GPC Global HIV Prevention Coalition

UNAIDS

World Health Organization

Scalable and sustainable primary HIV prevention models for people from key populations

A review of country approaches

Contents

Executive summary

Primary HIV prevention programmes are vital for reducing new HIV infections and saving domestic resources which otherwise would be expended on treatment and support services if HIV transmission is not curbed.

About half of all new HIV infections worldwide in 2024 occurred among people from key populations and their sex partners, including gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs. In most countries, these key populations face stigma and discrimination in public health settings, which impair their access to and use of HIV and other health services.

UNAIDS and the World Health Organization therefore continue to advocate for differentiated service delivery models for people from key populations, including through community-led services. The 2021 Political Declaration on HIV and AIDS specified that community-led organizations should be delivering 80% of HIV prevention services for populations at high risk of HIV infection by 2025.

Despite many challenges, some countries have adopted HIV service delivery models for people from key populations that are entirely or partly financed domestically and that could be sustainable at scale. Civil society organizations are vital for these models, yet much of their work is unrecognized and underfunded.

This report provides an analysis and evaluation of the evidence to January 2025 for HIV prevention service delivery models for people from key populations, with a focus on models that are scalable and potentially sustainable. It includes real-world examples from different contexts that can guide efforts to enhance HIV prevention for people from key populations.

Three main funding modalities were identified:

- **Funding Model 1** applies to countries where primary HIV prevention programmes for people from key populations are funded primarily by external donors (e.g. Kenya, Nigeria and Zimbabwe).
- **Funding Model 2** entails arrangements where services are funded predominantly from domestic resources through a semi-autonomous agency, such as a health insurance company. It includes two subtypes, each using a different funding mechanism. Model 2(a) uses a tendering process for service providers such as civil society organizations (e.g. in the Republic of Moldova), or grants to provincial and municipal governments. In Model 2(b), services delivered by public primary healthcare entities and civil society organizations s are reimbursed (e.g. in the Philippines and Thailand).

- **Funding Model 3** involves HIV prevention services that are fully funded from domestic resources, either at point of care or through reimbursement (e.g. in Australia, Brazil).

The main service delivery types that were identified range from public sector primary healthcare clinics and drop-in centres managed by civil society organizations, to outreach activities and referrals to hospitals for specialized care and treatment. Of note is the crucial role of those organizations and integration or co-location of public and civil society healthcare infrastructure and services that allow for key population-friendly services to be delivered. Additionally, the use of virtual interventions such as online consultations, mobile phone apps and websites and social media for delivering targeted information to key population communities, was notable.

Based on the key findings, the following good practices are identified for sustainable and scalable primary HIV prevention programmes for people from key populations:

- Sustainability of the HIV prevention response will require governments to invest more domestic resources in primary prevention programmes, including for people from key populations;
- External partners can assist governments to establish sustainable domestic funding mechanisms; and
- Governments can choose the sustainable funding models that suit their economic and policy environments. Proactive engagement with government agencies can identify opportunities for sustainable and scalable HIV prevention approaches.

Integration of civil society organizations services with government primary healthcare infrastructure and services can reduce costs and increase access. Revised policies can facilitate differentiated service delivery to increase uptake of primary HIV prevention services, including pre-exposure prophylaxis and post-exposure prophylaxis. Government and civil society collaboration can establish appropriate costs for sustainable HIV prevention services for key populations. Revisions to legislation and policies can enhance primary HIV prevention access and use.

Background

The HIV pandemic disproportionately affects key populations. Although they constitute only about 5% of the global population, they account for almost half of all new HIV infections *(1)*.[1] *Globally in 2024, the risk of acquiring HIV was estimated to be up to 34 times higher for people who inject drugs, 18 times higher for gay men and other men who have sex with men, and 17 times higher for sex workers and transgender women than the general population (15–49 years) (2).*

Combination HIV prevention involves evidence-informed, strategic and simultaneous use of complementary biomedical, behavioural and structural interventions. It is essential for meeting the HIV prevention needs of individuals and communities and for reducing new HIV acquisitions among key populations. Several approaches and interventions have proved to be highly effective for doing so *(3)*.

Primary prevention interventions are a subset of biomedical prevention options that directly reduce the chances of HIV acquisition. Essential primary prevention interventions recommended by the World Health Organization (WHO) as part of combination prevention include: the provision and use of condoms and lubricants; harm reduction services; voluntary medical male circumcision (VMMC), and antiretroviral-based prevention such as HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP). Interventions to address structural, legal, social and logistical barriers (including criminalization, stigma and discrimination) are of critical importance to support broader prevention efforts.

Very limited funding goes towards primary HIV prevention programmes for key populations: in 2023 they received only 2.6% of total HIV resources, mostly from international donors. The share of the funding coming from donors to low- and middle-income countries ranged from under 30% in Latin America and the Caribbean to nearly 100% in western and central Africa. Following reductions in contributions from external donors, including the United States of America, access of key populations to services has declined further.

Since early 2025 there has been great uncertainty about the future availability of external donor assistance for HIV programmes in low- and middle-income countries, especially for HIV prevention in key populations. Sustainability planning for HIV responses, tailored to the needs of key populations, is urgently needed. Efforts are underway to support such planning, including through the development of HIV Response Sustainability Roadmaps *(4)*.

Despite many challenges, some countries have adopted HIV service delivery models for people from key populations which are entirely or partly financed domestically and sustainable at scale. Those examples provide valuable, 'real-world'

[1] These populations include gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and people in prisons and other closed settings.

implementation evidence that can inform efforts to promote and strengthen primary HIV prevention programmes for people from key populations, as well as guide international and domestic investment.

Civil society organizations (CLOs), especially with staff from affected populations, play vital roles in preventing new HIV infections among key populations *(5)*.[2]

Those organizations tend to be more successful than government health services at earning trust and promoting health-seeking behaviours that are tailored to people's specific needs. Accordingly, the 2021 Political Declaration on HIV and AIDS specified that CLOs should deliver 80% of HIV prevention services for populations at high risk of HIV infection by 2025 *(6)*. However, much of the work of CLOs is unrecognized and underfunded.

Photo: Dan Agostini

[2] Civil society organizations are non-state, not for profit entities that are created and operated by people in the social sphere.

Purpose, methodology and clarifications

Purpose

This report reviews real-world HIV prevention service delivery models and provides practical examples from different contexts that can guide efforts to enhance HIV prevention access and use by people from key populations. The focus is on services for gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs and on models that can be expanded and made sustainable.

Data collection

A desk/literature review was conducted and discussions were held with the working group to define the terms 'scalable' and 'sustainable' in the context of primary HIV prevention programmes for people from key populations. Insights were drawn from a review of potential good practice programmes and from discussions with UNAIDS staff at regional and country levels about additional programmes which potentially held useful lessons.

An in-depth review was conducted of selected examples of good practices. Searches were conducted via Google and PubMed for peer-reviewed articles and other publications, and for press releases and programme reports, by using the search terms 'HIV', 'prevention', 'key population', 'program' and 'programme', and 'best practice'. A secondary search was performed using those terms plus the names of countries and programmes suggested by key informants who had responded to emailed requests for assistance in identifying suitable examples.

More than 250 organizations and potential informants working on HIV prevention and key populations were contacted by email, including civil society, donors, technical agencies, HIV programme managers, programme evaluators, service providers and HIV/health consultants at global, regional and national levels to suggest interventions that match the selection criteria.

Based on the desk review and suggestions received from informants, a list of potential good practices, scalable and sustainable primary HIV prevention programmes was created. The working group refined that list based on feedback from UNAIDS regional and country offices, with an eye on geographical and income-level diversity. It featured countries which were considered to have made meaningful progress in the sustainability and/or scalability of their programmes. A detailed analysis was then conducted for each of those country examples, using a data collection template which had been developed in consultation with the working group.[3]

[3] The interview guide is available on the website of the Global HIV Prevention Coalition (GPC): GPC 3.0 operational roll-out plan 2024-10 v2 30.01.2026.xlsx.

With the support of UNAIDS in-country staff, online individual or stakeholder meetings (with multiple key informants) were conducted between September 2024 and February 2025. A minimum of one meeting was held with each type of stakeholder per country/programme, including civil society organizations (CSOs) and, where possible, CLOs. All quantitative and qualitative data were analysed, and a structured summary of each model was developed, including results achieved (acceptability, coverage, impact, outcome and sustainability). After each case study had been drafted, it was sent to the respective UNAIDS country office for validation.

In addition, a typology of good practices was developed and their relevance for different contexts and policy and operating environments was analysed. The full draft report was reviewed by the working group before being finalized for publication.

Limitations

Data collection and analysis were completed prior to the freeze on funding for HIV imposed in January 2025 by the United States Government on funding for HIV *(7)*. That policy change affected all countries receiving support from PEPFAR (United States President's Emergency Plan for AIDS Relief) reviewed here, though the extent of the impact and likely consequences for prevention programming in those countries did not fall within the scope of this report. The impact of the reductions in funding for HIV is being monitored and publicized by UNAIDS and others *(8)*. There would be benefit in revisiting, in the near future, the case studies featured in this report, to not only assess the impact of the funding cuts but also examine the subsequent actions taken by countries which may have substantially altered how programmes are funded, governed and delivered.

In addition, the report did not collect evidence on the values and preferences of people from key populations, nor did it detail the costs or value for money of the good practice funding and service delivery models. Furthermore, detailed guidance on how to establish and maintain good practice domestic funding mechanisms for primary HIV prevention programmes for people from key populations described in the report fell outside its purview. It is recommended that a follow-up publication provide such guidance for governments and their civil society partners.

A condom demonstration to a group of sex workers by a staff member at Care for Basotho, an organization that provides HIV prevention and treatment services for sex workers in Maseru, Lesotho.
Photo: UNAIDS/M. Hyoky

Clarifications

Which key population groups are included in the report?

