle rider	131	374	14	54	97	32	79	**781**
Unemployed/ individual loitering	102	356	29	62	73	68	13	**703**
Trader/ businessperson	137	266	20	70	82	25	89	**689**
Women who exchange sex for money	176	323		8	96	3	19	**625**
Hawker/street vendor	171	168		59	99	65	34	**596**
Individual socializing at a venue	161	249	16	26	62	22	46	**582**
Youth out of school	73	190	1	75	48	33	24	**444**
Taxi driver	125	196		57	19	8	14	**419**
Hairdresser	66	162	2	31	23	6	23	**313**
Other/blank	1	102	112	19	10	34	24	**302**
Truck driver	139	51			10	15	4	**219**
Youth in school	33	112	3	13	14	21	10	**206**
Community health worker	34	111	9	11	2	5	33	**205**
Transgender person	22	136	1		15		1	**175**
Security guard	21	85		28	3	3	13	**153**
Community leader	22	43			12			**77**
Person who injects drugs	10	51		7			2	**70**
Men who have sex with men	8	51			5		5	**69**
Fisher folk		12	14		7		31	**64**
Military/police		39					2	**41**
Peer educator		29					1	**30**
CBO/NGO staff		1			3		4	**8**
TOTAL	**1,599**	**3,500**	**237**	**540**	**712**	**365**	**605**	**7,558**

3.1.5.2 Female sex workers

Development of Level 1 master list of venues for FSWs: Following the interviews with 7,558 CIs, a total of 2,466 unique venues were listed across seven districts during L1 mapping. During the L2 interviews, 85 additional venues were identified, resulting in a total of 2,551 unique venues where FSWs congregate in the seven districts (see Table 3).

Table 3. Number of FSW venues identified in each district

District	Venues listed during L1	Additional venues identified during L2	Total number of venues identified
Blantyre	569		569
Lilongwe	1,009	76	1,085
Machinga	93		93
Mangochi	183	1	184
Mzuzu	259	8	267
Phalombe	133		133
Zomba	220		220
TOTAL	**2,466**	**85**	**2,551**

Verification of venues: Table 4 summarizes the status of the venues that were identified during the L1 exercise. Of the 2,551 venues listed, 1,484 (58.2%) were found to be operational and were reportedly frequented by FSWs, while 695 (27.2%) were operational but were not visited by FSWs. Approximately 10% of the listed venues were not found, and 3.3% were closed.

Table 4. Status of the FSW venues in each district

Status of venue	District							Total N (%)
	Blantyre N (%)	Lilongwe N (%)	Machinga N (%)	Mangochi N (%)	Mzuzu N (%)	Phalombe N (%)	Zomba N (%)	
Venue operational and had FSWs	499 (87.7)	432 (39.8)	61 (65.6)	88 (47.8)	223 (83.5)	79 (59.4)	102 (46.4)	**1,484 (58.2)**
Operational but not a KP venue	58 (10.2)	381 (35.1)	27 (29.0)	64 (34.8)	22 (8.2)	29 (21.8)	114 (51.8)	**695 (27.2)**
Venue not found	8 (1.4)	220 (20.3)	2 (2.2)	11 (6.0)	7 (2.6)	-	-	**248 (9.7)**
Closed permanently	1 (0.2)	31 (2.9)	2 (2.2)	9 (4.9)	1 (0.4)	2 (1.5)	1 (0.5)	**47 (1.8)**
Closed temporarily	3 (0.5)	21 (1.9)	-	6 (3.3)	3 (1.1)	3 (2.3)	3 (1.4)	**39 (1.5)**
Not visited	-	-	1 (1.1)	6 (3.3)	11 (4.1)	20 (15.0)	-	**38 (1.5)**
TOTAL	**569**	**1,085**	**93**	**184**	**267**	**133**	**220**	**2,551**

Of the 1,484 venues that were operational and frequently visited by FSWs, at least one interview was conducted at 923 (62%) of them (Table 5). No data were available for 561 (38%) of the sites that FSWs frequented: This was mainly due to the absence of FSWs or the refusal by FSWs and other key informants at the study sites. Due to COVID-19-associated movement restrictions, many FSWs may have moved to other venues or other geographic areas. Due to time constraints, the study team was unable to revisit those sites at which they were unable to recruit participants on their first visit.

Table 5. FSW operational venues by interview status

District	Number of venues where no interviews were conducted		Number of venues where at least one interview was conducted	Percent of venues where interviews were conducted	Total # of venues
	KP not available	No key informant available at the venue			
Blantyre	10	277	212	42.5%	499
Lilongwe		118	314	72.6%	432
Machinga	1	8	52	85.2%	61
Mangochi	4	4	80	90.1%	88
Mzuzu	13	77	133	59.6%	223
Phalombe	27	1	51	64.6%	79
Zomba	1	20	81	79.4 %	102
Total	**56**	**505**	**923**	**62.2%**	**1,484**

Table 6 shows the location of the KP venues where interviews were conducted and the average number of interviews per site. Most of the venues were urban. An average of 2.8 interviews were conducted at each venue, with an average of 3.3 and 2.4 interviews per venue for Blantyre and Mangochi, respectively.

Table 6. Average number of respondents at FSW venues where at least one interview was conducted

District	Number of venues where at least one interview was conducted			Total number of interviews conducted	Average number of interviews per venue
	Rural	Urban	Total		
Blantyre	7	205	212	691	3.3
Lilongwe	89	225	314	800	2.5
Machinga	47	5	52	139	2.7
Mangochi	57	23	80	195	2.4
Mzimba	64	69	133	385	2.9
Phalombe	40	11	51	132	2.6
Zomba	67	14	81	207	2.6
Total	**371**	**552**	**923**	**2,549**	**2.8**

Table 7 shows the characteristics of the venues that were found to be operational and frequented by FSWs. Approximately two-thirds (601/923) of the operational FSW venues were bars with lodging, followed by guesthouses/rest houses (126/923) and bars without lodging (120/923).

Table 7. Type of FSW venues by district

Type of Venues	Districts							
	Blantyre	Lilongwe	Machinga	Mangochi	Mzimba	Phalombe	Zomba	Total
Bar with lodging	135	212	29	39	93	33	60	**601**
Guesthouse/rest house	24	44	18	17	7	5	11	**126**
Bar without lodging	42	31	2	11	23	6	5	**120**
Shebeen	2	13	1	7	3	2	1	**29**
Brothel	1	3	2	6	3	5	3	**23**
Nightclub/disco	6	3			3			**12**
Hotel/lodge/inn	2	5			1			**8**
Restaurant		1						**1**
Truckstop							1	**1**
Street		2						**2**
Total	**212**	**314**	**52**	**80**	**133**	**51**	**81**	**923**

District venue geocoded maps

In each of the seven districts, venues were geocoded and plotted on maps by KP type (Annex H), Annex G shows the summary of venues mapped and geocoded and a breakdown by district and KP type.

Table 8 shows the times during a typical day when FSWs could be found at the identified venues. The most common times during which FSWs could be found at the operational venues were evenings (5–9 p.m.) and nights (9 p.m. to midnight).

Table 8. Time of operation of FSW venues by district

District	Blantyre	Lilongwe	Machinga	Mangochi	Mzimba	Phalombe	Zomba	Total
Morning (before noon)		7			1	3		**11**
After 12 (12–5 p.m.)	7	10	5	3	1	3	7	**36**
Evening (5–9 p.m.)	164	167	38	36	77	25	40	**547**
Night (9 p.m.–late night)	35	81	5	27	32	11	23	**214**
Anytime	6	36	3	10	19	8	10	**92**
Don't know		13	1	4	3	1	1	**23**
Total	**212**	**314**	**52**	**80**	**133**	**51**	**81**	**923**

FSW count: Table 9 shows the crude and adjusted estimates of the number of FSWs in the seven districts in which this study was conducted. The crude estimates, derived by summing the average number of FSWs who reportedly visit the 923 sites where at least one interview was conducted, represent the estimated number of FSWs before adjusting for mobility. Since FSWs may visit multiple sites during any given week, the crude estimate is an overestimate of the actual population size, as some FSWs would have been counted at more than one venue during the week. After adjusting for mobility across venues, we estimated that there were 8,602 unique venue-based FSWs in the seven districts, with the highest numbers in Blantyre, Lilongwe, and Mzimba. When the population was further adjusted to include those FSWs who may not frequent venues but instead find clients through means such as phone, internet, or other intermediaries, the total FSW population in the seven districts increased to 11,966. These estimates of the number of FSWs in the seven districts would likely be higher if respondents were found at all 1,484 operational FSW venues.

Table 9. FSW count by district

District	Estimated weekly number of FSWs		
	Crude estimate	Adjusted for mobility across venues	Adjusted to include the hidden FSWs (venue- based plus non-venue- based)[2]
Blantyre	5,428	2,770	3,649
Lilongwe	4,966	2,727	4,038
Machinga	589	362	494
Mangochi	755	448	649
Mzimba	2,593	1,298	1,646
Phalombe	391	239	331
Zomba	1,204	757	1,159
Total	**15,926**	**8,602**	**11,966**

[2] Values adjusted for estimated mobility and proportion of non-venue-based FSWs

3.1.5.3 Men who have sex with men

Development of Level 1 master list of venues for MSM/MSW: A total of 98 unique venues were identified across the seven districts as places where MSM congregate; 74 were identified during L1 mapping, while 24 additional venues were identified during L2 mapping (Table 10).

Table 10. MSM venues identified by district

District	Venues listed during L1	Additional venues identified during L2	Total number of venues identified
Blantyre	33	3	36
Lilongwe	20	11	31
Machinga	1		1
Mangochi	2	3	5
Mzuzu	17	2	19
Phalombe	0	5	5
Zomba	1	0	1
TOTAL	**74**	**24**	**98**

Verification of venues: The status of the venues identified during the L1 mapping is summarized in Table 11. Of the 98 venues listed in L1, 90.8% (89/98) were found to be operational and frequented by MSM. Four of the remaining venues were reported as operational but were not frequented by MSM, while two were closed, one was not found, and two were not visited.

Table 11. Status of MSM venues

Status of venue	District							
	Blantyre	Lilongwe	Machinga	Mangochi	Mzuzu	Phalombe	Zomba	Total
Venues found to be operational	36	24	1	5	17	5	1	89
Not a KP venue		4						4
Not found		1						1
Closed permanently		2						2
Closed temporarily								
Not visited					2			2
GRAND TOTAL	**36**	**31**	**1**	**5**	**19**	**5**	**1**	**98**

Out of the 89 operational MSM venues, at least one interview was conducted at 28 (31%) of them (Table 12). No data were available for 61 (69%) sites that MSM frequented. This was mainly due to the absence of MSM when the team visited and the refusal by MSM and other key informants who were present to be interviewed for the study. Due to time constraints, the study team could not revisit those sites where they failed to recruit an interviewee on the first visit. Due to COVID-19-associated movement restrictions, many MSM may have moved to other venues or other geographic areas.

Table 12. MSM operational venues by interview status

District	Number of venues where no interviews were conducted	Number of venues with at least one interview conducted	Percent of venues where interviews were conducted	Total number of venues
Blantyre	32	4	11%	36
Lilongwe	13	11	46%	24
Machinga	1	0	0%	1
Mangochi	1	4	80%	5
Mzuzu	14	3	18%	17
Phalombe	0	5	100%	5
Zomba	0	1	100%	1
Total	**61**	**28**	**31%**	**89**

Table 13 summarizes the location of the MSM venues where interviews were conducted and the average number of interviews at each venue. An average of 3.2 interviews were conducted in each of the 28 sites where interviewees were identified. The average number of interviews per venue ranged from 2.4 in Lilongwe to 4.0 in Mzimba, Phalombe, and Zomba.

Table 13. Average number of respondents at MSM venues where at least one interview was conducted

District	Number of venues where at least one interview conducted			Number of interviews conducted	Average number of interviews per venue
	Rural	Urban	Total		
Blantyre	0	4	4	13	3.3
Lilongwe	2	9	11	26	2.4
Machinga	0	0	0	0	0
Mangochi	2	2	4	14	3.5
Mzuzu	1	2	3	12	4.0
Phalombe	4	1	5	20	4.0
Zomba	0	1	1	4	4.0
Total	9	19	28	89	3.2

Table 14 summarizes the type of venues at which MSM congregate. Nearly half (13/28) of the MSM venues were bars with lodging or hotels, followed by hotels/lodges/inns (7/28).