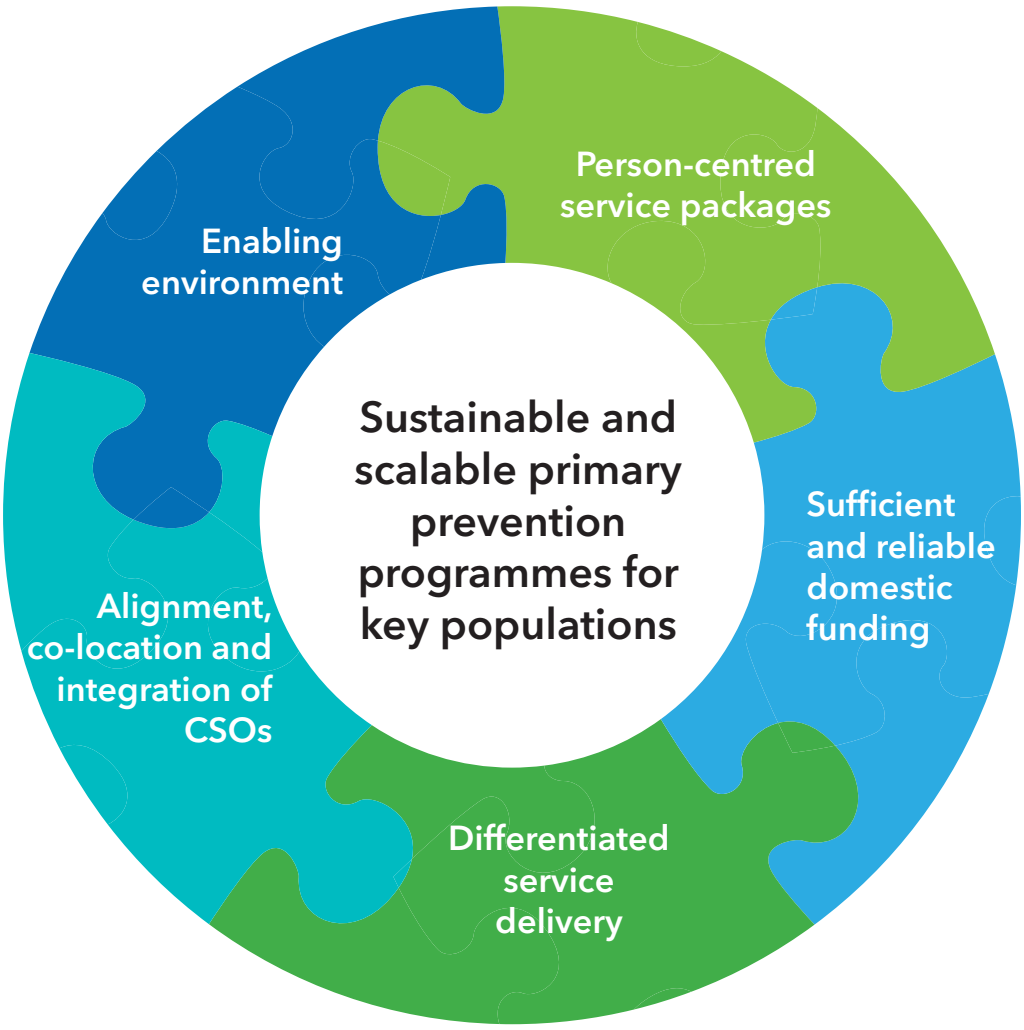
Gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and people in prisons and other closed settings are the five main key population groups considered to be highly vulnerable to HIV and who frequently lack adequate access to services *(9)*. This study focused on services for key populations that are implemented in their respective communities. As a result, it did not include people in prisons and other closed settings.

What is entailed in scalable and sustainable primary HIV prevention programmes?

Scalability and sustainability are important to ensure that HIV responses achieve and sustain impact. Scalable HIV prevention programmes are those that can be expanded to reach broad geographical areas and large segments of a target population, while maintaining effectiveness and achieving a population-level impact. A sustainable HIV prevention programme uses the available financial and human resources efficiently and is typically embedded within the national (or subnational) HIV response.

In addition, these prevention programmes must also be well-designed to meet the needs and preferences of the individuals and communities who would benefit from them. This requires approaches that are adaptable and tailored to specific contexts and settings, and that receive reliable institutional and budgetary support *(10, 11)*. It is important to recognize that both sustainability and scalability exist on a continuum: programmes may have good elements or approaches that should be supported even when they are not yet perfectly sustainable and/or scalable (Fig. 1).

Figure 1. Key elements of a scalable and sustainable primary HIV prevention programmes for key populations



Programmes are scalable and sustainable when a combination of factors exist:

- An enabling environment (laws, regulations, policies and strategies) that is conducive to making services available to, and accessible by people from key populations and their sexual partners, as well as a secure environment for CSOs to deliver the services.
- Sufficient and reliable funding from domestic sources and adequately resourced and capable multistakeholder platforms.
- Person-centred service packages that offer a comprehensive range of prevention options and adapt to the changing needs and preferences of individuals and communities over time. Demand generation for people who may benefit from HIV prevention services is also crucial and should be community led.
- Partnerships between and alignment, co-location and/or integration of existing public primary healthcare service providers and CSOs working with people from key populations, ideally as part of a national system. Considerations should include a focus on geographical areas where people from key populations are located, and differentiated service delivery (DSD) approaches that emphasize acceptability and accessibility (Box 1).

A further dimension of sustainability is the monitoring and accountability of the services provided, including through community-led monitoring, which can significantly improve the quality of the services.

Box 1 Funding to Government (e.g. Kenya, Nigeria, Zimbabwe)

DSD is a client-centred approach that simplifies and adapts health services in ways that better serve the needs of affected people, while reducing burdens on the health system. These models consider where (service location), by whom (service provider), which (service package) and when (service frequency) relevant interventions are provided, with the goal of increasing access to services. Differentiated service delivery models are wide-ranging and include community-based and community-led models, pharmacy models and virtual interventions.

Virtual interventions can be a cost-efficient option to extend the range of services provided through traditional (in-person) approaches and can provide added convenience and discretion for individuals, as well as support self-care models.

What are the various types of civil society organizations?

Civil society organizations are diverse and serve a wide range of interests, though they typically are non-state, not-for-profit entities. In the context of this report, they refer to nongovernmental organizations (NGOs),[4] some of which are community-based organizations (CBOs)[5] and/or CLOs.[6] These organizations tend to be formally constituted, self-governing, non-profit-distributing and voluntary. Other, broader definitions of CSOs also exist *(12)*.

In general, CLOs that provide primary HIV prevention services for people from key populations are staffed by paid or volunteer personnel who belong to those key population communities and are accountable to them. CLOs that work within the HIV response also bring critical insights and promote stronger accountability through community-led monitoring of HIV prevention interventions.

[4] These organizations are generally registered with local or national authorities as legal entities. Some operate only at the community level, or are part of larger NGOs that operate at national, regional and/or international levels.

[5] These bodies usually arise from within communities and are locally organized by community members. Not all CBOs are community-led.

[6] An umbrella term which includes organizations that are managed by members of key populations. In community-led HIV organizations and networks, the leadership, staff, members and volunteers reflect and represent the experiences, perspectives and voices of their constituencies. Those engaged in HIV responses are generally autonomous from government, commercial or donor agendas.

Examples of countries with good practices in primary HIV prevention programmes for key populations

The eight countries discussed here offer a range of good practices for providing scalable and sustainable primary HIV prevention services to people from key populations.

Australia

Australia manages a sustainable national HIV prevention programme which is funded from domestic resources and implemented at scale as a public (government)/private (CSO) partnership. Decision-making (budget allocation and implementation) is decentralized to the state level. Accessible services are provided free of charge or are heavily subsidized through various mechanisms, and include the active involvement of people from key populations. The programmes have been associated with declining HIV incidence among gay and bisexual men, especially those who inject drugs, as well as with very low HIV incidence among other people who inject drugs, transgender people and sex workers.

Epidemiological background

The overall incidence of HIV in Australia is very low, but the epidemic disproportionately affects gay men and other men who have sex with men, including those who inject drugs. HIV incidence among other people who inject drugs, sex workers and transgender persons is very low (Table 1).

Table 1. Incidence and prevalence of HIV among key populations in Australia

	HIV incidence	HIV prevalence	
Overall population (15–49 years)	**2023**	**2023**	
	<0.1/1000 population[a]	0.14%[b]	
Key populations	**2023**	**2021**	**2023**
Gay men and other men who have sex with men (self-reported)	0.2/100 person-years*	9.2%**	7.1%**
Gay men and other men who have sex with men attending needle and syringe programmes			28%**
People who inject drugs			1.8%**
Sex workers	0.16/100 person-years**	nd	
Transgender persons			5.0%[c]

[a] AIDSInfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] King J, McManus H, Kwon JA, Gray R, McGregor S. HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2024. Sydney: Kirby Institute; 2024 (https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual_Surveillance_Report_2024_HIV.pdf, accessed 26 January 2026).

[c] Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multi-sources estimation. J Acquir Immune Def Syndr. 2024;95(1S):e34–e45 (supplementary materials).

nd: no data.

Primary HIV prevention programme

The full package of WHO-recommended HIV prevention services is available in Australia *(3)*, with extensive coverage among each key population (Table 2). Oral PrEP is available with a prescription, including from authorized nurses. Pharmacies can dispense PrEP. Uptake of PrEP by gay men and other men who have sex with men is high and continues to increase *(13)*.

Harm reduction services are widely available at both public health facilities and through CBOs using mobile vans, community outreach, pharmacies, vending machines and delivery by postal services. However, the sharing of needles/syringes and drug preparation equipment remains a concern. Engagement in opioid agonist maintenance therapy (OAMT) has been stable at a relatively high level, including after the introduction in 2019 of long-acting formulations of injectable buprenorphine *(14)*. Two supervised injecting facilities are in operation, in Sydney (since 2001) and in Melbourne (since 2018) *(15)*.[7]

[7] The Sydney facility is run by a not for profit organization, whereas the Melbourne service is run by a mix of public healthcare professionals and volunteers *(15)*.

Table 2. Coverage of HIV prevention services in Australia

Coverage of HIV Prevention services		
	2014	**2024**
Gay men and other men who have sex with men: Use of at least one HIV prevention strategy	69%[a]	79%[a]
	2018	**2024**
PrEP use in the previous six months among eligible gay men and other men who have sex with men	40%[a]	68%[a]
	2019	**2023**
People who inject drugs and who are engaged in OAMT	44–55%[b]	44–55%[b]
Sex workers	nd	
Transgender people	nd	

[a] King J, McManus H, Kwon JAJ, Gray R, McManus H, McGregor S. HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2025. Sydney: Kirby Institute, UNSW Sydney; 2025 (https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual_Surveillance_Report_2025_HIV.pdf, accessed 30 April 2024. Sydney: Kirby Institute; 2024 (https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual_Surveillance_Report_2024_HIV.pdf, accessed 26 January 2026).

[b] Heard S, Mathers B, Maher L. Australian needle syringe program NSP survey national data report 2019–2023: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees., 30-year national data report 1995-2024. Sydney; Kirby Institute; 2024 (https://www.kirby.unsw.edu.au/sites/default/files/documents/Australian-NSP-Survey-national-data-report_2019-2023.pdf)., UNSW Sydney; 2025 (https://www.kirby.unsw.edu.au/sites/default/files/documents/Australian-NSP-Survey-national-data-report_1995-2024.pdf).

nd: no data.

Australia's HIV response is decentralized to state level and uses DSD approaches that involve partnerships with CBOs, CLOs, Aboriginal health organizations, other NGOs, clinicians, researchers and public health services. In the state of New South Wales, for example, public health services are managed by local health districts and funded through service agreements. Implementation committees oversee service implementation and include representatives from local health districts, clinicians, academics and CBOs representing priority populations.

State health authorities support sexual health clinics which provide free and confidential services for people at high risk of HIV and sexually transmitted infections (STIs). Each state provides general practitioner and nurse training for PrEP prescribing and STI/HIV screening as part of routine care in general practice and other primary care settings. PEP can be accessed at the emergency departments of most public hospitals, from sexual health clinics and from some general practitioner clinics that specialize in sexual health. Many states and territories also have PEP information lines. OAMT is prescribed by authorized medical practitioners and specialist nurse practitioners, and is dispensed through community pharmacies, private and public clinics, and at local hospitals in rural areas.

Nongovernmental organizations, CBOs and CLOs are active in most states, are integrated in the HIV response and work in close partnership with public health

services. For example, in Western Australia, the health department contracts NGOs to deliver harm reduction services at clinics. Clinics also provide PrEP, antiretroviral therapy (ART) and direct-acting antivirals for treating hepatitis C virus infection. NGOs distribute naloxone and provide additional peer support through mobile and telehealth platforms. Retention in HIV prevention, care and treatment is relatively high and loss to follow-up is low. Secondary distribution[8] of HIV prevention commodities is also used. Some NGOs train public healthcare workers in the delivery of key population-friendly services.

Virtual interventions (including videoconferencing and telephone appointments with healthcare professionals) are provided by a range of health services and are especially useful in remote areas. HIV campaigns leverage social marketing on mobile apps and social media platforms for demand creation and the dissemination of HIV prevention information. Interactive website tools, including chatbots, are also used. Some HIV prevention commodities, such as HIV self-testing kits, can be purchased from online distributors and pharmacies.

Funding and governance

National and state governments in Australia jointly fund the HIV response, with publicly subsidized private sector clinical services also available. Prevention services provided by NGOs, CBOs and CLOs also receive public funding at the state and/or national level. Medicare, Australia's national healthcare system, provides free or subsidized health services and medicines to individuals.[9, 10] When a person's out of pocket spending on healthcare exceeds a specified level, services and medicines are provided free of charge. Other benefits include a healthcare card which provides access to cheaper medicines and some discounts for healthcare costs. Funding is also provided for services such as safe injecting facilities.[11, 12]

[8] Secondary distribution, or secondary exchange, involves people acquiring needles/syringes from formal services and redistributing them to others.

[9] Medicare covers all or part of the costs of: consulting a general practitioner or specialist; tests and scans; most surgery and procedures performed by doctors; and eye tests by optometrists. It does not cover: ambulance services; most dental work; prescription spectacles and contact lenses; hearing aids; and cosmetic surgery.

[10] An individual can choose to attend hospital as a public or private patient. For a public patient at a public hospital, costs will be covered by Medicare, including the costs of attending an emergency department. Private health insurance can help cover costs as a private patient in hospital. Medicare covers some costs for hospital services and procedures, but not accommodation, medicines and theatre fees for a private patient.

[11] Funding for the Uniting Medically Supervised Injecting Centre in Sydney comes from the 'Confiscated Proceeds of Crime' account, which is managed by the New South Wales State Treasury.

[12] The Medically Supervised Injecting Room in Melbourne is funded by the State of Victoria through the local North Richmond Community Health.

Brazil

Brazil provides HIV prevention services for people from key populations through a range of complementary strategies. Responsibilities within the Unified Health System (SUS) are distributed across federal, state and municipal levels, with prevention services primarily managed and implemented at the municipal level. These include the provision of prevention commodities through primary healthcare services, as well as publicly funded, community-based activities focused on prevention, testing and referral to care. Some municipal health departments have also expanded care delivery through online platforms to address barriers related to mobility and stigma. Overall, the HIV response in Brazil has historically been co-led by government and civil society, supported by national public funding.

Epidemiological background

The annual number of new HIV infections in Brazil has increased in recent years, with a gradual reduction in the year-on-year rate of increase *(16)*. This upward trend can be largely attributed to the expansion of testing coverage, reflected in the growing proportion of people who know their HIV status (78% in 2019 and 89% in 2024) *(17)*. In 2024, national data indicated a stabilization in this previously rising trend when compared to 2019 data. The country is classified as having a concentrated HIV epidemic, in which certain key populations and other priority groups experience markedly higher prevalence rates compared to the general population (Table 3).

Table 3. Incidence and prevalence of HIV among key populations in Brazil

	HIV prevalence
Overall population (15–49 years)	**2024**
	0.5%[a]
Key populations	**2022**
Gay men and other men who have sex with men (aged 18 years and older)	18.4%[b]
Transgender women and *travestis*	up to 34.4%[c]

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] Kerr LRFS, Kendall C, Guimarães MDC, Salani Mota RM, Veras MA, Dourado I, et al. HIV prevalence among men who have sex with men in Brazil: results of the 2nd national survey using respondent-driven sampling. Medicine (Baltimore). 2018;97(1 Suppl):S9–S15.

[c] Dourado I, Magno L, Veras MA, et al. Prevalence of HIV infection among transgender women and travestis in Brazil: data from the TransOdara study. Rev Bras Epidemiol. 2024;27(Suppl 1):e240004.

Primary HIV prevention programme, funding and governance

HIV prevention strategies are incorporated into official policy documents addressing the specific health needs of key populations. Brazil has established a National Policy for the Comprehensive Health of Lesbian, Gay, Bisexual, *Travesti* and Transgender People (2011), a Health Care Program for the Trans Population (2024), and a National Policy for Comprehensive Health Care for Persons Deprived of Liberty in the Prison System (2014). These instruments guide national health responses by considering the particularities and vulnerabilities of those populations. However, there is no specific national health policy dedicated to sex workers. Although sex work is not criminalized in Brazil, it is also not a formally regulated profession. Being outside the legal framework of rights is one of the factors causing gaps in the provision of comprehensive health policies for this population. All key populations are represented in national councils that address the HIV response. These councils function as formal mechanisms for social participation and oversight of government HIV policies *(18)*.

Historically, NGOs have played a central role in the Brazilian HIV response by placing the epidemic on the national political agenda and sustaining community-based actions in partnership with the Ministry of Health. As publicly funded organizations implementing a wide range of prevention, care and support activities, they contribute both to reducing new infections and to improving the quality of life of people living with HIV.

In addition to their role in shaping and advancing specific public policies, NGOs are key actors in the promotion and defence of human rights, supporting broader processes of democratization and strengthening mechanisms of representation, accountability and public transparency. They also provide comprehensive services that are tailored to the needs of the populations they serve, thereby expanding the reach and effectiveness of public policies and complementing government efforts in a more responsive and context-sensitive manner. In this way, NGOs function as a vital bridge between society and the Government delivering locally adapted interventions that are grounded in participatory health education and empowerment approaches *(19)*.

Brazil's PrEP policy is currently undergoing a sustained phase of expansion and remains a strategic priority for the Ministry of Health, having been implemented progressively in recent years.[13] At present, approximately 150 000 individuals are using PrEP nationwide, and this number continues to grow *(20)*. The majority of current users are concentrated among key populations, particularly gay men and

[13] With regard to long-acting injectable technologies for HIV prevention, their incorporation and wide availability within the SUS appears to be a distant prospect. At present, both long-acting injectable cabotegravir (CAB-LA) and Lenacapavir (LEN) are available free of charge only within the context of implementation studies and clinical trials in Brazil. CAB-LA can be accessed through private purchase in retail pharmacies, while LEN is expected to become available for commercial sale in private pharmacies in 2026, with announcement of its market price expected in June 2026.

other men who have sex with men (80%). However, expansion strategies have not yet effectively reached certain groups, such as transgender populations (4% of PrEP users), who currently experience some of the highest HIV prevalence rates in the country. Addressing this gap is an ongoing challenge, and the Brazilian Government is in the process of strengthening and refining its response to ensure more equitable access. Through a national regulation issued in 2023, the Ministry of Health authorized health professionals besides physicians (e.g. pharmacists and nurses) to prescribe PrEP. This measure aimed to reduce bureaucratic barriers and enhance access to PrEP, and it has since been adopted by health administrations across different territories.

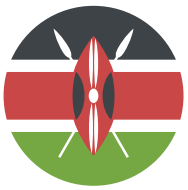
Some municipalities, such as São Paulo, have implemented telemedicine strategies to expand access to PrEP in a bid to reduce barriers related to urban mobility and the stigma and discrimination faced by users when seeking in-person health services. The initiatives have the potential to improve uptake and continuity of care, particularly among key populations. However, their implementation remains concentrated in a limited number of cities, primarily state capitals and large urban centres. Overall, telemedicine in the context of PrEP is still considered a pilot strategy in Brazil and has not yet been widely institutionalized across municipalities, despite being recognized as a promising good practice.

A major paradigm shift within the HIV response in Brazil has been the establishment of the Brasil Saudável Program *(21)*, a presidential initiative led by the Ministry of Health and the National HIV Program. It seeks to expand the understanding, across an additional 14 ministries, that the HIV response is not solely a public health issue, but also fundamentally a matter of protecting rights. In this framework, each of the ministries commits to an elimination agenda for a range of diseases, including the elimination of AIDS as a public health threat, within the scope of its respective mandate. This means that the Ministry of Health, the Ministry of Education, the Ministry of Justice, the Ministry of Human Rights and the Ministry of Women, among others, maintain their own set of targets and responsibilities aimed at delivering a coordinated, rights-based response that reduces barriers to access across the continuum of HIV care and, ultimately, achieve the elimination of AIDS as a public health threat.[14]

[14] Subsequent to the data collection for this report, the elimination of vertical transmission of HIV, included as a key milestone under the Brasil Saudável Program, was successfully achieved by the end of 2025, with the entire country certified by the Pan American Health Organization as having eliminated vertical transmission of HIV as a public health threat.

Kenya

Kenya has achieved steep reductions in overall HIV incidence and prevalence, while also increasing access to and use of key HIV prevention services among key populations, notably people who inject drugs. This has been done through increased funding for HIV prevention, effective coordination, expanded service delivery and closer collaboration with organizations managed by members of key populations. Kenya has also sought to address the underlying social, legal and policy factors that create and perpetuate vulnerabilities for people from key populations. Opportunities exist to increase access for key populations to the country's Social Health Insurance Fund.



Epidemiological background

Although HIV prevalence and incidence in Kenya have been reduced over the past decade, transgender people, sex workers, gay men and other men who have sex with men and people who inject drugs continue to be disproportionally affected by HIV (Table 4).

Table 4. HIV incidence and prevalence among key populations Kenya

	HIV incidence		HIV prevalence	
Overall population (15–49 years)	**2015**	**2024**	**2015**	**2024**
	1.4/1000 persons[a]	0.5/1000 persons[a]	4.7%[a]	3.0%[a]
Key populations	**2022**		**2024**	
Gay men and other men who have sex with men	0.7/100 person-years[b]		19.9%[d]	
People who inject drugs	0.12/100 person-years[c]		8.8%[d]	
Female sex workers	0.2/100 person-years[b]		26.8%[d]	
Transgender people	0.72/100 person-years[b]		22.5%[d]	

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multi-sources estimation. J Acquir Immune Def Syndr. 2024;95(1S):e34–e45 (supplementary materials).

[c] National AIDS and STI control. bio-behavioral survey among key populations in Kenya using respondent-driven sampling. Survey results. Survey Consensus Building Meeting, 25–26 November 2024. Nairobi: Ministry of Health; 2024.

[d] Bio-behavioral survey among key populations atlas, Kenya, 2024 (https://kpatlas.unaids.org/dashboard).nascop.or.ke/wp-content/uploads/2026/03/).