Table 14. Type of MSM venues by district

Type of venues	Districts							
	Blantyre	Lilongwe	Machinga	Mangochi	Mzimba	Phalombe	Zomba	Total
Bar with lodging	3	5		1		4		13
Hotel/lodge/inn	1	2		3		1		7
Nightclub/disco					2			2
Bar without lodging		1						1
Guesthouse/rest house							1	1
Other		3			1			4
Total	**4**	**11**	**0**	**4**	**3**	**5**	**1**	**28**

Table 15 shows the times when MSM were most likely to be found at the identified venues. Evenings (5–9 p.m.) and nights (9 p.m. to midnight) were the most common times of day for MSM/MSW venues to be operating.

Table 15. Time of operation of MSM/MSW venues by district

District	Blantyre	Lilongwe	Machinga	Mangochi	Mzimba	Phalombe	Zomba	Total
Afternoon (12–5 p.m.)		1				1	1	3
Evening (5–9 p.m.)	2	5		3		3		13
Night (9 p.m.–late night)	2	3		1	2	1		9
Anytime		1			1			2
No response		1						1
Total	**4**	**11**	**0**	**4**	**3**	**5**	**1**	**28**

Size estimates for MSM: The estimated number of MSM in each district is shown in Table 16. These values represent the average of the minimum and maximum values given by respondents. A total of 230 unique MSM could potentially be reached at the 28 venues where at least one interview was conducted. After adjusting for MSM mobility and those who find partners through other means such as phone apps and internet sites, the number of MSM in the seven districts was 360. These estimates of the number of MSM in the seven districts would likely be higher if respondents were found at all the operational venues that MSM frequent.

Table 16. MSM size estimates by district

District	Unadjusted number of MSM	Estimated size (venue- based)[1]	Estimated size (venue-based plus non-venue based)[2]
Blantyre	133	37	40
Lilongwe	3,129	103	172
Machinga	0	0	0
Mangochi	62	25	41
Mzimba	83	18	28
Phalombe	112	42	72
Zomba	27	5	7
Total	**3,546**	**230**	**360**

[1] Values are adjusted for estimated mobility.
[2] Values are adjusted for estimated mobility and % non-venue based.

3.1.5.4 Transgender people

Development of Level 1 master list of venues for transgender people: A total of 94 potential venues where transgender people congregate were identified across the seven districts, with 73 listed during L1 mapping and 21 additional venues identified during L2 venue verification (Table 17).

Table 17. Venues where transgender people are found by district

District	Venues listed during L1 mapping	Additional venues identified during L2	Total number of venues identified
Blantyre	33	3	36
Lilongwe	19	8	27
Machinga	1		1
Mangochi	2	4	6
Mzuzu	17	3	20
Phalombe	0	3	3
Zomba	1	0	1
TOTAL	**73**	**21**	**94**

Verification of the transgender venues: The status of the venues where transgender people can be found is summarized in Table 18. The majority (85/94) of the venues visited were operational and were reportedly places where transgender people could be found. Out of the remaining nine venues, four were not active KP venues, two were closed, one was not found, and two were not visited.

Table 18. Status of venues where transgender people are found

Status of venue	District							
	Blantyre	Lilongwe	Machinga	Mangochi	Mzuzu	Phalombe	Zomba	Total
Venue operational	36	20	1	6	18	3	1	85
Not a KP venue		4						4
Not found		1						1
Closed permanently		2						2
Closed temporarily								
Not visited					2			2
Total	**36**	**27**	**1**	**6**	**20**	**3**	**1**	**94**

Out of the 85 operational venues where transgender individuals were found, at least one interview was conducted at 24 (28%) (Table 19). No data were available for 61 (72%) of the sites that transgender people frequented. This was mainly due to the absence of transgender people when the team visited and/or the refusal by those present and other key informants who were present to be interviewed. Due to time constraints, the study team could not revisit those sites where they failed to recruit an interviewee on the first visit. Due to COVID-19 restrictions, many transgender people may have moved to other venues or other geographic areas.

Table 19. Operational transgender people venues by interview status

District	Number of venues with no interviews conducted	Number of venues with at least one interview conducted	Percent of venues where interviews were conducted	Total # of venues
Blantyre	32	4	11%	**36**
Lilongwe	13	7	35%	**20**
Machinga	0	0	0%	**1**
Mangochi	1	5	83%	**6**
Mzuzu	14	4	22%	**18**
Phalombe	0	3	100%	**3**
Zomba	0	1	100%	**1**
Total	**61**	**24**	**28%**	**85**

Table 20 shows the location of operational venues where interviews were conducted and the average number of interviews per site. Approximately 70% of the transgender people venues were identified in urban areas. The average number of interviews completed per venue was 2.6, ranging from 1.8 in Mangochi to 4.0 in Phalombe.

Table 20. Average number of transgender people venues where at least one interview was conducted

District	Number of venues with at least one KP interview conducted			Total # of interviews conducted	Average number of interviews per venue
	Rural	Urban	Total		
Blantyre		4	4	11	2.8
Lilongwe	2	5	7	19	2.7
Machinga			-	-	-
Mangochi	3	2	5	9	1.8
Mzuzu	1	3	3	7	2.3
Phalombe	1	2	1	4	4.0
Zomba		1	4	13	3.3
Total	**7**	**17**	**24**	**63**	**2.6**

Evenings (5–9 p.m.) and nights (9 p.m. to late night) were the most common times of day for transgender people venues to operate (Table 21).

Table 21. Time of operation of transgender people venues by district

District	Blantyre	Lilongwe	Machinga	Mangochi	Mzuzu	Phalombe	Zomba	Total
After 12 (12–5 p.m.)		1	-	1	2		1	5
Anytime		1	-					1
Evening (5–9 p.m.)	2	4	-		2	2		10
Morning (before noon)			-	1				1
Night (9 p.m.–late night)	2	1	-	3		1		7
Total	**4**	**7**	**-**	**5**	**4**	**3**	**1**	**24**

TG people count: The estimated number of TG people by district is shown in Table 22. The unadjusted estimate of the number of transgender people was derived by summing the average number of transgender people reported for each venue. As transgender people may visit several venues during a week, individuals may be counted more than once, and the data may overestimate the number of transgender people in the seven districts. The data were adjusted for mobility, resulting in 648 unique transgender people. This was then adjusted to account for those transgender people who do not visit a venue and remain hidden, resulting in approximately 1,131 transgender people in the seven districts. These estimates of the number of FSWs in the seven districts would likely be higher if respondents were found at all 1,484 FSW venues. These estimates of the number of transgender people in the seven districts would likely be higher if respondents were found at all the venues frequented by transgender people.

Table 22. Transgender people count by district

District	Crude (unadjusted) estimated number of transgender people	Estimated size (venue-based TG)[1]	Estimated size (venue-based plus non-venue-based TG)[2]
Blantyre	207	161	240
Lilongwe	349	223	411
Machinga	-	-	-
Mangochi	54	35	58
Mzuzu	208	167	231
Phalombe	48	24	35
Zomba	43	37	156
Total	**909**	**648**	**1,131**

[1] Values are adjusted for estimated mobility.
[2] Values are adjusted for estimated mobility and % non-venue-based.

3.2 Rapid Assessment for People Who Inject Drugs

To assess the nature and extent of injecting drug use in the seven districts, we conducted a qualitative exploratory study employing IDIs and FGDs to collect information. An exploratory approach was chosen for its flexibility to allow for an extensive probe into phenomena of interest and applies to topics where prior knowledge is minimal [19]. Furthermore, qualitative exploratory approaches lay the foundations for further studies [19]. The participants were drawn in two ways: Considering that PWID are a hidden population and not easily accessible, we employed exponential discriminative snowball sampling to recruit them [20]. In addition, FHI 360 collaborated with NAC and organizations that work with PWID to help recruit PWID. These assisted in identifying district representatives. Exponential discriminative snowball sampling allows the first subject recruited to provide multiple referrals. However, not all new referrals are explored. In our study, we followed up on referrals that seemed likely to fill specified objectives or information gaps. The initial seeds from each district were referred by a representative from a PWID organization, who is also a PWID. After that, the recruits referred each other in a chain referral technique. However, the PWID were asked to refer their peers, drug suppliers, and any other knowledgeable people willing to provide information regarding the practice of injecting drugs. Other participants were purposively selected to answer specific questions depending on their needs or insight. These included the police, immigration officers, journalists, other key populations (MSM, MSW, FSW, and transgender people), health workers, KP service providers, university students, youths, and religious leaders.

3.2.1 Study population

PWID refers to people who inject non-medically sanctioned psychotropic (or psychoactive) substances. These drugs include but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives, and hallucinogens. An injection may be through intravenous, intramuscular, subcutaneous, or other injectable routes [10]. PWID do not include people who self-inject medicines for medical purposes, referred to as "therapeutic injection," or individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance.

3.2.2 Data collection

Data collection for the rapid assessment focused on the types of drugs used in general, injecting drugs and use, suppliers of injecting drugs, any support needed for people who inject drugs, drug use venues, and behavioral risks related to drug use. Data were collected July 12 to August 6, 2021, by two experienced social scientists. All interviews were in-person within secluded places convenient to researchers and participants. To minimize potential role bias, participants did not have prior knowledge of who was going to conduct the interviews. We used FGDs and IDIs to collect data. For both approaches, we used a semi-structured topic guide (Annex D) to allow for the exploration of the subject. The IDI and FGD guides were piloted in Phalombe, and emerging data were included in the analysis. Piloting allowed for the incorporation of changes in both guides. Interviews and discussions were conducted in English or Chichewa, local commonly spoken dialects in Malawi, and were recorded with permission, translated, and transcribed verbatim.

One of the 72 IDIs was not recorded after the participant refused to consent to recording but allowed field notes to be taken. No repeat interviews were done. We employed an iterative process and developed new questions from the emerging gaps, which were explored in subsequent data collection sessions. Interviews and discussions were stopped when saturation was reached. Apart from the two social scientists, the study consultant and the Director of HIV and AIDS in the Ministry of Health (MOH) co-facilitated some of the interviews and discussions to gain a deeper understanding of the practice. Member checking1 was used during data collection sessions whereby the interviewer summarized each session before proceeding to the next sections for confirmation and/or to allow expansion of ideas. We assigned a personal identification number to each participant to maintain anonymity and excluded identifying information from the quotes.

We used the "peel the onion" metaphor to understand the issues and answer the who, what, when, why, and how questions, as shown below, to highlight and explain all the important details [21]. At each point, the team dug deep and asked probing questions to get to the innermost point on the subject. Knowledgeable people such as PWID were interviewed first and asked to recommend the next group of people to interview. This approach continued with each group of people being interviewed until saturation was reached. Respondents included the police, journalists, researchers, suppliers, university students, health workers, mental health experts/psychologists, religious leaders, and many more (Annex E). All study participants provided verbal consent before conducting the interviews. We conducted district stakeholder meetings to validate PWID assessment findings. We conducted 18 FGDs and 72 IDIs (Annex F).

The rapid assessment aimed to address the following areas:

- What are the drugs being used?
- What is the nature and extent of drug use?
- What is the nature and extent of injecting drug use?
- Who is injecting drugs, and where can they be found?
- What are the trends in drug injection over time?
- If there is little evidence of current injecting, what is the potential for it to occur?

[1] *Member checking is a social science qualitative method. Also known as participant or respondent validation, it is a technique for exploring the credibility of results. Data or results are returned to participants to check for accuracy and resonance with their experiences. Member checking is often mentioned as one in a list of validation techniques*.

3.2.3 Qualitative data management and analysis

Analysis was conducted using NVivo 12 software (QSR International, Melbourne, Australia) employing a thematic approach developed by Braun and Clarke [22]. Two experienced social scientists did the translation and transcribing. SS and NM read the transcripts several times to gain a deeper understanding of the narratives as an act of data immersion. SS then developed a codebook that underwent additional coding by NM. The codebook was developed using both inductive and deductive coding frameworks. SS then arranged similar codes into categories to reduce and present the data into manageable segments before arranging the codes into overarching themes. Unique codes were assigned to new categories. All coded transcripts and summaries of emergent themes were reviewed and approved by NM.

3.2.4 Rapid assessment summary findings for PWID

Our main findings indicate a growing culture of injecting drug use among youths, decreasing age on initiation across both sexes, and high prevalence of injecting drug use among KPs. We also reported increasing availability and variety of drugs, with few challenges in access and increasing home practices. We found a general lack of willingness to reduce use and/or stop, and limited knowledge of the effects of injecting drugs, implications of addiction, or therapeutic services available for PWID.

3.2.4.1 Types of injecting drugs and extent of use

Participants across all settings mentioned numerous drugs. The most mentioned drugs included cocaine, heroin, methamphetamines, ketamine, diazepam, valium, promethazine, pethidine, and diclofenac. Less-mentioned drugs included a mixture of heroin and cocaine called speedball, methylene, crack chlormethine, and a drug known as cam5.