Primary HIV prevention programme

HIV prevention service coverage is much higher for people who inject drugs (about 62%) than for sex workers (32%), while gay men and other men who have sex with men have the lowest coverage (20%); no data are available for transgender people. HIV prevention services for female sex workers were available in 44 of the country's 47 counties *(22)*. However, services for other key populations are less widely distributed across the country, for reasons that include high levels of stigma and discrimination, and conservative cultural and religious norms (Table 5).[15]

The available data indicate high rates of safe injecting among people who inject drugs, though the number of sterile needles/syringes reportedly distributed among people who inject drugs was very low (four per person per year in 2021). Coverage of OAMT appeared to be improving, but was still low.

Table 5. Coverage of HIV prevention services in Kenya

Coverage of HIV prevention services[a]	2020	2022	2024
Gay men and other men who have sex with men			
Service coverage		20%[b]	
Condom use			76%[c]
ART coverage		40%[c]	85.7%[d]
People who inject drugs			
Service coverage		62%[b]	
Condom use	76%[c] (2017)		44%[d]
ART coverage		15%[c]	91.8%
NSP coverage			
OAMT	10%[c]		
Safe injecting practices	88%[c] (2017)		71.8%
Female sex workers			
Service coverage		32%[b]	
Condom use	73%[a]		>75%[d,f]
ART coverage	nd	30%[b]	92.5%
Transgender people			
Service coverage	5%[a]		
Condom use			nd
ART coverage			91.5%[d]

[a] Musyoki H, et al. A decade and beyond: learnings from HIV programming with underserved and marginalized key populations in Kenya. J Int AIDS Soc. 2021;24(Suppl 3):e25729.

[b] Global HIV prevention coalition scorecards 2024—Kenya. Geneva: Joint United Nations Programme on HIV/AIDS; 2024.

[c] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

[d] Bio-behavioral survey among key populations, Kenya, 2024 (https://nascop.or.ke/wp-content/uploads/2026/03/).

[e] In the last 12 months.

[f] With clients.

nd: no data.

[15] Service availability was: female sex workers in 44 counties (94%); gay men and other men who have sex with men in 39 counties (83%); people who inject drugs in 32 counties (68%); and transgender people in 18 counties (38%).

Kenya's health system is decentralized, affording county health management teams considerable autonomy in the provision of services *(23)*. A DSD approach is used, with CSOs (primarily CBOs and CLOs) playing a leading role in the delivery of primary HIV prevention services. All of the primary HIV prevention services for key populations recommended by WHO are available in the country *(3)*.

Government-run health facilities, as well as CSO-managed drop-in centres, are registered with the respective county health authorities and are linked to nearby public healthcare facilities for referrals. Community outreach to key populations is also extensive *(23)*. HIV (and syphilis) rapid tests are administered by medical staff at public and CSO-run healthcare facilities. HIV self-tests are also available, including through pharmacies (staff receive training in basic counselling techniques) *(24)*.

Oral PrEP is available at public healthcare facilities and various service delivery approaches are being piloted, including through community pharmacies. PrEP and PEP are also available at CSO-run clinics and drop-in centres which have a certified clinician and are linked with a public health facility *(25)*. The provision of PEP by pharmacies was piloted in Nairobi in 2023 *(26)*, but PEP awareness appears to be limited among many members of key populations. Virtual interventions are still limited, but their potential for boosting PrEP uptake is increasingly recognized. Less than half of people from key populations have used PrEP and less than one third were reportedly using it in 2023 *(27)*.

Governance and funding

Oversight of the HIV programme is managed by the National Syndemic Diseases Control Council (which coordinates multisectoral efforts, mobilizes resources and fosters stakeholder collaboration)[16] and the National AIDS and STI Control Programme (which provides technical oversight).[17] The key and vulnerable population programme is responsible for overseeing the delivery of tailored services to key populations. All these entities operate under the Ministry of Health.

At the subnational/county level, services are coordinated through county health management teams, with services either integrated within public facilities or through CSOs. At the community level, the key population programme is coordinated by the Key Population Consortium, an association of networks comprising 90 organizations and community representatives working on issues affecting people from key populations.

Domestic resources accounted for about 45% of HIV prevention funding in Kenya in 2021–2023, with other donors, including the Global Fund and PEPFAR, contributing

[16] Including with county governments, CBOs and development partners (e.g. the Global Fund to Fight AIDS, Tuberculosis and Malaria through its Principal Recipient, the Kenyan Red Cross Society and UNAIDS).

[17] Such as the development of guidelines, training and tools to ensure that services are delivered in accordance with national policies and international standards.

the remainder. Civil society organizations rely heavily on funding from external donors, especially to pay staff costs. Government funding modalities for civil society stakeholders include grants and reimbursements when specific services are provided at government-run facilities or through approved implementing partners.

Efforts are under way to establish a legal framework for social contracting of CSOs. Reimbursement for service provision can occur through the Social Health Insurance Fund, although this is still rare for key population-specific services. Some private sector entities and social enterprises provide services, often as part of broader health service packages, with costs covered through out-of-pocket payments or insurance. Procurement of HIV commodities is pooled centrally by the Kenya Medical Supplies Authority.

Republic of Moldova

Collaboration between CSOs, government agencies and people from key populations in service delivery and advocacy is gradually increasing the coverage and use of HIV prevention services and tools. More than half of the HIV programme is government funded through national health insurance. Basic prevention services for key populations are contracted to CSOs in an open and competitive bidding process.

Epidemiological background

Both HIV incidence and prevalence are low and have declined since 2015 (Table 6). The HIV epidemic is concentrated among key populations.

Table 6. HIV incidence and prevalence among key populations in the Republic of Moldova

	HIV incidence	HIV prevalence
Overall population (15–49 years)	**2024**	**2024**
	0.48/1000 persons[a]	0.9%[a]
Key populations	**2022**	**2022**
Gay men and other men who have sex with men	1.9/100 person-years[b]	11%[c] (2020)
People who inject drugs	0.7/100 person-years[b]	11.%[a] (2020) 17%[a]
Sex workers	0.3/100 person-years[b]	2.7%[c] (2020) 4.2%[a]
Transgender people	2.0/100 person-years[b]	10.9%[b]

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multisources estimation. J Acquir Immune Def Syndr 2024;95(1S):e34–e45 (supplementary materials).

[c] Differentiated service delivery country profile: Republic of Moldova. Geneva: Joint United Nations Programme on HIV/AIDS; 2023 (https://dsd.unaids.org/, accessed 17 December 2024).

Primary HIV prevention programme

More than half of sex workers and people who inject drugs and a little over one third of gay men and other men who have sex with men received HIV prevention services in 2023 (Table 7). No data were available for transgender people. All HIV prevention interventions recommended by WHO are available *(3)*, except for OAMT on the east bank of the Dniester River, which is not under the direct control of the Moldovan authorities *(28)*.

Table 7. Coverage of HIV prevention services in the Republic of Moldova

Coverage and use of HIV prevention services[a]		
Gay men and other men who have sex with men	**2020**	**2024**
Service coverage	47%[b]	45%[b]
Condom use	60%[b]	69%[b]
ART coverage		nd
People who inject drugs	**2020**	**2020**
Service coverage	37%[a]	41%[b]
NSP	5.5%[b]	63%[b] (2023)
OAMT	41%[b]	7%[b]
Condom use	70%[b]	30%[b]
ART coverage	95%[b]	67%[b]
Safe injecting		94%[b]
Sex workers	**2017**	**2017**
Service coverage	61%[b]	26%[b]
Condom use	88%[b]	91%[a]
ART coverage	nd	
Transgender people		
Service coverage		nd
Condom use		
ART coverage		

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

nd: no data.

Since 2022–2023, needles/syringes, alcohol wipes, condoms and HIV self-test kits have been available through vending machines that are located across the country (including on the east bank of the Dniester River), an approach that has largely replaced the distribution of those commodities through pharmacies. HIV prevention services are primarily delivered through CSOs *(28)*.

Oral PrEP is available through facilities providing CSOs and at ART facilities. PrEP and related testing are fully funded by the Government, while psychosocial and adherence support and information activities are funded mainly by external donors. PrEP coverage is low, but has increased due to growing awareness among both healthcare providers and potential beneficiaries *(29)*. Gay men and other men who have sex with men are accessing PrEP the most, followed by sex workers. PrEP is not yet available through online platforms. PEP is available at major hospitals, but public awareness is very low.

HIV-related CSOs operate in all major urban areas of the Republic of Moldova.[18] Many of them use DSD approaches that are simplified and adapted to the needs of affected people. They provide services at facilities and through outreach activities, with the involvement of people from key populations. healthcare professionals employed by CSOs also provide basic medical care, while complex medical support is referred to government healthcare facilities. CSOs help train public healthcare staff on reducing stigma and discrimination. Virtual services are increasingly available.

Governance and funding

About 57% of funding for the national HIV programme in 2023 came from domestic sources and the rest was contributed by the Global Fund (41%) and other international sources *(30)*.[19] HIV prevention is funded primarily through Global Fund grants and mandatory health insurance funds. Even with Global Fund support, there was a significant funding gap for HIV prevention for key populations.

Domestic funding is managed by the National Health Insurance Company, an autonomous public institution. All health insurance revenues (including mandatory health insurance contributions and transfers from the state budget for the non-working population) are pooled into one autonomous budget which is by the National Health Insurance Company. Those funds are used to contract a mix of public and private service providers; as of 2021, almost 90% of the population was covered by national health insurance *(31)*.

Unit costs for HIV prevention interventions are determined through periodic costing exercises which are done under the authority of the National Health Insurance Company. Contractees must comply with the Public Procurement Law, and service quality is assessed against criteria set by the Ministry of Health. Notably, the Court of Accounts has the authority to exercise financial control over the development of projects and the execution of financing contracts with HIV prevention service providers.

The Ministry of Health issues periodic requests for proposals to implement a basic package of primary HIV prevention services for key populations.[20] Applicants must:

[18] AIDS Network is an informal NGO network which comprises, among others: the resource centre 'Young and Free'; information centre 'GenderDoc-M'; association 'Young Trainers from Moldova'; public organization 'Let's save the Future Together'; association 'Youth for the Right to Live' (TDV); association 'Youth for the Right to Live', branch from Balti (TDV Balti); youth centre 'Neovita'; association 'New Life'; educational centre 'Alcoholism and Drug Addiction', and the 'Union of Organizations Operating in the Field of Harm Reduction'.

[19] Of a total HIV programme budget of $10.2 million in 2023, domestic public sources contributed $5.9 million, while $4.2 million came from the Global Fund and $181 000 from other international donors.

[20] Services funded by the National Health Insurance Company include: the distribution of condoms and lubricants; the exchange of syringes and distribution of alcohol wipes; HIV counselling and testing; testing for syphilis, hepatitis B and C; TB screening; and communication, information and education for the purpose of preventing HIV, HBV, HCV, TB and STIs.

be registered in the Republic of Moldova; have experience in the HIV prevention sector; and have accreditation and public utility status to ensure minimum standards and quality control. In 2024, four projects were selected for implementation by six public associations.

The National Health Insurance Company also funds hospital-based services such as OAMT and the rehabilitation of people who are dependent on narcotic substances. The clinical hospital for infectious diseases coordinates and monitors implementation of the national AIDS programme.

The remaining challenges include: expanding prevention services for gay men and other men who have sex with men; increasing the number of people enrolled in OAMT; addressing the increased use of new psychoactive substances; and expanding access to and use of PrEP and PEP services *(32)*. Closer collaboration between CSOs and Government entities, and the increasing involvement of people from key populations in service delivery and advocacy, will help address those challenges.

Nigeria

Although Nigeria relies significantly on external donors for HIV prevention services for key populations, it has established an extensive network of key population-friendly service delivery sites within communities, using external donor support for implementation. The services are linked to and integrated with government facilities and CSO peer healthcare workers. The national government has put in place systems to increase domestic funding to support these services as part of its efforts to achieve universal health coverage.

Epidemiological background

HIV prevalence and incidence has been decreasing over the past decade, but key populations continue to be disproportionately affected (Table 8). HIV prevalence is comparatively high in the overall adult population, but is highest among transgender people and gay men and other men who have sex with men, while high prevalence of HIV has also been reported among sex workers and people who inject drugs. Key populations contribute an estimated 11% of adult new infections in Nigeria *(33)*.

Table 8. HIV incidence and prevalence among key populations in Nigeria

	HIV incidence		HIV prevalence	
Overall population (15–49 years)	**2015**	**2024**	**2015**	**2024**
	0.93/1000 persons[a]	0.26/1000 persons[a]	1.7%[a]	1.2%[a]
Key populations	**2022**		**2015**	**2020**
Gay men and other men who have sex with men	0.003/100 person-years[b]		23%[c]	25%[c]
People who inject drugs	0.5/100 person-years[b]		3.4%[c]	11%[c]
Sex workers	0.8/100 person-years[b]		14%[c]	17%[c]
Transgender people	0.003/100 person-years[b]		nd	29%[c]

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multi-sources estimation. J Acquir Immune Def Syndr. 2024;95(1S):e34–e45 (supplementary materials).

[c] The key population atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

nd: no data.

Primary HIV prevention programme

Coverage of HIV prevention services among key populations is fairly high, although the proportion of people who inject drugs and who report using safe injecting practices has declined over the past decade (Table 9). The proportion of people from key populations who tested for HIV and received their test results is larger than for the general public *(34)*. Harm reduction services for people who use drugs are being rolled out incrementally and are increasing in availability, though some sites also provide safe injecting facilities *(35)*. The use of oral PrEP among key populations is reported to be low, while PEP awareness and uptake is also low, partly due to inadequate community awareness, and engagement, and insufficient training of training of healthcare providers *(34)*.

Table 9. Coverage of HIV prevention services in Nigeria

Coverage and use of HIV prevention services[a]	
Gay men and other men who have sex with men	**2020**
Service coverage	96%[a]
Condom use	70%[b]
ART coverage	26%[b]
People who inject drugs	
Service coverage	65%[a]
NSP	nd
OAMT	nd
Condom use	25%[b] (2019)
ART coverage	36%[b]
Safe injecting	
Sex workers	
Service coverage	88%[a]
Condom use	86%[b]
ART coverage	24%[b]
Transgender people	
Service coverage	79%[b] (2021)
Condom use	66%[b]
ART coverage	20%[b]

[a] Global HIV Prevention Coalition scorecard: Nigeria. Geneva: Joint United Nations Programme on HIV/AIDS; 2024.

[b] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

nd: no data.

Nigeria supports differentiated HIV prevention service delivery through community and facility-based models. Since 2015, it has operated key population 'one-stop shops' (central, comprehensive clinics which are connected to community and mobile clinic sites) to enhance accessibility.[21] Most of the 'one-stop shops' are staffed by multidisciplinary teams of healthcare professionals *(36)* (usually employed by the Government) and key population community members (hired by CSOs, with funding from external donors).[22] 'One-stop shops' provide

[21] The 'One-Stop Shop' (OSS) model, which was fully funded and supported by external donors and partners, was impacted by the stop-work orders issued by the United States Government in 2025. The national policy direction now is shifting toward the integration of key population services into government and government-mandated health facilities, with a deliberate focus on strengthening their capacity to deliver comprehensive, inclusive and stigma-free services. This transition moves away from parallel, vertically managed OSS structures toward a more integrated, system-based approach which is widely recognized as a more sustainable and scalable pathway for key population programming in Nigeria. This will promote continuity of services, efficient resource utilization, and long-term resilience of the integrated national HIV response.

[22] The criteria for key population-friendly health facilities are as follows: 'Must create safe, friendly and stigma-free environment tailored to key population needs; should provide gender diversity and inclusivity training for staff; ability to collaborate with KP-led CBOs to support continuum of care; ability to provide and support accountability mechanisms for KP quality of care and human rights; willingness to provide mental health and psychosocial services; skills and willingness to manage STIs in key populations (e.g. anal warts and cervical cancer)' *(36)*.

comprehensive primary healthcare services, including HIV testing, PrEP, PEP, STI and TB screening, ART enrollment/initiation and ARV refills. These facilities also have referral pathways to link individuals to specialized services, including for tertiary-level care and structural and community-based interventions (such as legal services and peer support).

Community-level services are also provided by mobile community ART teams, usually at places where members of key populations congregate. Those teams deliver primary prevention interventions as part of a limited service package. In addition, focal service providers (nurses and community health workers who work with CSOs) provide a limited range of outreach services, including primary HIV prevention interventions and follow-up. Community pharmacies provide HIV self-tests, PrEP, PEP and ARV refills *(36)*. Secondary level facilities provide harm reduction services, while tertiary-level facilities also provide mental health support, cervical cancer screening and treatment, hepatitis screening, and OAMT. Digital platforms/telehealth, including mobile apps and websites, are being increasingly utilized for education, counselling and linkage to services *(34)*.

Governance and funding

The National Agency for the Control of AIDS coordinates and supports the national AIDS response in Nigeria. Total HIV expenditures in 2021 amounted to US$ 437.8 million, of which 76% came from PEPFAR, 19% from the Global Fund and the remainder from domestic public expenditures from central and state governments, the private sector and domestic non-profit institutions. HIV prevention, including testing and counselling, accounted for about 9% of all HIV expenditures in 2021 and 80% of the prevention expenditure was on interventions for key populations. Importantly, about 94% of prevention interventions were funded by PEPFAR *(37)*.

Domestic HIV funding comes from budgetary appropriations at the national and subnational levels through the National Agency, the National AIDS and STIs Control Programme, and state budgets. A national HIV/AIDS Trust Fund has been established by the Nigeria Business Coalition Against AIDS as a private sector-led contribution to help address HIV funding gaps, with a focus on the prevention of vertical transmission of HIV. However, as of mid-2025 the Trust Fund had not yet disbursed resources.

In addition, state and national health insurance schemes provide coverage for a basic minimum package of health services at eligible primary and secondary healthcare facilities, but at present they do not include HIV prevention commodities *(38)*. Nevertheless, they present a possible funding option for key population services in the future. The Government has put in place systems to increase domestic funding through health insurance to support key population services in the medium to long term. For example, services from 'one-stop shops' are eligible for reimbursement from state health insurance in Lagos state *(39)*.

Philippines

The incidence of HIV among some key populations in the Philippines is high and has risen steeply among gay men and other men who have sex with men. A range of innovative approaches are being used to make prevention services, including PrEP, more widely accessible to key populations. The national Government funds 80% of the HIV prevention programme as part of its effort to achieve universal health coverage. The National Health Insurance Programme (PhilHealth) provides some coverage for people from key populations. Many CSOs, especially those managed by peers, operate social enterprises and for-profit activities to subsidize services for members of key populations.

Epidemiological background

The prevalence of HIV in the general population is low, but HIV incidence is increasing rapidly in some key populations, particularly among gay men and other men who have sex with men (Table 10). HIV incidence has also risen among transgender people, people who inject drugs and sex workers. In 2023, almost 90% of new HIV infections in the Philippines were estimated to be among gay men and other men who have sex with men and transgender women *(40)*.

Table 10. HIV incidence and prevalence among key populations in the Philippines

	HIV incidence		HIV prevalence	
Overall population (15–49 years)	**2015**	**2023**	**2015**	**2023**
	<0.1/1000 persons[a]	0.24/1000 persons[a]	<0.1%[a]	0.3%[a]
Key populations	**2022**		**2018**	**2023**
Gay men and other men who have sex with men	3.4/100 person-years[b]		5.0%[c]	7.5%[c]
			2015	**2022**
People who inject drugs	7.4/100 person-years[b]		29%[c]	38%[c]
			2014	**2023**
Sex workers	0.2/100 person-years[b]		0.6%[c]	1.2%[c]
			2018	**2023**
Transgender people	3.4/100 person-years[b]		3.9%[c]	2.8%[c]

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multi-sources estimation. J Acquir Immune Def Syndr. 2024;95(1S):e34–e45 (supplementary materials).

[c] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

Primary HIV prevention programme

The coverage of HIV prevention services among key populations was under 50% in 2023, but was increasing among gay men and other men who have sex with men and among transgender people. Prevention services are available from government healthcare facilities, at other fixed sites and through mobile and outreach services run by CSOs in many cities. Private and social enterprise service providers and social hygiene clinics funded by local governments also provide HIV services.

The full package of HIV prevention interventions recommended by WHO is nominally available, although government-led efforts to eradicate illicit drug use have made needle/syringe programmes largely inaccessible and have deterred effective community-based HIV prevention services for people who use or inject drugs *(40)*. Oral PrEP access is expanding rapidly and is available from increasing numbers of government and non-profit healthcare providers, usually at no cost to the individual *(41)*.[23] Access to PEP is less readily available, mostly from government healthcare facilities or from private or CSO-led clinics (though on out-of-pocket payment terms) *(42)*.

Table 11. Coverage of HIV prevention services in the Philippines

Coverage and use of HIV prevention services[a]		
Gay men and other men who have sex with men	**2018**	**2022**
Service coverage	15%[a]	29%[a]
Condom use	40%[a]	59%[a]
ART coverage		89%[a]
People who inject drugs	**2016**	**2023**
Service coverage	52%[a]	
NSP	nd	
OAMT	nd	
Condom use	15%[a]	
ART coverage		58%[a]
Safe injecting	64%[a]	62%[a]
Sex workers	**2018**	**2023**
Service coverage	72%[a]	15%[a]
Condom use	85%[a]	71%[a]
ART coverage		88%[a]
Transgender people		
Service coverage	18%[a]	38%[a]
Condom use	41%[a]	58%[a]
ART coverage		86%[a]

[a] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

nd: no data.

[23] The Government, through the Department of Health, funds HIV test kits (screening and confirmatory) and PrEP, while mobile PrEP and mall-based PrEP services were supported by PEPFAR through the United States Centers for Disease Control and Prevention *(41)*.

The provision of healthcare in the Philippines is largely decentralized, with the national Department of Health providing policy direction. Provincial, city and municipal governments are responsible for managing and funding local health services *(40)*.