It is also common practice among PWID to mix products to create a homemade drug cocktail. PWID reported mixing, diluting salt and aspirin tablets to create an injectable concoction, burning, and then diluting antiretroviral drugs, codex and codeine, and cough syrups.

Furthermore, most suppliers and users could not name the drugs and would explain their presentation, for example, packaging and color. One respondent said:

> *"I cannot really disclose what drug it really is because my friend is the one who knows it."* IDI, PWID, FSW

> *"I sell two types, but like I said, I do not know their names. The people who sell them to me know the names."* IDI, supplier, PWID, male

Along with the ignorance of which drugs they were using, most PWID were unaware of the dosage of the drugs they use. While most mentioned the frequency of use, they were unclear on the actual dosages used.

> *"As for me, I inject four times in a day. I inject promethazine. I use the syringe that is used at the hospital."* IDI, PWID, lesbian

> *"The ones I buy at MK2000, I inject four times, but I inject two times per day."* IDI, PWID, FSW

The frequency of injecting was easier to ascertain among those who inject daily than those who skipped some days as they were less clear about their habits.

> *"Once a week but would also depend on my mood."* FGD PWID, male

> *"Sometimes three, sometimes four times a month. I mostly sniff but inject now and then when I am in the mood."* IDI, PWID, MSM

> *"I inject maybe once a month. I don't inject often because I am HIV positive."* FGD, PWID, MSM

The failure to quantify the dosage injected was common across most PWID. We singled out three that mentioned the exact amounts they use. All three had formal employment; two were married men, while one was an MSM (divorced from his wife). The divorcee worked for a KP organization and said his knowledge of KPs influenced him to limit how much he injects.

> *"I see how most MSM live. They live dangerous lives, and they live in the moment. I try to make sure that I control myself because I know how dangerous this is."* IDI, PWID, KP organization, MSM

The three respondents mentioned above reported injecting 2–5mls, with the KP representative more likely to use 5mls and the other two on the lower side. Regarding the injection period, the longest user mentioned he has been injecting since 2012 and is currently a university student, age 24. In contrast, others mentioned they started using other forms of drugs before 2012 and transitioned to injecting later. However, in one KP-led organization, a member reported that her peers started injecting as early as 2004.

> *"I knew that people were injecting way back in 2004 and 2005. Those ones I happened to have interacted with them because, at that time, I was working in a rehabilitation center. So, you know, people were referred to as such. I wouldn't say that they were from Mzuzu but from other quarters, especially Nkhata Bay."* IDI, KP Lead, female

3.2.4.2 Profile of people who inject drugs

An emerging picture indicates that the profile of PWID cuts across all layers of society in terms of age, sex, economic status, marital status, and sexual orientation. The age of initiation of drug use appears to be decreasing over time.

> *"I started with cocaine; I would sniff. I started in 2012, and I was introduced by my friends at a boarding school, and I was young then because I was in standard 6; I was 12."* PWID, FGD, male, college student

A drug supplier confirmed this development, reporting that young people are demanding and using drugs. When asked about this pattern, most respondents concurred on the ages they initiated drug injections. However, they could not establish a reason for it. One drug supplier confirmed that they sometimes follow the supply of drugs to students at their learning institutions. During such visits, students "silently" call each other and buy drugs.

> *"These kids can come twice a week … some we follow them at school, so when we go to their school, they just know we are there, and they tell each other the business is quick."* PWID, supplier, FGD, male

According to our informants, most drug users are youthful, ranging from teens to twenties and early thirties, with a few in their forties.

> *"The drugs are used by youths from teens to twenties."* IDI, pastor

Most PWID operate in “circles,” comprising an estimated 25 people of similar ages and sex. However, some have interactions regardless of age or gender. We found that in the quest to access and use drugs, it is common for PWID to break out of these “circles” and interact with individuals with a different sexual orientation, including MSM, FSW, MSW, lesbians, and transgender people. The interaction would range from friendships and sharing drugs to sexual relationships or drugs in exchange for sexual favors.

Our interviews suggest that the number of PWID is increasing overall, especially among females. It was reported that some girls prefer injecting drugs to drinking alcohol or smoking cigarettes, thus avoiding being seen or labeled as smokers or alcohol drinkers while maintaining the "high" status associated with the use of drugs.

> *"At first it was mostly boys, but now it’s girls ... what happens is that most girls, when they are at drinking places, they do not want to be seen smoking, for example, Chamba, or smelling of alcohol. Instead, the best that they can think of for them to get high is through injecting drugs."* FGD, supplier, male

> *"There are four institutions, and our neighbors do it openly, and most girls do it openly at their campus."* PWID, IDI, male student

We asked each person how much they inject daily and found males inject more frequently and in higher doses than females. Suppliers also confirmed selling higher amounts of drugs to males than females, suggesting that the frequency of use was higher among males.

While factors contributing to initiation were similar, with most mentioning peer pressure and recreation, some differences exist across settings, with the lakeshore district of Mangochi commonly singling out having lived in South Africa as a significant influence toward injecting drugs. One respondent said:

> *"I can't really say when exactly people started using the drugs, but a lot of young men here in Mangochi travel to South Africa and come back with practices reported they learned while they were there."* IDI, police officer

Being exposed to tourists was mentioned as another factor in drug injection initiation. For example, one respondent in Mzuzu said that it is common in Nkhata Bay, one of the lakeshore districts. Mangochi is another lakeshore district, where travel to South Africa is attributed to drug injection initiation. However, one respondent said that in Mangochi, youths are more likely to be introduced to injecting by peers.

Economic status featured highly as a determinant of injecting drugs across all participants. Expressions like "*injecting is not for the poor"* (PWID, IDI, male)*, "you need to have money to inject"* (police officer, female)*, and "most kids who inject are from rich families"* (PWID, female, student) imply that injecting is associated with higher socioeconomic status.

> *"The thing about drugs is that drugs are expensive. How can you do drugs while you are broke? It doesn't make sense. If you do drugs while you are broke, it means you are stealing. If you are well off, then you will access drugs because you will call the dealer, the syringe dealer, and it's just some minutes they come to your place."* IDI, PWID, male

On the other hand, despite drug costs acting as a barrier to access, users will still find alternative ways to get drugs to inject. PWID named cocaine and heroin among their preferred drugs, and many users mentioned using alternative drugs. Over-the-counter drugs, including promethazine and codeine cough syrup, were the most mentioned across all settings. PWID mentioned that these are readily available, accessible, and affordable, thus rendering them easier to use.

> *"We buy (promethazine) at the pharmacy. A bottle sells at MWK2000, sometimes at MWK1500."* PWID, IDI, female student

> *"You go to a pharmacy, so those pharmacists actually know that this child is not sick; rather, he/she is buying this cough syrup for other purposes, and sometimes they can ban you, so you have to change."* FGD, PWID, male, student

> *"Promethazine, you can buy like MWK500, but it starts from MWK300 … codeine, MWK3500, MWK2500. Promethazine, the whole bottle at MWK1500."* PWID, IDI, female student

> *"Heroin is sold like we do move in the crew, so in our crew we can just put the money together, let's say like MWK10,000"* FGD, PWID, male, student

We found it difficult to ascertain the standard prices of drugs because different users and suppliers mentioned different prices for the same product. However, the standard price for [purer] drugs like cocaine would be considered expensive compared to some alternative drugs.

> *"MWK40,000 a gram. And if it is cheap, then it is mixed with other substances such as baking powder to increase the quantity and make a profit, but by the end of the day, it is the consumer that suffers."* PWID, IDI, Machinga

One supplier mentioned that the price determination varies:

> *"We just charge by looking at the person who wants the drug."*

The lack of fixed price may drive some people toward "less safe" products rather than drug reduction or quitting.

> *"Cocaine K1000? The way you know cocaine, you cannot access cocaine at K1000 … I don't know what they are talking about; that must be diluted."* IDI, PWID, male

Sharing drugs or pooling resources is a common method of getting drugs where finances are minimal among PWID. PWID reported that they would pool resources, gather at one place at specified times, and inject and leave.

> *"I am lucky I am a girl, and I have friends who can plug (share) me up like most of the time boys would not share each other. So, I have these friends ... good friends on a good day, who buy when I do not have money, and we share."* FGD, PWID, female, out-of-school youth

> *"We put the money together, buy the drugs, and whenever 9 o'clock comes, they call me, and we meet at 9 a.m. and 4 p.m. every day."* IDI, PWID, MSM, male, informal laborer

Once PWID can't access their drug of choice, they improvise with other substances such as salt, soft drinks, and aspirin tablets. Considering that these are cheap and readily available products, the lack of finances alone does not seem a major deterrent from drug use for those from lower economic classes.

> *"There is also aspirin that we mix with salt, and we put that mixture into a syringe. The last one is done when you don't have money."* IDI, PWID, MSM, male, businessperson

The innovation needed to get drugs stretches PWID such that they would use the internet to learn easy ways of making injectable drugs. This development highlights the role of factors beyond pricing in continued injecting behavior; these factors include exposure to technology.

> *"What happens is that we watch, and we can easily get these from the internet. How to mix and how to create a drug you can easily access it on the internet."* FGD, PWID, male

> *"You can google how to make a good codeine mixture."* FGD, PWID, male, student

Another common method of obtaining drugs where finances are limited is offering sex for drugs. This also seems to be a common practice for both genders.

> *"Sometimes it's possible, and it depends on how you have agreed; we understand each other; if he is also MSM, we can discuss, and it happens we have sex."* FGD, supplier, male

> *"I meet many girls, and sometimes they offer themselves, and it happens that I have sex with them. Sometimes some of the girls are very high, I slept with them. Now because I have kids, so I reduced; I have never done sex with a man, but I have gays that are customers."* FGD, PWID, supplier, male

Injecting drugs appears to be common among KPs, with most KP respondents expressing that they used them to enhance performance during sexual intercourse. About 50 PWID interviewed in this study were FSW, MSM, lesbians, and transgender people.

Answering the question, "How do you feel when you inject yourself?" one participant had this to say:

> *"You cannot understand unless you try it. That's the first question I asked before I started. You can't understand until you try it. You just feel this … Everything just gets enhanced. Your sex hormones are enhanced, and to other people appetite is good. Things are just enhanced, you hear a lot, and you see a lot."* IDI, PWID, male

> *"That question is like a virgin asking how someone feels when having sex. It's a feeling you cannot describe unless one tries it him/herself."* IDI, PWID, male

Injecting drugs is considered a social norm among health care workers including clinicians, medical assistants, nurses, pharmacists, and doctors. Some young injecting drug users have said they acquire drugs and syringes from health care workers.

> *"In the hospitals, it is the medical guys mostly that I have seen using drugs. When I say the medical guys, I am talking about clinicians, medical assistants, and to some extent some doctors because those are the people that have typical access to those drugs."* Health worker, male

> *"We get from the hospital; we approach hospital staff. They let us get some. We make deals with them since these are government supplies."* PWID, male

> *"The case that I can share is of a certain health worker who was using drugs, and he was stealing opioids from the hospital, and I know another nurse who could go to the extent of maybe going to work late at night just to inject herself and ending up sleeping in the ward under the influence of the drugs, and she was too into the drugs that she ended up getting fired from work."* KP expert, male

It is also worth noting that the increase in injecting drug users is not reflected in the number of PWID seeking care at rehabilitation facilities. Rehabilitation services for drug users, such as Saint John of God in Mzuzu, take a cohort of 10 to 12 people and have them in the program for four weeks. The clients are referred country wide. While the services are free, there are also slots reserved for patients referred from government institutions.

> *"We can't say necessarily very often, but we can say it's rare as compared to alcohol and cannabis. You may find that with drug injection, it would be very rare. Two, three, or four cohorts (groups of people admitted to the rehabilitation center at a particular period) without any client injecting. Sometimes we can have two consecutive cohorts with at least one client injecting, and we believe that the population for these injecting drugs is also few."* FGD, psycho-social counselor, male

Anecdotal estimates from respondents working in rehabilitation institutions did not reflect increasing numbers of users among young populations needing rehabilitation services.