Municipal governments provide primary healthcare through rural health units, health centres and 'barangay' health stations. For-profit and non-profit healthcare providers, including CSOs, generally charge user fees, though the fees are sometimes subsidized through social enterprise activities *(43)*.[24] In cooperation with local government, CSOs also provide HIV prevention services (including PrEP) through mobile outreach activities. Virtual services are common and are generally provided by CSOs using a mix of social media, chatbots, apps and websites to offer online consultations with healthcare professionals, case management, appointment reminders, purchasing of condoms and HIV self-test kits, oral PrEP and ARV refills. Many CSO providers are managed by paid or volunteer peers from their respective key population communities.[25]

Governance and funding

In 2024, more than 80% of Filipinos were registered with the Philippine Health Insurance Corporation (PhilHealth), a Government corporation that is attached to the Department of Health. PhilHealth administers the National Health Insurance Programme and ensures that a basic minimum package of healthcare that is affordable, acceptable, available and accessible to all citizens as part of the Government's efforts to achieve universal health coverage.

About 80% of the total budget for HIV prevention (US$33.2 million in 2023) comes from domestic resources, largely through health insurance, while about 1% comes from the Global Fund and the remaining 19% from other donors. Between 2021 and 2023, however, only 41% of the overall national strategic plan for HIV was funded *(44)*. Support for CSO prevention service delivery and capacity building comes mainly from the Global Fund, other external donors and through reimbursements from PhilHealth.[26] Because reimbursements can take six–to-nine months, CSOs tend to need seed funding support.[27]

[24] For example, 'LoveYourself' and Sustained Health Initiatives of the Philippines.

[25] For example, 'hack-a-thons' run by LoveYourself identify and quickly solve issues (usually within 48 hours). The approach was used successfully to address Mpox.

[26] For some CSOs, the funding received from PhilHealth provides sufficient support to cover the basic costs of HIV primary prevention services for people from key populations who are not covered by the health insurance programme.

[27] Start-up funds come from a range of sources, including low-cost loans from high-net-worth individuals or from profits from social enterprises run by the CSO. In some instances, PEPFAR has also supported start-up costs.

Thailand

HIV incidence and prevalence is very low in the general population but is much higher among gay men and other men who have sex with men, male sex workers and people who inject drugs. A key population-led health services model, implemented by CLOs, is being used to address low uptake of HIV services. Services delivered by CSOs are widely available, including for PrEP and PEP, at fixed and mobile sites, through community outreach and through online services and apps. The Ministry of Public Health and the government-funded National Health Security Office have integrated key population-led healthcare services and costs into the broader health system as part of efforts to achieve universal health coverage.

Epidemiological background

Overall HIV prevalence and incidence in Thailand are very low, but key populations are disproportionally affected by the epidemic, with HIV incidence especially high among sex workers, gay men and other men who have sex with men, and people who inject drugs (Table 12).

Table 12. HIV incidence and prevalence among key populations in Thailand

	HIV incidence		HIV prevalence	
Overall population (15–49 years)	**2015**	**2024**	**2015**	**2024**
	0.36/1000 persons[a]	0.23/1000 persons[a]	1.4%[a]	1.0%[a]
Key populations	**2022**		**2018**	**2023**
Gay men and other men who have sex with men	1.7/100 person-years[b]		12%[c]	1.7%[c]
			2014	**2022**
People who inject drugs	1.2/100 person-years[b]		21%[c]	10%[a]
			2021	**2023**
Sex workers	2.2/100 person-years[b]		1.7%[c]	4.2%[c]
			2018	**2023**
Transgender people	0.2/100 person-years[b]		11%[c]	2.2%[a]

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multi-sources estimation. J Acquir Immune Def Syndr. 2024;95(1S):e34–e45 (supplementary materials).

[c] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

Primary HIV prevention programme

Except for naloxone for managing opioid overdoses, all of the HIV prevention services recommended by WHO are available *(3)*. However, prevention service coverage has been decreasing among key populations (Table 13). Since 2015, a key population-led healthcare service model has been used to increase access to and uptake of HIV services. The model involves training lay providers, often peers from key population communities, to deliver a range of HIV and other healthcare services at CSO clinics *(45)*.

Table 13. Coverage of HIV prevention services in Thailand

Coverage and use of HIV prevention services		
Gay men and other men who have sex with men	**2021**	**2023**
Service coverage	50%[a]	36%[a]
Condom use	78%[a]	86%[a]
ART coverage		78%[a]
People who inject drugs	**2020**	**2023**
Service coverage	35%[b]	62%[a]
NSP	9%[b]	
OAMT	9%[a]	3.3[a]
Condom use	40%[a]	33%[a]
ART coverage	43%[a]	77%[a]
Safe injecting	95%[a]	87%[a]
Sex workers	**2021**	**2023**
Service coverage	86%[a]	98%[a] (2024)
Condom use (last paid sex)	95%[a]	95%[a]
ART coverage	9%a (2019)	71%[a] (2024)
Transgender people	**2020**	**2023**
Service coverage	44%[a]	34%[a]
Condom use	79%[a]	80%[a]
ART coverage		75%[a]

[a] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

[b] Global HIV prevention coalition scorecard: Thailand. Geneva: Joint United Nations Programme on HIV/AIDS; 2024.

Condoms, lubricants, needles/syringes, OAMT and PrEP are available at both government and CSO healthcare facilities, though people from key populations seem to prefer accessing the services through CSOs. More than 80% of people who currently use PrEP in Thailand receive it through key population-led health-care services *(46)*. PEP is available free of charge, but only at government hospitals *(47)*. The Ministry of Public Health and CSOs have been seeking ways to improve access to HIV prevention.[28]

[28] The differing views of the Ministry of Public Health and CSOs can be reviewed at: Pengnonyang S, et al. Certification of lay providers to deliver key population-led HIV services in Thailand's national healthcare system: lessons learned. J Int AIDS Soc. 2022;25(7): e25965; Lertpiriyasuwat C, et al. Thailand's commitment to support community-led HIV services. Lancet HIV. 2023;11(3):e141; and Phanuphak N, et al. Response to Thailand's commitment to support community-led HIV services. Lancet HIV. 2024;11(3):e141-e142.

More than 60% of people who inject drugs were receiving HIV prevention services in 2023. Although the use of sterile injecting equipment was reported to be high, it had declined over the previous decade, with the number of sterile needles/syringes distributed per person who injects drugs remaining low. Coverage of OAMT has stagnated at very low levels. A little over one third of gay men and other men who have sex with men were covered by HIV prevention services in 2023, but reported coverage was much higher (almost 100%) among sex workers.

Governance and funding

The health system in Thailand is decentralized, with DSD provided by CSOs (chiefly CBOs and CLOs) at drop-in centres, community health hubs and through community outreach. Virtual interventions managed by CSOs are increasingly available and include online outreach, case management assistance, targeted information and online purchasing of condoms, lubricants, HIV self-test kits and PrEP refills.

In 2016, the National Health Security Office, which is funded by the Government and responsible for financing the universal health coverage programme, began paying CSOs for HIV-related 'reach and recruit' activities through a social contracting mechanism. In 2018, the Ministry of Public Health introduced a certification system for all types of service providers, based on service quality, administration/management skills and personnel capacities, with reassessments done every two to three years *(48)*. Since 2019, lay providers working for CSOs have been able to receive training and certification from the Ministry.[29] Community health workers supporting people living with HIV receive training and certification from the Ratchasuda Institute, at Mahidol University.

The National Health Security Office recently increased its investments in CSOs which implement key population-led delivery models, via social contracting and indirect reimbursements to CSOs that pair with government hospitals. The pairing model allows CSOs to work under in-person or remote professional supervision *(49)*.

A recent review of the key population-led delivery model noted the shift from community engagement to community leadership in the design of the model, as well as the value of the certification element and of integration with the national healthcare system. It also found increased uptake of HIV testing and PrEP among key populations. Donor support is being leveraged to generate data on programme feasibility and impact, which in turn is facilitating high-level policy discussions on how to transition to increased domestic funding and sustainability. The review also noted the importance of building coalitions with multiple domestic and international stakeholders to overcome regulatory and policy barriers *(48)*.

[29] Training includes counselling, sample collection for HIV and STI testing, conducting rapid/point of care tests, and dispensing ART and PrEP as prescribed by a doctor.

Zimbabwe

Combination prevention services are provided by CSOs, including CLOs, to people from key populations at scale throughout the country, at fixed sites and through community outreach. Those services are supported by well-coordinated referral mechanisms to government healthcare facilities. Some are being overseen by health facility monitoring committees. The integration of CSO activities and key population services with the public health system is supported by the national Government, which also allocates domestic resources for social contracting of CSOs. These and other efforts have reduced HIV prevalence and incidence among all key populations and in the overall population.

Epidemiological background

Zimbabwe is experiencing a generalized HIV epidemic, although both HIV incidence and prevalence have been reduced over the past decade (Table 14). HIV incidence and prevalence are especially high among sex workers, but appear to have declined considerably in recent years among gay men and other men who have sex with men, transgender people and people who inject drugs. HIV prevalence among adolescent girls and young women remains a major concern.

Table 14. HIV incidence and prevalence among key populations in Zimbabwe

	HIV incidence		HIV prevalence	
Overall population (15–49 years)	**2015**	**2023**	**2015**	**2024**
	5.1/1000 persons[a]	1.4/1000 persons[a]	15%[a]	9.8%[a]
Key populations	**2022**		**2017**	**2023**
Gay men and other men who have sex with men	0.5/100 person-years[b]		31%[c]	8.1%[c]
			2014	**2023**
People who inject drugs	0.12/100 person-years[b]			5.6%[b]
			2016	**2023**
Sex workers	3.33/100 person-years[b]		59%[c]	40%[c]
			2019	**2023**
Transgender people	0.6/100 person-years[b]		28%[c]	17%[c]

[a] AIDSinfo. Geneva: Joint United Nations Programme on HIV/AIDS (https://aidsinfo.unaids.org/).

[b] Korenromp EL, Sabin K, Stover J, Brown T, Johnson LF, Martin-Hughes R, et al. New HIV infections among key populations and their partners in 2010 and 2022, by world region: a multi-sources estimation. J Acquir Immune Def Syndr. 2024;95(1S):e34–e45 (supplementary materials).

[c] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

Primary HIV prevention programme

Available HIV prevention services include all those recommended by WHO except for needle/syringe programmes, OAMT and naloxone for the management of opioid overdoses *(3)*. Coverage of HIV prevention services for each key population is less than 30%, and it appears to have declined in recent years among both sex workers and gay men and other men who have sex with men (no detailed service data are available for people who inject drugs).

Table 15. Coverage of HIV prevention services in Zimbabwe

Coverage and use of HIV prevention services		
Gay men and other men who have sex with men:	**2019**	**2024**
Service coverage	26%[a]	
Condom use	69%[a]	92%[a]
ART coverage	94%[a]	100%[a] (2021)
People who inject drugs	**2020**	**2022**
Service coverage:		<50%[b]
NSP	nd	
OAMT	nd	
Condom use	nd	
ART coverage	nd	
Safe injecting		
Sex workers		
Service coverage		79%[b]
Condom use	43%[a]	50%[a]
ART coverage	78%[a]	95%[a]
Transgender people	**2019**	**2024**
Service coverage	28%[a]	
Condom use	82%[a]	86%[a]
ART coverage		100

[a] The key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (https://kpatlas.unaids.org/dashboard).

[b] Global HIV prevention coalition scorecard: Zimbabwe. Geneva: Joint United Nations Programme on HIV/AIDS; 2024.

nd: no data.