> *"And it's mostly males, and females are very few. We have had cohorts of all males, cohorts of very few females, and cohorts of one female. In the cohort where we had a good number of females, then it did not exceed two. So, it's either two females or one or none."* FGD, coordinator for addiction recovery, female

Table 23. Number of PWID who participated in the assessment

Category	Number
Female sex workers	3
Men who have sex with men	39
Transgender people	6
Lesbians	2
Business people	4
University students	15
Students in school	2
Students in other tertiary institutions	23
Out-of-school youth	33
Police officers	3
Teachers	1
Health workers	3

3.2.4.3 Sources and characteristics of suppliers of injecting drugs

We attempted to profile who is supplying the injectable drugs, and we learned that the supply chain is long, complex, and hidden from the suppliers and users themselves. It is established that these suppliers are not the main dealers for users exposed to or who get their supply from suppliers. Most suppliers interface with middlemen and do not know the actual owners of the cocaine, heroin, and ketamine. However, they would know suppliers of prescription drugs, for example, pethidine and promethazine. Suppliers can tell where a

supplier of a prescription drug works, but they don't have detailed information on suppliers of opioid-based drugs. Most suppliers of prescription drugs are said to work in hospitals, pharmacies, and government drug stores, while suppliers of opioid-based drugs are said to be *"tourists and 'big people' in Malawi."* In the same way, some users are described as *"big people from the court, big people who are rich, policemen, health workers, soldiers, married people, and religious leaders."* Networks are described below.

> *"In a scenario that you have been arrested because of drugs, let's say with Ndirande police, and you have your friends at Blantyre police that you share drugs, you can just call and inform them, and you can be released. So, it depends. I have witnessed this."* FGD, PWID, male

> *"There is a certain doctor who supplies me, and there are a lot of hospital personnel who also use drugs. They either use, or they just sell because they need the money."* IDI, PWID, female

Attempts to solicit information from the police were futile; they said they did not know who the drug suppliers were. We saw that drug users were more knowledgeable about drug suppliers than the police.

> *"The drugs really enter here but with difficulties. I am saying with difficulties because you can confiscate, as police officers, we can confiscate from a person, take the person in, and question the person so well about the source, but the person will not say it, but the drugs have been confiscated."* IDI, police officer, male

We talked to drug specialists at two city branches, and we got the impression that the police were less informed than people on the streets.

> *"We don't have information on that; people may inject, but we do not know who they are, where they are getting the drugs. It's difficult to know a drug addict who uses drugs. I am just coming from training in Cairo. We learned many things regarding drug trafficking, and we hope to be able to use that knowledge."* IDI, police officer, female

In terms of how the drugs come into the country, a few things were clear: They come in through unchartered routes and the usual chartered routes. Truck drivers were also mentioned as one way to get drugs into Malawi. One respondent said that these truck drivers are not searched or are deliberately let through the borders. As a result, they easily transport drugs, and the cost of buying from the truck drivers is less expensive than other sources.

> *"Truck drivers. And it's cheaper to buy from them because they don't get searched in borders. Sometimes from police when they convict."* IDI, PWID, male

Most respondents claimed that police or immigration officers assist with smuggling drugs into the country but had no proof. However, most agreed that importation was possible because the border posts are porous and there is not serious scrutiny of goods coming into the country.

> *"They come in through our porous borders, foreigners; in airports people are also transmitting; lack of capacity in the border places, lack of training due to corruption is also another factor."* IDI, police officer, male

There were also many references to the importation of drugs across Lake Malawi from Tanzania to Nkhata Bay. Respondents mentioned that Nkhata Bay gets a significant amount of drugs supplied from Tanzania, some of them by road and boat.

> *"In Nkhata Bay … it is a hot spot; there are many people that do drugs. It's more than Mzuzu. At the lake you see people thinking that they are just chatting, but they are doing drugs."* FGD, PWID, supplier, male

More dangerous ways of transporting drugs were also mentioned. One participant highlighted that these drugs could be concealed in the human body.

> *"Through truck drivers and sometimes boss smugglers send their subordinates, they cut them in muscles and suture. They use parts that have bigger muscles. They make deep incisions in several parts to maximize profit."* IDI, PWID, male

Some also explained using items like dolls loaded with drugs that they would give to a child in transit without the child knowing, and children can be dressed heavily and nicely while carrying loads hidden on their clothes.

Other ways mentioned were loading the drug with items imported for business. This includes small-business people who bring in clothes from Tanzania and South Africa by road. Another man confirmed smuggling drugs packed in a suitcase and crossing the border on his feet.

> *"I just carried an old suitcase with clothes inside, packed the drugs in there. I also carried a bag with pots; then I walked and was dropped near the border. I crossed on feet and was picked on the other side of the border."* IDI, PWID, supplier, MSM

We were not able to reach the main suppliers. All the suppliers we interviewed were middlemen. All PWID refused to link us to the main dealers, and we did not press on due to safety concerns.

3.2.4.4 Initiation into injecting drugs

Not surprising is the finding that peer pressure features highly with most PWID's initiation into injecting across all settings. Peer pressure is featured among all age groups, even among professionals like health care workers. More than half the students involved in this study were medical students. Peer pressure was as common among them as among the rest of the population. This calls for exploring how knowledge (or lack of it) affects drug use.

Some users confessed to having been introduced to injecting by a relative, and for some of them, someone meant to be a guardian. A network of social connections in neighborhoods and institutions such as schools fulfills a certain need, ranging from entertainment to academics.

> *"My aunt uses cocaine. I started staying with her in 2007, so in 2015 while still young, I was smoking Chamba. Then she injected me … she said I would sleep. It was something more powerful, then I saw that Chamba was not better, but in 2017 is when I could go and buy drugs because I knew places because of my aunt."* PWID, FGD, male

> *"It was during a holiday, and I went to my uncle. My uncle is a drug user and likes using diazepam, which helps sleep. We sometimes drank together, and one day he asked me to try, and I did. From that day, I have been using it."* PWID, male, student

Some users noted they started injecting after learning from the internet. This came out among younger participants, who expressed that they deliberately set out to learn about injecting drugs on the internet.

> *"What happens is that we get influence from friends, and mostly what we watch, and we can easily get these from the internet, how to mix and how to create a drug; you can easily access it on the internet."* PWID, IDI, female student

We also asked how participants came to inject. Did they start with injecting or transition from other modes of drug use, and what fueled the transition? The main reasons for transition mostly pointed to the need to "feel high" for longer periods than the previous drugs accorded. From our findings, most PWID transitioned from other drug use, starting with alcohol or smoking before moving to injection. Smoking Indian hemp featured highly among most PWID as the next step after alcohol or smoking ordinary cigarettes.

> *"I was introduced to drugs by my friends, and I started with smoking. Then I had to move to the injections because I could see that my friends were doing well. So, with time, the way I wanted my morale to be from low to high, that moved from stages, from stage 2, 3, 4, and so on."* IDI, MSW, PWID

It is also clear that injecting is a response to an addiction to drug users' current products. Most indicated that they moved on to injecting because what they were using before could no longer provide euphoric feelings. With encouragement from friends, most moved on to injecting.

> *"I started smoking Kayte in 2011 because I was influenced by a friend, and I reached a point where I could drink beer and never got drunk. So, my friend introduced me, but someday we went to his home, and we did not get the sniff ones, so we found some friend who was injecting, and he told us that injecting lasted longer and worked fast, so then I started to inject."* FGD, PWID, male

For others, injecting was something peers introduced to them, and they kept doing it as a performance enhancer. Performance was used in reference to several activities including reading, farming, and sex. PWID expressed satisfaction with themselves when they did these activities under the influence of injected drugs.

> *"I started long ago because I am a male sex worker. So, there was a time I used to travel with female sex workers, and there was a time I had sex with an Asian to whom we had agreed. So, I found five Asians, and I sniffed and managed to have sex with all five. So, since that time, it has become my habit. And in the long run, I became addicted, and they introduced me to injecting, too. So, every time I inject myself or sniff, I become very ready all the time."* FGD, PWID, MSW

3.2.4.5 Reasons for continued use of injecting drugs

We also detailed reasons for the continued use of drugs among users. This information was solicited to understand individual intentions or perceptions toward potential reduction or quitting drugs. We explored voluntary intention to quit, and our findings indicate gray areas, with some users having considered quitting while others vehemently said they did not see the need.

> *"Drugs help me refresh my brain, and then I can handle books very well. I can read without any problem … so I am okay for now."* PWID, FGD, male, college student

One FGD participant proceeded to show the researcher his end-of-semester results (two results being distinctions and two very good passes) to justify drug use and show he is still able to function normally, and quitting was, therefore, not an urgent need. Workers referred to physical tasks, adding that PWID have more energy once injected.

> *"It helps you to do something that you would not do, like in my case, as I explained that I inject so that I should work on something which is hard."* PWID, IDI, male, unemployed

Participants also confirmed that most current users maintained the habit for recreational purposes, citing similar reasons for use.

> *"Chill and stuff (and have sex)."* FGD, male, businessperson

> *"For confidence not only in class but whenever I would like to approach a girl, then I use."* FGD, male, student

> *"I usually inject on Fridays since it's an enjoyment day."* PWID, IDI, female, health worker

Injecting is also related to idleness or lack of employment among youths. Most participants mentioned that youths sometimes use drugs because they are frustrated with their lives, citing lack of employment.

> *"I started in 2017 in Lilongwe. I had nothing to do when I was not working. At first, I did not know what it was. I used drugs, and I did not know what I was doing. Then some guy slept with me, and I was found pregnant."* PWID, IDI, female, youth leader

A representative from a KP organization and representatives from Saint John of God, a rehabilitation center, expressed concern that apart from the lack of jobs among youths, the absence of parents in children's lives also plays a major role in youths continuing to use drugs.

3.2.4.6 Venues of PWID

We inquired about the venues where PWID are likely to meet. Considering that most use drugs for self-entertainment purposes, it was unsurprising that venues like clubs, bars, and school social activities were often cited.

> *"Sometimes when we have social weekends, and usually business really does well during such events. We just sell them, and the person knows where to inject himself."* FGD, PWID, student, male

On campus, student hostels (especially rooms for users), the beach, and markets often came up as venues for injecting drugs. Some students said they and their roommates were all users, and therefore, free to use anytime.

Other places of note were city gardens, youth clubs, drop-in centers (DICs), and private homes.

> *"We can say so based on the finding we might do, like here at DIC. As for me, I mostly visit peer educators in different clusters. So, I know that at this center, people gather and do this and do that. Now there are some centers where people gather, and you will find that some are drinking, some are smoking Indian hemp, and others are injecting. So, we call those places small DICs owned by peer educators. In essence, they are not DICs; many are houses owned by peer educators."* IDI, KP representative, male

DICs often came up as centers for use.

> *"I am told some come here to inject, but we don't know if that is true. They normally sit behind there."* IDI, KP representative, female

3.2.4.7 Influence of injecting drugs on sexual behavior

In this study, injecting drugs was linked to risky sexual behavior. Participants mentioned that injecting drugs affects one's thinking capacity and enhances users' sexual drive. Because of limited decision-making capacity, users often found themselves having unprotected sex, having multiple sexual partners, or engaging in transactional sex.

> *"As I said earlier, I don't have a girlfriend, so whenever I have taken the drug, and I feel that whoever has come to my lane, then it happens (I have sex with her)."* FGD, PWID, male

Another participant highlighted that users sometimes forget to wear a condom at such times, potentially exposing themselves to sexually transmitted infections, HIV, and unwanted pregnancy.

> *"Like in my case, I am not married, but I have six children, so in this state, what happens is that with the issue of sleeping together, even when there is a condom, you do not have judgment. You just have plain sex. It's different with alcohol because it takes a lot of time for it to work, but with drugs, it's right there and then that it starts working, so there is indeed a poor mental judgment."* FGD, PWID, supplier, teacher, male

> *"That is true. Sometimes you remember that you have a condom, and you can put it on, but because you think that you are delaying, you end up taking it off."* IDI, PWID, male

There is a possible correlation between injecting drugs and HIV-related interventions. We attempted to understand the effect of drug use on the uptake of interventions such as oral pre-exposure prophylaxis, post-exposure prophylaxis, and antiretroviral therapy.

There are reported cases of PWID sharing syringes. Although many did not intend to share needles, they ultimately do share needles in the heat of the moment, thus exposing themselves to the risk of HIV and hepatitis. Most mentioned they share syringes because they cannot afford to buy them every time; they must use them. Once under the influence of drugs, decision-making is poor, thus risking disease exposure.

> *"Sometimes we can share because sometimes the drug is little, and the syringe is just one, so yes, we can just share. We cannot afford it because they are expensive."* FGD, PWID, female

The trust issue among users also emerged as a potential challenge to engaging in prevention activities. PWID expressed that they felt safe sharing needles with each other because they knew their peers were not HIV positive.