HIV testing, including confirmatory testing, as well as ART initiation, are available in both public and CSO clinics, as are condoms, lubricants, PrEP and PEP. Demand creation for PrEP among key populations is achieved by CSO peers in the community and at CSO drop-in centres. In addition, CSOs use websites and social media platforms to reach specific groups, especially gay men and other men who have sex with men and transgender women.

Knowledge of PrEP among key population communities is relatively low, but may be increasing *(50, 51)*. Assessment for, and dispensing of, PrEP is accomplished

by nurses who have undergone mandatory training delivered by the Ministry of Health and Child Care using guidelines consistent with WHO recommendations. Many CSO-run services are linked to, or co-located with, government healthcare facilities, which eases access to nurses with PrEP training *(52)*. Awareness of PEP is low and demand is very limited, though services for both occupational and non-occupational exposure are available from doctors at hospitals and healthcare centres. Demand creation efforts are mostly focused on PrEP.

Migration of healthcare workers to neighbouring countries and elsewhere is affecting the delivery of healthcare, including HIV prevention services, throughout the country. Efforts to reduce stigma and discrimination at public healthcare facilities include the piloting of Key Populations Health Facility Monitoring Committees which are integrated into existing Health Centre Committees run by the Ministry of Health and Child Care. They comprise key population representatives, the National AIDS Council, CSOs and other community stakeholders *(53)*.

Progress in introducing harm reduction services for people who inject drugs is limited, due mainly to legislative and regulatory barriers *(54)*. A small needle/syringe programme is planned for the capital, Harare, and further efforts to introduce OAMT are under way, with both services supported by the Global Fund.

Governance and funding

The National AIDS Council coordinates and facilitates the national HIV response and administers the National AIDS Trust Fund, which receives funds from the AIDS Levy.[30] The Government plans to invest 21% of domestic HIV funds in prevention in coming years, with a focus on adolescents and young people and key populations, especially people who use drugs *(55)*. Funding for HIV prevention for key populations has come primarily from external donors, especially PEPFAR and the Global Fund *(56)*.[31][32]

In 2021, policy guidelines were launched for the social contracting of CSOs to deliver services, with HIV combination prevention one of the priority areas. About 30 CSOs are accessing domestic funding through this mechanism. Community-led monitoring was implemented in late 2022 as part of the National Health Strategy 2021–2025 *(57)*; almost 5% of health service delivery sites in 2023 had such a mechanism in place *(55)*. While efforts to scale up HIV prevention programming for key populations continue across the country, more investments in an enabling legal and policy framework are needed for optimal uptake of prevention services among key populations.

[30] The AIDS Levy is a 3% levy that is collected from the taxable income of individuals and companies.

[31] In 2023, the National AIDS Council funded 6% of HIV primary prevention services for sex workers, whereas PEPFAR provided 51% and the Global Fund 30% of the funding for a comprehensive package of HIV primary prevention for sex workers *(55)*.

[32] In 2024, for gay men and other men who have sex with men, 18% of prevention funding came from the Global Fund and 59% from other sources, including PEPFAR *(56)*.

Main funding and service delivery models

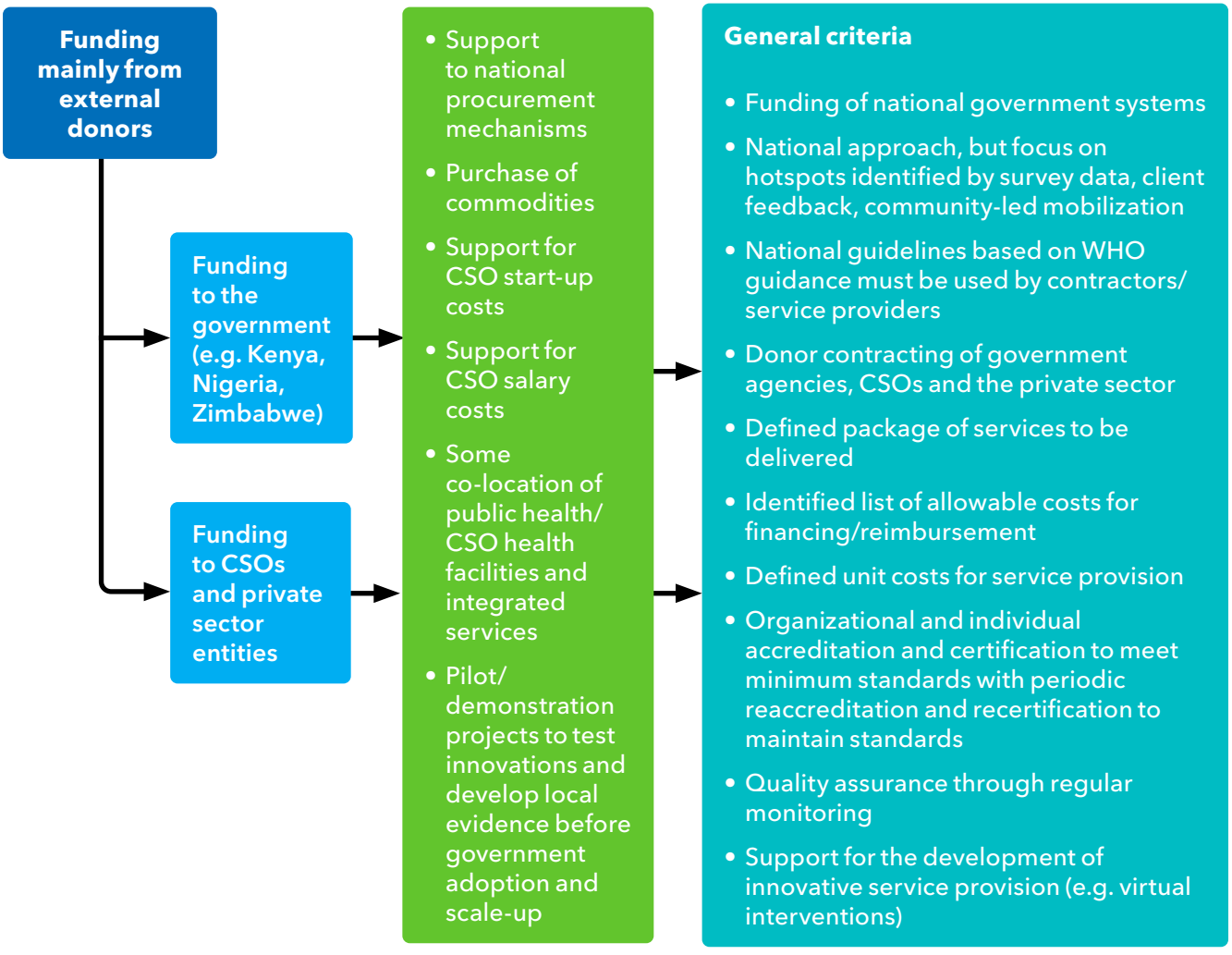
Based on the eight countries that were examined, several common characteristics were identified among the funding models and service delivery typologies that are being used for primary HIV prevention programmes that target key populations. These models are not entirely distinct or mutually exclusive and, consequently, have several overlapping features.

Main funding models

Funding Model 1

Funding Model 1 is characterized by a heavy reliance on external donor funding to support primary HIV prevention services for key populations. In this model, donor funding is channelled primarily to the government and/or CSOs and less frequently to private sector actors (**Figure 2**). Examples of countries using this model include Kenya, Nigeria and Zimbabwe.

Figure 2. Funding Model 1: funded mainly by external donors



While some dedicated domestic resources may also be allocated in Funding Model 1, the amounts tend to be limited in comparison to funds provided by external donors. Domestic funding for the HIV response that is *not* specific to HIV prevention services for people from key populations was not considered under this model.

In this model, donor funding tends to go directly to government agencies, most commonly to the Ministry of Health. Support is often focused on strengthening capacity and operations, such as for the national procurement mechanism for the purchase of primary HIV prevention commodities (including ARVs for PrEP and PEP). In some countries, such as Nigeria, procurement of HIV prevention commodities for both government and CSO service providers is undertaken by donors or as a collaborative effort between government, donor and CSO representatives on behalf of the national programme.

Donor-led pooled procurement may be more cost effective in the short term, with higher procurement volumes typically leading to substantially lower prices. However, in the medium to long term, capacity building of national staff and systems is vital so that future procurement becomes sustainable without direct donor assistance.

Donor funding may also: support capacity building and operations; the purchasing of commodities and equipment; logistics for assisted referrals between CSOs and public hospitals or clinics; start-up costs; staff salaries, including topping up salaries to attract and retain competent individuals in CSOs and sometimes in the public sector/government; and/or international management and technical assistance staff costs. External donor support is sometimes also used to pilot innovative health interventions, prior to the government adopting the intervention for possible scale-up.

In addition, CSOs may receive funding directly from external donors, as grants or contracts, to deliver HIV prevention services in specified areas for specific key population groups. CSOs and CLOs are particularly important where government primary healthcare facilities are underfunded and/or staff lack specialized training for primary HIV prevention for key populations, such as in Kenya.

Some countries, Thailand among them, were initially highly dependent on external donor support for primary HIV prevention services for key populations, but then transitioned to more sustainable approaches, such as those described under Funding Model 2.

Funding Model 2

Funding Model 2 is characterized by high use of domestic funding to support primary HIV prevention services for people from key populations. Under this model, national governments allocate domestic resources to a semi-autonomous agency which administers a funding mechanism for disbursement of resources to entities

responsible for service delivery, with established linkages and referrals to public services. Examples of countries using this model include the Republic of Moldova, the Philippines and Thailand. External donors may also fund selected service providers, targeted interventions or innovations. For example, in the Philippines, donor funding has facilitated the introduction of virtual services and novel approaches to PrEP delivery among key populations.

In broad terms, semi-autonomous funding agencies use one of three mechanisms.

Model 2a

Funding Model 2a involves the *pre-purchasing*, in bulk, of services and their delivery through the issuing of *contracts* (e.g. in the Republic of Moldova, the National Health Insurance Company manages the process), or the issuing of *grants* by a national authority to municipalities which then provide grants to CSOs to deliver services in communities.

Typically, a tender or a request for quotations is issued by the semi-autonomous agency for the provision of a specified package of services in certain areas. Entities that meet the eligibility criteria can submit proposals or bids. Using pre-set criteria, a selection committee decides which bids will be selected. A contract is then created between the semi-autonomous agency and the selected bidder to provide the services. Service delivery is monitored by the semi-autonomous agency in collaboration with the Ministry of Health.

In the Republic of Moldova, for example, an open tender is issued annually for the provision of specified services in specific areas of the country, with unit costs predetermined by a semi-autonomous funding agency. Any entity registered in the country can submit a proposal covering one of more geographical area and key population communities. A key requirement is the ability of the bidding entity to work in partnership with the public health sector at community level. Bidders also need to provide evidence of mechanisms to monitor service delivery standards and, increasingly, the quality of services. Contracts are usually for a limited period (e.g. one year). The lowest-cost proposals that meet the criteria are most likely to be successful.