> *"Yes, it's possible to do that in a 'circle' because we rely on each other, and we just think that our colleagues can't have diseases, and he can use the same injection, and I can use the same."* FGD, PWID, male, student

> *"On the same, in my case, even if I don't do needles in a group, as a group, we have these talks about HIV, and we usually develop that blind trust towards our girls. We think that our girls are faithful. And that most people that can be found with these diseases are the ones in bars, but now when it comes to our partners, we are just blind; maybe that's where the risk would come."* FGD, PWID, male

Risk compensation also emerged among some of the populations that inject drugs. The users expressed hope that they would be protected even after sharing needles because they later would access HIV prevention services.

> *"With our career and professionalism, we have access to things like PrEP and PEP, so we believe that even if it happens (even if I have unprotected sex), then I can get PEP."* IDI, PWID, male student

Some participants were aware of the risks of HIV as an injecting drug user and observed preventative measures.

> *"I use cocaine, and I rarely inject. I am HIV positive."* IDI, PWID, male

> *"A PWID to take ART is very difficult because we are busy injecting drugs. PrEP even is hard because there are no support groups. We need our own peer navigators."* IDI, PWID, MSM

Others did not see the need for prevention as they already had HIV.

> *"I have never thought about it, and I contracted HIV because of it. How should I stop, and why?"* IDI, PWID, FSW

3.2.4.8 Limited awareness about complexities around drug use and addiction

Most participants are not aware of how exactly drugs work. While most users know that drugs are addictive, they lack understanding of the complexity around the practice, such as how or when one becomes an addict and how to stop using.

> *"I inject, yes, but I am not an addict so that I can inject once a month, and I inject heroin, and the body tells me that it's enough."* IDI, PWID, male

The impression we got from some PWID was that they did not realize that reducing or quitting drugs is a complex process that needs support. Some PWID presented their stories as if they were still in the experimental stages of use and could control their intake, but when probed about their use habits, they painted a picture of abuse.

> *"I am just not ready to stop now, and I still like it. I only use it when I feel like it. I will stop when I want."* FGD, PWID, female

This statement came from a user who said she used it once weekly but would sometimes use it more frequently for entertainment purposes. The statements by a counselor at a rehabilitation center put this into perspective:

> *"Another level is called abusers. At this level, some people do not take these drugs daily, but when they decide to take the drug then, they have no limit, and their behavior is uncomfortable for their relations, and for young men, they would take those drugs to feel high and lose touch with reality."* IDI, counselor, male

> *"The other level is addicts. They don't take much, but they are consistent; they are aware of the quantity that they need. They may say they need two bottles of Malawi gin before they, let's say, start doing their work, and these may do well like in class after using the drugs, and some may even pass exams after smoking Chamba maybe."* IDI, counselor, male

3.2.4.9 Reducing or quitting injecting drugs

We inquired about ways to help PWID reduce or quit injecting drug use. Most references were to reducing contacts with suppliers and friends who use them. A few acknowledged that proper counseling would help them to at least quit injecting drugs.

> *"The support that I would need is maybe just encouragement so that we should not inject ourselves and counseling because we can't stop drugs on our own or finding a way that we should be protected when injecting each other because we are at a risk of infecting each other with HIV."* IDI, PWID

Intention to stop taking drugs was more pronounced among students and younger users than among the older population. Again, the need for work was frequently mentioned, supporting the notion that most youths continued to use drugs because they had nothing important to do. We believe that students and younger PWID imagine that when they finish

school and are employed, they will be engaged with other things and therefore quit. The three formally employed people we spoke with and others also wished to stop drugs but acknowledged that it was difficult to quit independently.

> *"I have tried to quit. When I am sober, I think about quitting, but when I use, I like the feeling."* IDI, PWID, health worker, female

3.2.4.10 Suggested support that drug injectors need

The study solicited ways that participants suggest helping drug injectors. A prominent key population expert highlighted that in Malawi, there are very few interventions to help PWID, and a lot must be done.

> *"Here in Malawi, doing our studies, it was very clear there was no support. There was no social support, and there is no support in the health sector or interventions which can help people who inject drugs or people who abuse substances."* Key population expert

Another participant, an FSW, also felt that there was a need to provide psychological support to the users.

> *"So, the support is really needed, even me right now. I need it psychologically just for you to keep every single day going. You can say I am out; I have stopped; it never happens. It never stops; even if it stays 10 years, it never stops. Those things are still there, and they will always be there. So, you need a support system to keep going. Every single day you need something to keep you going every single day that you wake up. You need people that know your triggers. They know, okay, if this happens, it will happen."* FSW, IDI

Giving adequate information on the risks and factors associated with injecting drugs was recommended as another way of providing support. Participants highlighted that some drug users inject out of ignorance, and they need accurate information to decide whether to continue using the drugs.

> *"There is a need to counsel them and give them advice. There is a lot of needle sharing, and they don't think straight when they are high. They can't even think of using their own needle. There can easily be the transmission of diseases like hepatitis and others. If syringes could be readily available, it could be helpful. Most of the time, they only afford drugs and ask for syringes from colleagues. So, I think there is a need to at least give them an orientation about risks. To let them know of the drug."* Shebeen owner, Mangochi

3.2.4.11 PWID count by district

Each respondent in the IDIs and FGDs was asked to estimate the number of PWID in their location and the district. Table 24 below presents crude estimates of PWID as reported by study participants.

Table 24: Distribution of PWID by district

District	Number of PWID
Phalombe	100
Zomba	700
Blantyre	2,845
Lilongwe	3,230
Mangochi	1,520
Machinga	310
Mzuzu	2,415

3.2.4.12 Summary of the findings

Our findings indicate that the number of people injecting drugs in Malawi is increasing with a concomitant decrease in age at initiation. Also, there is an increase in injecting drug use among girls and school-going youths. This increase includes peer pressure, psychological pressure, unemployment, and exposure to the internet. Most injecting drugs used are opioids based. However, the use of prescription drugs is also common. Although suppliers are unknown, most are foreigners, with Malawians acting as middlemen. While law enforcers like police and immigration authorities seem not to have information about the practice, participants mentioned that some users come from the same professions. The practice may, therefore, be shielded by the police. Some high-ranking government officials have been mentioned as injecting drug users and may be important players in the network. Most PWID are unaware of other diseases they may be exposed to because of injection. Drugs are being sold within neighborhoods, and sales are targeting children.

3.3 Recommendations

1. Prioritize designing, developing, and investing in national PWID programming, including a policy framework.
2. Create and intensify awareness about HIV and hepatitis preventive measures among PWID. Because most PWID expressed difficulties accessing syringes and coping with the lack of self-control after injecting, they could benefit more from PrEP than PEP given that some participants indicated they do plan before injecting. If counseled, PWID may learn to take PrEP effectively and reduce the risk of acquiring HIV.
3. Introduce a center of excellence to address issues related to PWID, including implementation of harm reduction interventions such as needle-syringe programs and opioid substitution therapy. There is strong evidence that new HIV infections drop sharply when PWID have access to harm reduction and other public health programs.
4. Intensify health education on drug abuse in schools to highlight the long-term catastrophic consequence of using drugs.
5. Train health workers to screen and identify PWID and counsel them accordingly.
6. Introduce and intensify public health interventions such as HIV testing for PWID.

4.0 District Validation Meetings

Between June 27 and July 4, 2022, NAC and FHI 360 conducted KP district stakeholders' validation exercises in all seven districts, including Lilongwe, Blantyre, Mzuzu, Mangochi, Phalombe, Zomba, and Machinga. We aimed to share study findings for district stakeholders' validation. In each district, two PowerPoint presentations were shared on the KP programmatic mapping study and a rapid assessment of PWID. Each presentation was followed by a question-and-answer session where district stakeholders asked questions on the methods, findings, and recommendations and received feedback

KP programmatic mapping study

In almost all districts, stakeholders confused KP programmatic mapping with KP size estimation and did not recognize it as a venue mapping and validation exercise. The relatively lower weekly KP count presented in this study from identified venues generated a growing consensus from all the districts on the need for NAC to conduct a national KP size estimation. However, NAC highlighted the importance of the KP mapping study that provides information about the location of venues where programs could reach KPs with HIV services, including last-mile distribution of condoms, and NAC announced that a national KP size estimation study is being planned.

Rapid assessment for PWID

The PWID rapid assessment elicited great interest and was seen as an eye-opener, prompting stakeholders to demand immediate inclusion of PWID harm reduction strategies in national HIV policies. People were more interested in understanding the injectable drug supply chain network and how it could be interrupted. They sought immediate implementation of interventions to prevent individuals from getting into injecting, interventions to manage those already injecting, and interventions to support those who have developed complications such as mental breakdown following injecting drug use.

5.0 Conclusions and Programmatic Implications

5.1 Venues where FSWs, MSM, and Transgender People Congregate to Meet Sexual Partners

This study's findings provided important clues on where, how, and when to identify and find key populations to provide them with precision HIV prevention and care services. Consistent with previous reports, this study highlights bars and other venues, such as guesthouses/rest houses, as the venues where FSWs most commonly congregate to meet sexual partners. Bars with lodging were identified as the most common venue where FSWs can be reached with HIV prevention and care services. Other common sites included guesthouses/rest houses and bars without lodging. The high preponderance of live-in venues where FSWs were found may also be due to travel restrictions that were in place while the study was being conducted, but it provides an opportunity to reach FSWs at any time of the day with services.

5.2 FSWs, MSM, Transgender People, and PWID Count in the Seven Districts

This study conducted a KP count of 11,966 FSWs, 360 MSM, 1,131 transgender people, and 11,120 PWID in the seven districts. Most of the KPs were found in the three main cities of Blantyre, Lilongwe, and Mzuzu. The number is much lower than what other studies have previously reported. This could largely be attributed to the government's COVID-19-related measure requiring venue closure by 10 p.m. during the study period. Several KP venues were closed, which affected the availability of KPs at the venues that were visited. Also, the KP count could be biased as it is based on reports from a subset of the KP population.

5.3 Best Times and Places to Reach KPs with Services

The best times that FSWs, MSM, and transgender people could be reached with services at venues were between 5 p.m. and midnight. However, because most members of these populations were found at venues with lodging, they could also be reached at other times during the day. Programmatic mapping is good for identifying people who visit known venues and may miss those who do not visit venues regularly. This study confirmed the previous suspicion that a large proportion of MSM, MSWs, and transgender people do not congregate at venues and that additional studies are required to fully understand their dynamics and the best approach for reaching them with much-needed services.

5.4 Future Studies

Future studies should focus on the following:

- Investigating the supply chain further to understand how confiscated drugs are handled
- Understanding the "getting high" metaphor that seems to drive the use of injecting drugs
- Using different methodology to identify MSM, MSWs, and transgender people
- Need for KP size estimation

6.0 Study Limitations and Implementation Challenges

The programmatic mapping method captures only the subset of FSWs, MSM, MSWs, and transgender people who visit physical venues. The method relied on the interviewed KP individuals and key informants to count the number of KP members visiting the venues on a usual day, a peak day, and over the course of a usual week, but there was no way to confirm the accuracy of this count, which was based solely on the impressions of the informants. Some FSWs, MSWs, MSM, and transgender individuals were not known to key informants or identifiable as members of those populations, and they might not have been included in the estimates.

Although the methodology specified the definitions of FSWs, MSM, and transgender people with respect to sexual behavior and sexual identity, these definitions were very broad, and it would not have been possible to confirm these characteristics in all cases because interactions were not possible with all individual KP members being estimated. For example, sex workers were defined as “any female 18 years or older who received money or goods in exchange for sexual services with a man either regularly or occasionally,” and MSM were defined as “all men who engage in sexual and/or romantic relations with other men during the past 12 months.” It would be difficult for key informants to know which people visiting venues met these criteria.

To overcome the potential bias from individual respondents, we had planned to conduct four interviews at each venue and, for each variable, take the average value provided by respondents. The average number of interviews per venue ended up being less than four. We had initially planned to visit each venue on three occasions or until the desired number of respondents was reached. Due to time limitations, the team could only visit each venue once, resulting in interviews at 62%, 31%, and 28% of venues frequented by FSWs, MSM, and transgender people, respectively.

In the case of MSM, the definition was broad (i.e., all men who engage in sexual and/or romantic relations with other men). Not all such men would frequent physical venues during the study week, and perhaps ever. Moreover, some of those who did may not have been identifiable as MSM. Homosexuality is stigmatized in Malawi, so the tendency for MSM to be open and identifiable is likely low. The adjustment factors used for mobility to correct for double-counting and for “hidden population” (to account for those KP members who do not frequent venues during the study week or at all) were based on the best guesses of the respondents and could not be validated. Furthermore, these correction factors were applied at the district level, so they took only average estimates across respondents into account.

Conducting the study while COVID-19 restrictions were in place was a significant limitation. The restrictions and lockdowns resulted in the closure of some venues, reduced operating hours of others, and reduced attendance of customers and KP members at venues. During this time, most venues had resorted to operating only during the weekends or month ends, and some temporarily closed or opted to operate seasonally as they could not cope with the economic challenges imposed by COVID-19 that affected patronage of the venues as well as caused migration of FSWs to other districts with more economic activities at the time. This proved very challenging for the field teams, who had difficulties locating the required number of key informants to be interviewed during the allotted time. The short period for the design and implementation of this study limited data collection as the study team could only make one visit to each site. When the venues closed, KPs were not present during the visit, a suitable key informant could not be identified, and no time was available for repeat visits.

The study design was unable to investigate the drug supply chain among PWID further to understand how confiscated drugs are handled. However, it provides an area for further research

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Annex A – The research team

FHI 360 Project Leader	Melchiade Ruberintwari, FHI 360 Malawi
Site Principal Investigator	David Chilongozi, FHI 360 Malawi
Co-Investigators	Melchiade Ruberintwari, FHI 360 Malawi Allison Zakaliya, FHI 360 Malawi Navindra Persaud, FHI 360, USA Virupax Ranebennur, FHI 360, India Chris Akolo, FHI 360, USA
Consultants	Tobi Saidel, International Consultant, USA Nyanyiwe Mbeye, Local Consultant, Malawi

To ensure wide stakeholder participation, a technical working group (TWG) comprised of NAC; FHI 360; key population representatives; central statistics office; The Global Fund to Fight AIDS, Tuberculosis, and Malaria; USAID; U.S. Centers for Disease Control and Prevention; and other key stakeholders supporting KP programs were established to provide oversight of the study. This group met every two weeks to review the study implementation from initiation through data collection and analysis until dissemination of results.

A national programmatic mapping TWG monitored results. This was convened by FHI 360 in partnership with the MOH and NAC and was constituted of key members of KP groups, civil society organizations, and the Government of Malawi. The TWG had its mandate overseeing the implementation of this study and ensuring that the rights and confidentiality of key populations were always protected.

Annex B – L1 form for community informants

TOOL L1 FORM FOR COMMUNITY INFORMANTS

Venue Identification Number						Location		Date of interview					
						Urban	1						
District code		Zone Code		Venue code		Rural	2	DD		MM		YY	
District Name _____				**Geo-Coordinates**_____									
Venue: _____ Name: _____T/A: _____						Interviewer ID Code							
Type of KP (Circle all that apply)		1 FSW		2 MSM		3 TG							

LOCATION OF THE VENUE THE RESPONDENT SHOULD BEGIN WITH VENUES NEARBY BUT CAN NAME OTHERS ELSEWHERE IN THE DISTRICT.

1. Description of Venue	
2. Venue cluster Name. *99 if no cluster*	
3. How to find venue (Landmarks)	

CIRCLE A CODE

Brothel 1
Street 2
Bar- Sex on Site 3
Bar-not sex on site 4
Hotel 5
Guesthouse/Lodge/Inn 6
Rest House 7
Nightclub/ Disco 8
Construction Site 9
Shopping Mall 15
Beach/Lake 16
Shebeen 17
Bush/Forest 18
Massage parlor 12
Restaurant/ Fast Food 13
School Block/Univ. Campus 14
Truck stops 10
Taxi Rank 11

4. Busiest day (Up to 4)						5. Busiest Time						6. Number at the busiest time					
FSW		MSM		TG		FSW		MSM		TG		FSW		MSM		TG	
Monday	1	Monday	1	Monday	1	11 AM-2 PM	1	11 AM-2 PM	1	11 AM-2 PM	1	< 30	1	< 30	1	< 30	1
Tuesday	2	Tuesday	2	Tuesday	2	2 PM-5 PM	2	2 PM-5 PM	2	2 PM-5 PM	2	30-100	2	30-100	2	30-100	2
Wednesday	3	Wednesday	3	Wednesday	3	5 PM-8 PM	3	5 PM-8 PM	3	5 PM-8 PM	3	101-200	3	101-200	3	101-200	3
Thursday	4	Thursday	4	Thursday	4	8 PM-11 PM	4	8 PM-11 PM	4	8 PM-11 PM	4	> 200	4	> 200	4	> 200	4
Friday	5	Friday	5	Friday	5	11 PM-2 AM	5	11 PM-2 AM	5	11 PM-2 AM	5	DK	8	DK	8	DK	8
Saturday	6	Saturday	6	Saturday	6	DK	8	DK	8	DK	8						
Sunday	7	Sunday	7	Sunday	7												
Month End	8	Month End	8	Month End	8												
Market Day	9	Market Day	9	Market Day	9												
DK	88	DK	88	DK	88												

ASK: Do these people come to this site?	YES	NO	DK
7. Women who sell sex for money or other benefits (Female Sex Workers)	1	0	8
8. People who inject drugs	1	0	8
9. Men who have sex with men	1	0	8
10. Transgender people	1	0	8
11. Men who sell sex for money (Male Sex Workers)	1	0	8
12. Do people drink alcohol on site?	1	0	8
13. Is there sex on site?	1	0	8
14. Do sex workers live there?	1	0	8

15. Feasibility Yes=1 No=0 DK=8	Feasible ☐	Insufficient information ☐	Inaccessible/ too far ☐	Not available during the day ☐	Other specify: _____

Annex C – L2 forms for key informants

C.1 L2 FORM FOR KEY INFORMANT - FSW																	
Venue Identification Number						**Location**		**Date of interview**									
						Urban	1										
District code		Venue Zone/area code		Venue code		Rural	2	DD		MM		YY					
District Name _____				Venue Area Name_____ **Coordinates**_____													
Venue Name_____						Interviewer ID Code											
Type of FSW 1 – Establishment 2 – Street 3 Home (Circle One)																	

Section I: To be completed by the interviewer

1	Type of Key Informant **(Please circle one)**	KP FSW (EB)	1				
		Taxi Driver	2				
		Client/Patron of Establishment	3				
		Pimp	4				
		The staff of NGO/CBO	5				
		Peer/Outreach Worker	6				
		Street Vendor	7				
		Establishment Owner/Manager	8				
		Security Guard/Bouncer	9				
		Establishment Staff	10				
		Hairdresser	11				
		Police	12				
		Other (specify)	96				
2	Select the code that best describes the type of venue ***(Please circle one)***	Disco	1		Park	12	
		Dance Bar	2		Market	13	
		Cabin Restaurant	3		Bus Stand	14	
		Massage Parlor	4		Street – (Urban)	15	
		Local Bar	5		Jungle	16	
		Restaurant	6		Highway – (Outside the city)	17	
		Hotel/Lodge	7		Home	18	
		Casino	8		Flat	19	
		Cinema Hall	10		Other (specify)	96	
		Beauty Parlor	11				

Section II: To be asked of the Key Informant

3	Do females visit this establishment/street location/home to look for clients to have sex within exchange for money or goods? Please circle one **INTERVIEWER: If the respondent says no or don't know, please end the interview**	Yes	1		
		No	2		
		Don't know	8		
		No response	9		
4	On a usual day, how many FSWs visit this venue?	☐☐☐ **MIN**		☐☐☐ **MAX**	
5	Which day of the week would you find the highest number of FSWs coming to this venue to visit or look for clients? **INTERVIEWER: CIRCLE ONLY ONE**	Monday	1	Friday	**5**
		Tuesday	2	Saturday	**6**
		Wednesday	3	Sunday	**7**
		Thursday	4	Don't Know	**8**
				No response	**9**
6	During the day that you mentioned, which is the time period when you would find the highest number of FSWs coming to this venue to visit or look for clients? **INTERVIEWER: READ OUT RESPONSES AND CIRCLE ONE**	Morning (before 12 noon)	1	Night (PM-Late night)	4
		After 12 (12 PM-5 PM)	2	Don't Know	**8**
		Evening (5 PM-9 PM	3	No response	**9**
7	During a normal week, how many female sex workers usually come to this establishment/street/home to look for clients? (***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively***) **INTERVIEWER: If the respondent says don't know or does not respond**	☐☐☐ **MIN**		☐☐☐ **MAX**	

8	During a normal week, how many of the FSWs who come to this establishment ***(please refer to Q7)*** also go to other establishments to look for clients? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively*** **INTERVIEWER: If the response is 0, 888, or 999, skip to Q10**	**MIN** ☐☐☐	**MAX** ☐☐☐
9	Among those FSWs who also go to other establishments ***(please refer to 8)***, on average, how many establishments do you think they go to during the week, including this one? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively***	**MIN** ☐☐☐	**MAX** ☐☐☐
10	Among the FSWs who come to this establishment ***(please refer to Q7)***, how many of them also look for clients outside of establishments (e.g., in *Parks, Markets, Bus Stands, streets (if in urban areas), Jungle Areas, and Highway Areas)?* **Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively**	**MIN** ☐☐☐	**MAX** ☐☐☐

INTERVIEWER: ASK REMAINING QUESTIONS TO ALL KEY INFORMANTS REGARDLESS OF VENUE TYPE

11	During which months of the year would you find the highest number of FSWs at this establishment/street location? **INTERVIEWER: Circle all months that apply** **If there is no peak month circle 97** **If respondent does not know or does not give any response, please code 88 or 99** **respectively**	1	2	3	4	5	6	7	8	9	10	11	12
		INTERVIEWER: CIRCLE ALL THAT APPLY **97 – No Peak Months** **98 – Don't Know** **99 – No Response**											
12	How many FSWs do you know who live or work in this district? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively*** **INTERVIEWER: If the response is 0, 888, or 999, skip to Q15**	**MIN** ☐☐☐		**MAX** ☐☐☐									

13	How many of the FSWs that you know who live or work in this district do not **EVER** come to **ANY** establishments, street locations, or homes to look for clients? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively***	**MIN**	**MAX**
14	How many sex workers who come to this establishment/street location/home ***(refer to Q7)*** do you think injected any drugs for non-medical purposes in the last one month? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively***	**MIN**	**MAX**
15	How many sex workers who come to this establishment/street location/home ***(refer to Q7)*** do you think use social media or websites to look for clients? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively***	**MIN**	**MAX**

16 In the past six months, were you able to receive the following services free of cost? (Circle response)

	Services	**Response**	**From where?**		
a	Condoms	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others……
b	HIV testing	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others……
c	HIV treatment	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others……
d	STI treatment	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others……
e	Counseling	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others……
f	Other services	Specify_____			

17 Please name three other venues where FSWs go to look for clients

SN	Venue name	Estimated MIN	Estimated MAX	Type of Venue	Type of Venue code	Description of location

18	How old are you?		
19	What nationality do you belong to?	**Malawian** **2**	**1**
20	Did you have a different gender at birth?	**Yes** **No**	**1** **2**
21	What was your gender at birth	**Male** **Female**	**1** **2**

C.2 L2 FORM FOR KEY INFORMANT – MSM/TG people

TOOL L2 FORM FOR KEY INFORMANT (MSM/TG)–ENGLISH												
Venue Identification Number						**Location**		**Date of interview**				
						Urban	1					
District code		Zone Code		Venue code		Rural	2	DD		MM		YY
District Name _____				Zone Name_____		**Geo-Coordinates**_____						
Venue Name_____						Interviewer ID Code						

Section I: To be completed by the interviewer

1	**Type of Key Informants** **INTERVIEWER, please circle one**	KP TG/MSM	1
		The staff of NGO/CBO	2
		Peer/Outreach Worker	3
		Establishment Manager/Owner	4
		Street Vendor	5
		Patron of Establishment	6
		Pimp	7
		Police	8
		Other Specify	96
2	**Type of Venue** **INTERVIEWER, please circle one**	Park	1
		Street	2
		Bus Stand	3
		Highway	4
		Massage Parlor	5
		Hotel/ Lodge	6
		Restaurant	7
		Local Bar	8
		Barber Shop/Beauty Parlor	9
		Dance Bar Restaurant	10
		Cabin Restaurant	11
		Disco	12
		Market	13
		Jungle	14
		Other Specify	96

Section II: To be asked of the Key Informant

3	Do men visit this location to meet friends or look for male sexual partners? **INTERVIEWER: If the respondent says no or don't know, please end the interview**	Yes	1
		No	2
		Don't know	8
		No response	9

4	On a usual day, how many MSM/TG visit this venue:	Total	**MIN** ☐☐☐	**MAX** ☐☐☐
		MSM	**MIN** ☐☐☐	**MAX** ☐☐☐
		TG	**MIN** ☐☐☐	**MAX** ☐☐☐

5	Which is the day of the week when you would find the highest number of MSM coming to this venue to visit or look for clients? **INTERVIEWER: CIRCLE ONLY ONE**	Monday	1	Friday	**5**
		Tuesday	2	Saturday	**6**
		Wednesday	3	Sunday	**7**
		Thursday	4	Don't know	**8**
				No response	**9**

6	Which is the day of the week when you would find the highest number of TG coming to this venue to visit or look for clients? **INTERVIEWER: CIRCLE ONLY ONE**	Monday	1	Friday	**5**
		Tuesday	2	Saturday	**6**
		Wednesday	3	Sunday	**7**
		Thursday	4	Don't know	**8**
				No response	**9**

7	During the day that you mentioned, which is the time period when you would find the highest number of MSM/TG coming to this venue to visit or look for clients? **INTERVIEWER: READ OUT RESPONSES AND CIRCLE ONE**	**MSM**	Morning (before 12 noon)	1	Night (PM-Late night)	4
			After 12 (12 PM-5 PM)	2	Don't know	8
			Evening (5 PM-9 PM	3	No response	9
		TG	Morning (before 12 noon)	1	Night (PM-Late night)	4
			After 12 (12 PM-5 PM)	2	Don't know	8
			Evening (5 PM-9 PM	3	No response	9

8	During a normal week, how many MSM/TG come to this location to visit, meet friends, or look for potential male sex partners? **INTERVIEWER - Enter <u>TOTAL</u>** MIN/MAX in "TOTAL" How many of them do you think are TGs? **INTERVIEWER –** Enter **<u>TG</u>** MIN/MAX in TG	**Total**	**MIN** ☐☐☐	**MAX** ☐☐☐
		TG	**MIN** ☐☐☐	**MAX** ☐☐☐

	How many of them do you think are MSM? **INTERVIEWER –** Enter **MSM** MIN/MAX in MSM (***Please provide a range for each. If respondent does not know or does not give any response for any of the categories, please code 888 or 999, respectively***) INTERVIEWER – If the respondent says "00" for all the categories – SKIP to Q11	**MSM**	**MIN**	**MAX**
9	During a normal week, how many of the MSM/TG who come to this location **(refer to Q8)** also go to other locations to visit, meet friends, or look for potential male sex partners or clients? ***Please provide a range for each. If respondent does not know or does not give any response, please code 888 or 999, respectively*** **INTERVIEWER: If respondents say 0, 888, or 999 for all the categories, SKIP to Q11**	**TG**	**MIN**	**MAX**
		MSM	**MIN**	**MAX**
10	Among those MSM/TG who also go to other locations during the week (**refer to Q9**), on average, how many locations do you think they go to, including this one? ***Please provide a range for each. If respondent does not know or does not give any response, please code 888 or 999, respectively***	**TG**	**MIN**	**MAX**
		MSM	**MIN**	**MAX**

11	During which months of the year would you find the highest number of MSM/TG at this location? **INTERVIEWER: Circle all months that apply** **If there is no peak month, circle 97** **If respondent does not know or does not give any response, please code 88 or 99 respectively**	1	2	3	4	5	6	7	8	9	10	11	12
		INTERVIEWER: CIRCLE ALL THAT APPLY (Please follow the Nepali calendar) **97 – No Peak Months** **98 – Don't Know** **99 – No Response**											

12	How many MSM/TG do you know who live or work in this district? ***If respondent does not know or does not give any response, please code 888 or 999, respectively*** **If the respondent says 0, 888, or 999, SKIP to Q16**	**MSM**	**MIN**	**MAX**
		TG	**MIN**	**MAX**
13	How many of the MSM/TG that you know who live or work in this district do not **EVER** come to **ANY** location to visit, meet friends, or look for potential male sex partners? (***Please provide a range, if respondent says don't know and does not give any response, please code 88 and 99, respectively***)	**MSM**	**MIN**	**MAX**
		TG	**MIN**	**MAX**

14	How many TG/ MSM who come to this location do you think injected any drugs for non-medical purposes in the last month? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively***		MIN	MAX
15	How many TG/MSM who come to this location do you think to use social media or websites to look for male sexual partners or clients? ***Please provide a range. If respondent does not know or does not give any response, please code 888 or 999, respectively***	**TG**	MIN	MAX
		MSM	MIN	MAX

16 In the past six months, were you able to receive the following services free of cost? (Circle response)

	Services	Response	From where?		
a	Condoms	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others ……..
b	Lubricants	1=Yes, 2=No			
c	HIV testing	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others ……..
d	HIV treatment	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others ……..
e	STI treatment	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others ……..
f	Counseling	1=Yes, 2=No	1. NGO/INGOs	2. Govt Facility	Others ……
g	Other services	Specify_____			

17 Please name three other venues where MSM go to look for clients

S.N	VENUE NAME	ESTIMATES (MIN)	ESTIMATES (MAX)	TYPE OF VENUE CODE	DESCRIPTION OF LOCATION
A					
B					
C					

	INFO ABOUT THE KI		
18	How old are you?		
19	What nationality do you belong to?	Malawian	1 2
20	Did you have a different gender at birth?	Yes No	1 2
21	What was your gender at birth	Male Female	1 2

Annex D – Draft interview guide for FGDs and KIIs

Group	Type of Interviews and Number	Questions
PWID	FGDs: 1 FGD/district, total = 7 FGDs with PWID	1. Tell me about the local drug scene. What do you know? 2. Are people injecting drugs? If so, what drugs? 3. What kinds of people are injecting drugs? 4. When did you first become aware that people were injecting drugs? 5. What drugs are people injecting? 6. Is injection a common mode of administration? 7. How else do people consume drugs? 8. How do people obtain drugs? 9. How much does someone typically use in a day? 10. How much does it cost? 11. How do people obtain syringes? 12. Do people inject in groups or alone? 13. What are the circumstances around the transition to injecting drug use? 14. Did they start with other forms of drugs, like sniffing, before they moved to injecting? 15. What motivated them to start injecting) 16. What drives people to continue injecting drugs? 17. Do some people want to quit? ▪ How do they do that? ▪ Are there resources to help them? 18. Do you think people who inject drugs need support? ▪ What type of support? ▪ From whom? ▪ How often? 19. What challenges do people who inject drugs face? 20. Regarding access to health services? ▪ Stigma? 21. How are they perceived by the community and by their families? 22. Is the drug scene changing? How? Is injection use becoming more or less common? Is it the same people?)

		23. What specific programs or services are available for people who inject drugs? 24. What specific places do you meet as a group? 25. Where do most people who inject drugs live? ▪ Which areas in the district? 26. Are drugs freely available? Are they restricted/controlled or not available? 27. How many people do you know personally who inject drugs? 28. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100 ▪ 100-500 ▪ > 500 29. Please, share with us any information related to injecting drug use we might not have discussed 30. Who else do you think we should interview (someone who would provide more information about PWID in Malawi)
PWID	IDIs with PWID 3 IDIs per district	1. Since when have you been injecting drugs? 2. In the past 12 months, what types of drugs have you injected? 3. How often do you typically inject drugs (in a day, week, month, or year) 4. Where do you get the drugs, and what challenges do you face in trying to get the drugs? 5. Do you think you need any support? What support? 6. Tell us about syringes. Where do you get the syringes that you use? ▪ Probe if he/she shares syringes with others 7. Do you inject drugs in groups or alone? 8. Please tell us how drugs get into Malawi and how they reach you. 9. How did you transition to injecting drugs? ▪ Probe if he/she started with other forms of drugs, e.g., sniffing/smoking before injecting drugs 10. Please share with us circumstances surrounding your starting of using injecting drugs/drugs in general 11. What challenges do you meet related to injecting drugs?

		12. Do you have specific venues where you meet people who inject drugs? (Probe types of venues where they meet) 13. How many people do you know personally who inject drugs…? 14. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100 ▪ 100-500 ▪ > 500 15. Please, share with us any information related to injecting drug use we might not have discussed 16. Who else do you think we should interview? ▪ Someone who would provide more information about PWID in Malawi
Health workers	One health worker interview in each district Total = 7	1) Is drug use a problem in your district? Can you tell me about it? 2) What drugs are people using? 3) Are people injecting drugs? If so, what drugs are being injected? 4) When did you first hear or notice injection drug use? 5) Who uses drugs? ▪ (Probe: ▪ types of people, ▪ their ages, occupation, and ethnicity - What are the social characteristics of people who inject drugs ▪ Is it the same people)? 6) How do they use these drugs? 7) Do they inject in groups or alone? 8) What is the nature and extent of injecting drug use in Malawi/in this district? (Probe: magnitude and whether it is practiced in the district) 9) What is the geographical location of people who inject drugs in this district? 10) What are the trends of Injecting drug use over time? ▪ (Is it increasing or decreasing? Has it remained the same? ▪ Common in specific groups of people? Who are they? (Is it Key Populations or the general population?) 11) What do you think influences injecting drug use in this district?

		12) What personal encounters have you had with people who inject drugs 13) What role do the health workers play in injecting drug use (probe if there are any programs, active mobilization, or support provided to PWID) 14) Do you think people who inject drugs need support? ▪ What type of support? 15) How many people do you know who inject drugs? 16) Approximate number of drug injectors in the district. These should be very rough estimates for example. ▪ 0-100 ▪ 100-500 ▪ > 500 17) Please, share with us any information related to injecting drug use we might not have discussed 18) Who else do you think we should interview? ▪ (Someone who would provide more information about PWID in Malawi)
Police **Customs/ immigration**	• One police officer at the national level • One police officer in each district • One customs/ immigration officer at the national level • One customs/ immigration officer in each district Total = 10 interviews with the police	1. Tell me about the local drug scene. What do you know? 2. Are people injecting drugs? If so, what drugs? 3. What kinds of people are injecting drugs? ▪ When did you first become aware that people were injecting drugs? ▪ What drugs are people injecting? ▪ Is injection a common mode of administration? ▪ How else do people consume drugs? ▪ How do people obtain drugs? 4. How do you think drugs come into Malawi? ▪ (Probe to know who is behind drug dealing) 5. What national and district-level policies are in place regarding Injecting drug use? 6. How does the police work with other stakeholders in dealing with this issue? 7. What incidents related to drug use has your department encountered 8. What drug-related arrests were there in the past 12 months? ▪ What drugs are available? 9. What are the trends of Injecting drug use over time? (Is it increasing or decreasing? Has it remained the same? Common in specific groups of people? Who are they?)

		10. Where do you think people get the drugs? Are there special drug dealers? 11. What are the legal issues surrounding injecting drug use in Malawi? 12. How are injecting drugs transported through the country? (Probe for source and final destination, who brings them into the country) Is Malawi just a shipment site? 13. How many arrests related to injecting drug use have been made in the past 12 months? (Ask to see records) 14. In which districts are people who inject drugs mostly found in Malawi? (This question is meant for key informants at the national level) 15. How many people do you know who use drugs in this district? 16. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100 ▪ 100-500 ▪ > 500 17. Please, share with us any information related to injecting drug use we might not have discussed 18. Who else do you think we should interview (someone who would provide more information about PWID in Malawi)
Taxi drivers	1 FGD with taxi drivers in each district Total = 7 FGDs	1. Tell me about the local drug scene. What do you know? 2. Are people injecting drugs? If so, what drugs? 3. What kinds of people are injecting drugs? 4. When did you first become aware that people were injecting drugs? 5. What drugs are people injecting? 6. Is injection a common mode of administration? 7. How else do people consume drugs? 8. How do people obtain drugs? 9. How do these drugs get here? 10. From your own experience, have you had a chance to meet someone who injects drugs? Where? How? 11. What types of people are involved in injecting drugs use?

		12. Who is involved in the selling of these drugs/ where do these drugs come from? 13. Do you think injecting drug use is becoming more common or is decreasing? 14. Roughly how many people do you think inject drugs in this area 15. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100 ▪ 100-500 ▪ 500 16. Please, share with us any information related to injecting drug use we might not have discussed 17. Who else do you think we should interview (someone who would provide more information about PWID in Malawi)
Journalists	1 IDI with journalist/district Total = 7 IDIs with journalists	1. Tell me about the local drug scene. What do you know? 2. Are people injecting drugs? If so, what drugs? 3. What kinds of people are injecting drugs? 4. When did you first become aware that people were injecting drugs? 5. What drugs are people injecting? 6. Is injection a common mode of administration? 7. How else do people consume drugs? 8. How do people obtain drugs? 9. How do these drugs get here? 10. Do you think injecting drug use is common? Do you think it is increasing or decreasing? 11. Are there any places where people who inject drugs regularly meet? 12. As a journalist, what injecting drug use-related incidents/stories have you covered? 13. Where do you think injecting drug use is more common (universities? Homes? Hospitals?) 14. What do you think influences injecting drug use in this district/or in Malawi? 15. Roughly how many people do you think inject drugs in this area 16. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100

		▪ 100-500 ▪ > 500 17. Please, share with us any information related to injecting drug use we might not have discussed 18. Who else do you think we should interview (someone who would provide more information about PWID in Malawi)
Religious leaders	1 IDI with a religious leader in each district 7 IDIs with religious leaders	1. Tell me about the local drug scene. What do you know? 2. Are people injecting drugs? If so, what drugs? 3. What kinds of people are injecting drugs? 4. When did you first become aware that people were injecting drugs? 5. Is injection a common mode of administration? 6. How else do people consume drugs? 7. How do people obtain drugs? 8. How do these drugs get here? 9. What have you heard about injecting drug use? 10. Do you think this is a common problem in Malawi? 11. As a church, what type of drug use-related incidents do you meet? 12. What type of people do you think are involved in injecting drug use? 13. What do you think influences injecting drug use in this district/or in Malawi? 14. Roughly how many people do you think inject drugs in this area 15. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100 ▪ 100-500 ▪ 500 16. Please, share with us any information related to injecting drug use we might not have discussed 17. Who else do you think we should interview (someone who would provide more information about PWID in Malawi)
Social workers	1 IDI with a social worker per district 7 IDIs with social workers	1. Tell me about the local drug scene. What do you know? 2. Are people injecting drugs? If so, what drugs? 3. What kinds of people are injecting drugs?

		4. When did you first become aware that people were injecting drugs? 5. Is injection a common mode of administration? 6. How else do people consume drugs? 7. How do people obtain drugs? 8. How do these drugs get here? 9. Would you share with us what you know about injecting drug use? 10. What cases related to injecting drug use have you dealt with? 11. Where do you think injecting drug use is more common? 12. Which people are mostly involved in injecting drug use? 13. What do you think influences injecting drug use in this district/or in Malawi? 14. What services are available for people who inject drugs? 15. What challenges do you think people who inject drugs face? 16. Roughly how many people do you think inject drugs in this area 17. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100 ▪ 100-500 ▪ > 500 18. Please, share with us any information related to injecting drug use we might not have discussed 19. Who else do you think we should interview (someone who would provide more information about PWID in Malawi)
KP NGO	3 KP NGOs	1. Tell me about the local drug scene. What do you know? 2. Are people injecting drugs? If so, what drugs? 3. What kinds of people are injecting drugs? 4. When did you first become aware that people were injecting drugs? 5. Is injection a common mode of administration? 6. How else do people consume drugs? 7. How do people obtain drugs? 8. How do these drugs get here?

		9. What do you know about injecting drug use in Malawi (does it exist, where, what's the extent) 10. Where (geographical location) do you think this injecting drug use is common (location in the country and within the districts) 11. Do people who inject drugs have platforms where they regularly meet 12. What challenges do they face? 13. What types of people are involved in injecting drug use? 14. What do you think influences injecting drug use in this district/or in Malawi? 15. What is the role of NGOs in injecting drug use? 16. Roughly how many people do you think inject drugs in this area 17. Approximate number of drug injectors in the district. These should be very rough estimates…. for example. ▪ 0-100 ▪ 100-500 ▪ > 500 18. Please, share with us any information related to injecting drug use we might not have discussed 19. Who else do you think we should interview (someone who would provide more information about PWID in Malawi)

Annex E – Participants in IDIs and FGDs

E.1 Characteristics of participants for in-depth interviews

Age	Sex	Education	Marital status	Occupation	Role
46	M	Tertiary	M	Business	Supplier
26	M	Tertiary diploma	S	Clinician	Clinician
34	F	Tertiary	S	FSW	PWID
44	F	Degree	M	Formal employment	KP rep
24	M	Degree	S	Student	PWID
33	M	Tertiary	D	Formal Employment	KP Rep, MSM
40	M	MSCE	M	Police	Police
38	F	Degree	M	Formal employment	KP Rep
26	M	Degree	M	Student	PWID
31	S	MSCE	S	Informal Employment	MSM
26	M	MSCE	M	Informal Employment	PWID
26	M	JCE	M	Taxi driver	Taxi driver
NA	M	Diploma	-	Clinician	Clinician
NA	F	Diploma	S	Nutritionist	PWID/FSW
NA	M	MSCE	M	Police	Police
NA	M	Diploma	S	Clinician	Clinician
24	F	MSCE	F	Youth leader (YL)	Youth Leader
25	M	Tertiary	M	Student	PWID
24	M	Tertiary	S	Student	PWID
33	M	Tertiary	M	Soldier	PWID
24	M	Tertiary	S	Student	PWID
26	M	Tertiary	S	Student	PWID
36	F	MSCE	S	Informal Employment	PWID lesbian
30	M	Degree	S	Accountant	PWID
26	M	Tertiary	S	Student	PWID
40	M	MSCE	M	Police	Police/ PWID
36	M	MSCE	M	Police	Police PWID
NA	M	Tertiary	M	Police	Police
36	M	Diploma	M	Counsellor	Counsellor
28	F	JCE	S	Supplier	Supplier
33	F	Tertiary	S	Journalist	Lesbian Journalist
40	M	Tertiary	M	Journalist	Journalist
32	M	Tertiary	S	Journalist	Journalist
31	M	Tertiary	M	Clinician	Clinician
29	M	Tertiary	M	Clinician	Clinician
37	M	MSCE	D	KP Rep	PWID MSM
38	M	Diploma	S	Public Health	MSM
38	M	Tertiary	S	Field Supervisor	MSM

Age	Sex	Education	Marital status	Occupation	Role
31	M	MSCE	M	Bartender	-
43	M	MSCE	M	Lodge manager	-
47	M	MSCE	M	Pastor	Pastor
37	F	Tertiary	-	Paralegal/ Journalist	FESW
26	F	Tertiary	S	Journalist	Resident
44	M	-	-	-	KP expert
-	M	-	-	Lab Personnel	MSM
47	M	Primary	M	Business	Chief
30	M	Primary	M	Farming	Farmer
20	M	University	S	Student	-Student
26	F	MSCE	-	Police	Police
44	F	MSCE	-	Police	Police
30	M	-	S	Police	PWID
34	M	Drop-Out	M	Builder	Resident
29	M	Bachelors	S	Business	Shabeen Owner
31	M	MSCE	M	Driver	Resident
54	M	Drop-Out	M	Chief	PWID
27	M	JCE	-	Resident	PWID
27	M	MSCE	M	Music Producer	PWID
30	M	Primary	M	Sheik	Religious Leader
29	F	Tertiary	S	Field Supervisor	Youth/PWID
26	M	JCE	M	-	PWID/MSM
49	M	Diploma	M	Nurse	Health Care Worker
29	F	University	M	clinician	Health Care Worker
47	M	Diploma	M	Pastor	Religious leader
35	M	MSCE	M	Police	Police
44	F	-	-	Police	Police
37	M	MSCE	M	Police	Police
29	M	-	S	Social Worker	Social worker
27	M	MSCE	S	Child Safety Officer	Social worker
49	M	PhD	-	Psychologist	Key Informant
42	TG	-	-	Unemployed	Transgender
28	M	-	S	Student	PWID
29	M	-	S	Social Worker	Social Worker

Sex: M=Male, F=Female; Marital Status: M=Married, S=Single, D=Divorced, TG=Transgender people, NA=Not Available

E.2 Characteristics of participants for focus group discussions

FGD #	Age	Sex	Education	Marital Status	Occupation	Role	District
1	28	M	Tertiary	S	Student	PWID	Blantyre
	24	M	Tertiary	S	Student	PWID	
	24	M	Tertiary	S	Student	PWID	
	25	M	Tertiary	S	Student	PWID	
2	27	M	MSCE	S	Business	PWID	Mzuzu
	30	M	MSCE	M	Business	PWID/supplier	
	28	F	MSCE	S	Business	PWID-Transgender	
3	28	F	Tertiary	S	Student	PWID	Mzuzu
	24	M	Tertiary	S	Student	PWID	
	25	M	Tertiary	S	Student	PWID	
	23	M	Tertiary	S	Student	PWID	
	25	M	Tertiary	S	Student	PWID	
	25	M	Tertiary	S	Student	PWID	
	22	M	Tertiary	S	Student	PWID	
	23	F	Tertiary	S	Student	PWID	
	30	F	Tertiary	M	Student	PWID	
4	27	M	MSCE	S	Business	Supplier PWID	Mzuzu
	28	M	JCE	S	Business	Supplier PWID	
5	23	M	MSCE	S	Unemployed	PWID	Lilongwe
	24	F	MSCE	S	Student	PWID	
	23	M	MSCE	S	Unemployed	MSM PWID	
	26	M	JCE	S	Unemployed	MSM PWID	
	25	M	MSCE	S	Unemployed	PWID	
	26	M	MSCE	S	Unemployed	Transgender PWID	
	33	M	Tertiary	D	Formal employed	MSM PWID	
	42	M	MSCE	S	Teacher	Supplier PWID	
6	-	M	Tertiary	M	Counsellor	Counsellor	Lilongwe
	-	F	Tertiary	M	Counselor	Counselor	
	-	M	Tertiary	M	Counselor	Counselor	
	-	M	Tertiary	M	Pastoral care	Pastoral care	
	-	M	Tertiary	M	Social worker	Social worker	
7	27	M	JC	S	Informal employee	PWID	Mzuzu
	32	M	MSCE	S	Business	PWID	
	31	M	MSCE	M	Business	Supplier/ PWID	

8	26	M	JCE	M	Not employed	MSW PWID	MZ
	32	M	MSCE	M	Business	PWID	
	26	M	JCE	M	Not employed	MSW PWID	
	29	M	JCE	M	Not employed	MSW PWID	
	22	M	MSCE	M	Not employed	MSM PWID	
	30	M	JCE	M	Not employed	MSM	
9	31	M	MSCE	M	Taxi driver	Taxi driver	Zomba
	36	M	MSCE	M	Taxi Driver	Taxi driver	
	28	M	MSCE	M	Taxi Driver	Taxi driver	
	40	M	JCE	M	Taxi Driver	Taxi driver	
	37	M	MSCE	M	Taxi Driver	Taxi driver	
10	18	M	Primary	S	Not employed	PWID	Phalombe
	25	M	JCE	M	Business	PWID	
	25	M	PCE	M	Business	PWID	
	18	M	Primary	S	Not employed	PWID	
	16	M	Secondary	S	Student	PWID	
	33	M	No school	S	Farmer	PWID	
11	31	M	No education	M	Driver	PWID	Mangochi
	33	M	No education	M	Driver	PWID	
	28	M	No education	S	Business	PWID	
	25	M	No education	S	Business	PWID	
	23	F	No education	S	Tailor	PWID	
	31	M	No education	S	Business	PWID	
	30	M	No education	S	Business	PWID	
12	25	M	Tertiary	S	Formal employee	PWID	Zomba
	25	M	MSCE	S	Not employed	PWID	
	25	M	Tertiary	M	Employed	PWID	
	29	M	Tertiary	M	Taxi driver	PWID	
	55	M	Tertiary	M	Retired	PWID	
	24	M	Tertiary	M	Student	PWID	

13	23	M	NA	S	Not employed	PWID	Machinga
	26	M	MSCE		Not employed	PWID	
	27	M	NA	S	Not employed	PWID	
	22	M	NA	S	Not employed	PWID	
	25	M	MSCE	M	Not employed	PWID	
	22	M	NA	S	Not employed	PWID	
	21	M	MSCE	S	Not employed	PWID	
14	37	M	NA	M	Taxi drivers	Taxi drivers	
	40	M	NA	NA			Blantyre
	47	M	NA	NA			
	33	M	NA	NA			
	NA	M	NA	NA			
15	37	M	NA	M	Taxi drivers	Taxi drivers	Mangochi
	25	M	NA	M			
	NA	M	NA	M			
	NA	M	NA	M			
	27	M	NA	M			
	22	M	NA	NA			
16	Not available	All males	Not available	Not available	Taxi drivers	Taxi drivers	Lilongwe
17	25	All males	Not available	M	Taxi drivers	Taxi drivers	Machinga
	25			M			
	30			M			
	40			M			
	32			M			
	31			M			

Sex: M=Male, F=Female; Marital Status: M=Married, S=Single, D=Divorced, NA=Not Available

Annex F – Total number of IDIs and FGDs conducted

DISTRICT	IDIs	FGDs
Phalombe	5	2
Zomba	9	1
Blantyre	16	3
Lilongwe	11	3
Mangochi	11	2
Machinga	11	3
Mzuzu	9	4
Total	**72**	**18**

Annex G – Summary of venue mapped and geocoded by district