Model 2b

In **Funding Model 2b**, a semi-autonomous agency *reimburses* health service providers for specified services, commodities and medicines, akin to a health insurance company. CSOs and the private sector can enrol with the semi-autonomous agency if they meet certain criteria (which can include minimum standards for healthcare facilities and staff), as is the case in the Philippines and Thailand. In the Philippines, PhilHealth reimburses government entities and CSOs for delivering specified services. In Thailand, CSOs are required to be linked to existing government healthcare facilities that provide oversight of the standards and quality

of service delivery. Efforts are under way to allow CSOs to deal directly with the country's National Health Security Office through accreditation and certification of their staff and systems. In both the Philippines and Thailand, larger CSOs have developed ways to streamline the processes.

Since it can take time for reimbursements to occur (it can take six-to-nine months for a CSO to be reimbursed by PhilHealth), CSOs may need other income streams to cover rent and staff costs while awaiting reimbursement. Many CSOs also operate as social enterprises or solicit low-interest loans from high-net-worth individuals. Start-up funding is often needed to cover initial outlays on commodities and medicines.

Funding Model 2b can also involve funding delivery of healthcare services through the *social security contributions* of individuals in formal employment; such services may only be available to individuals who pay into social security schemes. The services provided under this model are available at designated healthcare facilities. Typically, medical staff who provide the services receive specialized training from CSOs to make the service key population friendly. In some cases, CSO staff may be integrated in service delivery.

Funding Model 3

In **Funding Model 3**, only domestic resources are used to fund primary HIV prevention services for people from key populations.

In Australia, federal and state Governments share funding of the overall healthcare system and have separate and joint responsibilities for meeting the healthcare needs of populations in their jurisdictions. The federal Government has the main responsibility for primary care, while state-level departments of health focus on public health *(63)*. Strategic plans to respond to HIV and other communicable diseases exist at both the state and federal levels. Primary prevention of HIV is delivered through public healthcare services and primary, with each department of health having a budget for its HIV response which it can allocate to a wide range of activities.

Departments of health may also *contract* CSOs to deliver HIV prevention and related services for people from key populations (as in **Funding Model 2a**) to fill gaps in servicethe availability of services in a geographicgeographical area, or as an adjunct to government-run primary healthcare facilities. Examples include supervised drug consumption rooms in Sydney and Melbourne, and harm reduction services in Western Australia. Similarly, in the private sector, general practitioners providing primary HIV prevention services for key populations are subsidized with domestic government funding. Budgets for specific HIV activities, such as sexual health clinics, are available in the form of reimbursements (similar to **Funding Model 2b**).

In addition, non-earmarked funding is available, based on needs that are determined by local authorities, though such funding is not necessarily allocated to HIV prevention services for people from key populations. The procurement of commodities and medicines is often pooled to reduce unit costs.

In Brazil, the process is slightly different in that the central Ministry of Health provides funding to provinces for the delivery of specified services. Each province then negotiates with the respective municipalities under its jurisdiction, after which the funds are allocated. In addition to public health agencies, CSOs and other entities in each municipality negotiate with the respective administration to secure funds for service delivery.

While **Funding Models 2 and 3** share some features, the main difference is the degree of government responsibility for the provision of funding and the delegation of decision-making and operationalization of domestic funds to a semi-autonomous entity, akin to a health insurance company. Another difference is that no external funding is present in **Model 3**, whereas **Model 2** (and its variants) involves some degree of external funding that supplements domestic funding.

Figure 3. Funding Model 2: significant funding from domestic resources

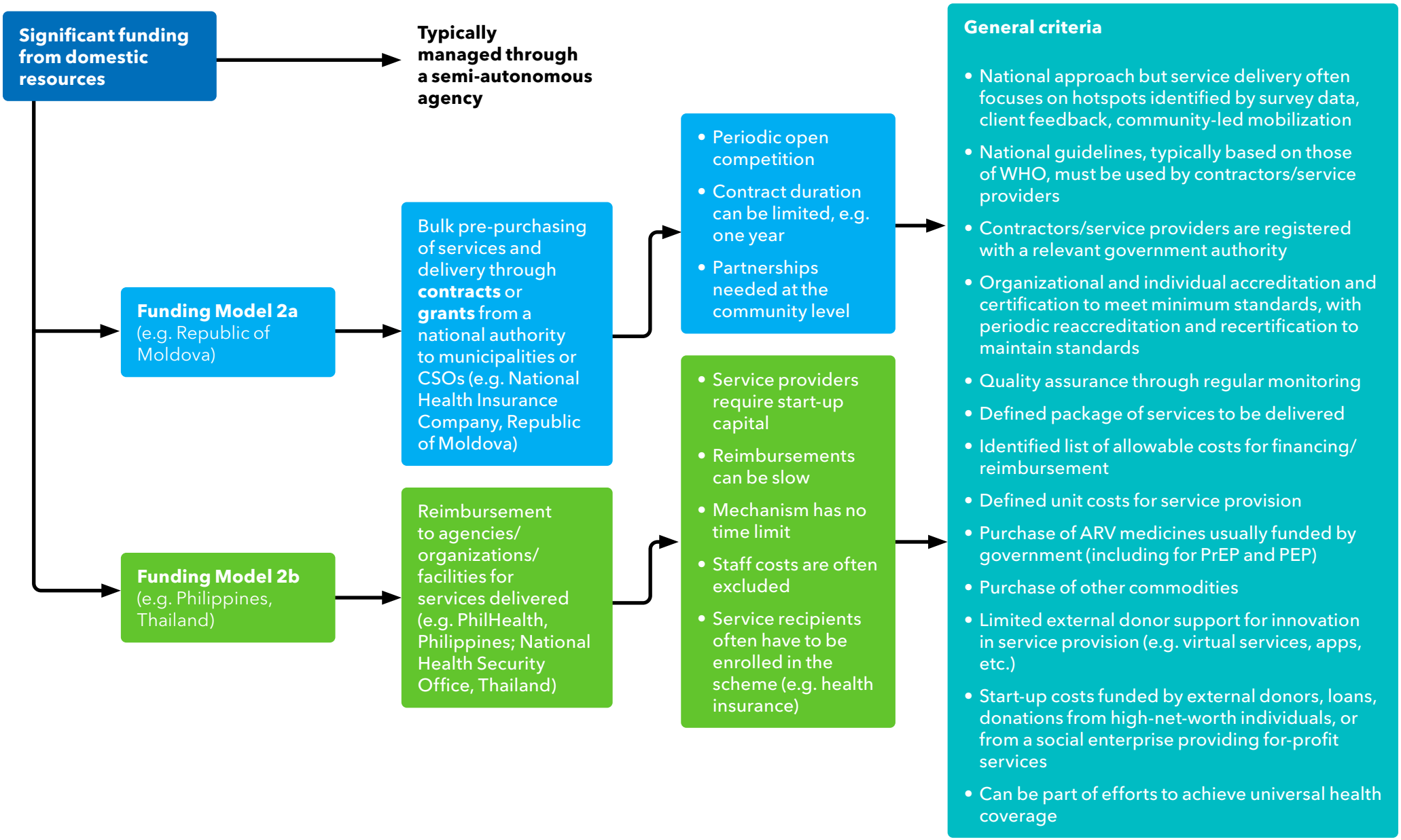
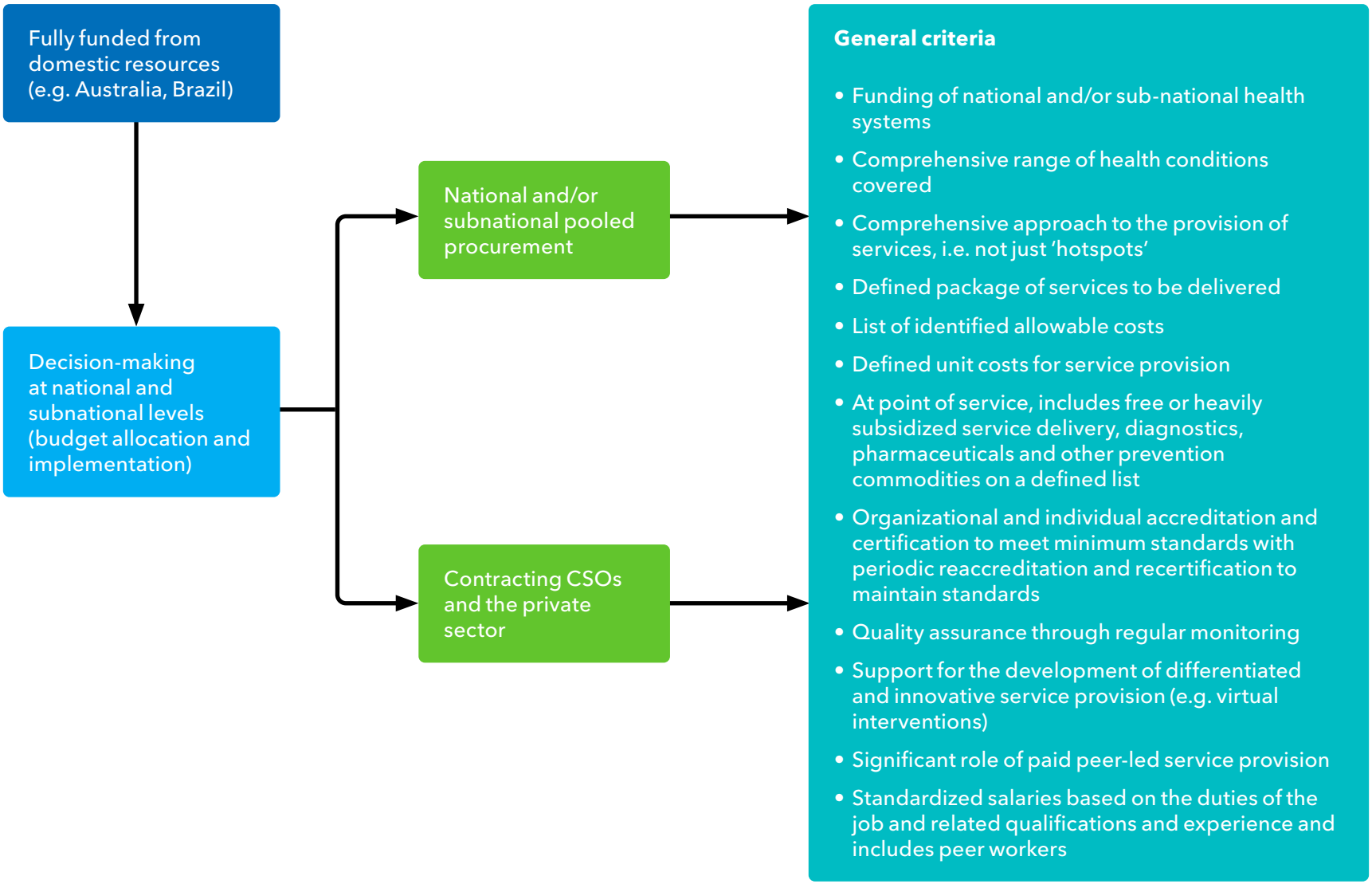


Figure 4. Funding Model 3: fully funded from domestic resources



Main service delivery typologies

The main primary HIV prevention service delivery typologies for people from key populations are outlined in Figure 5.

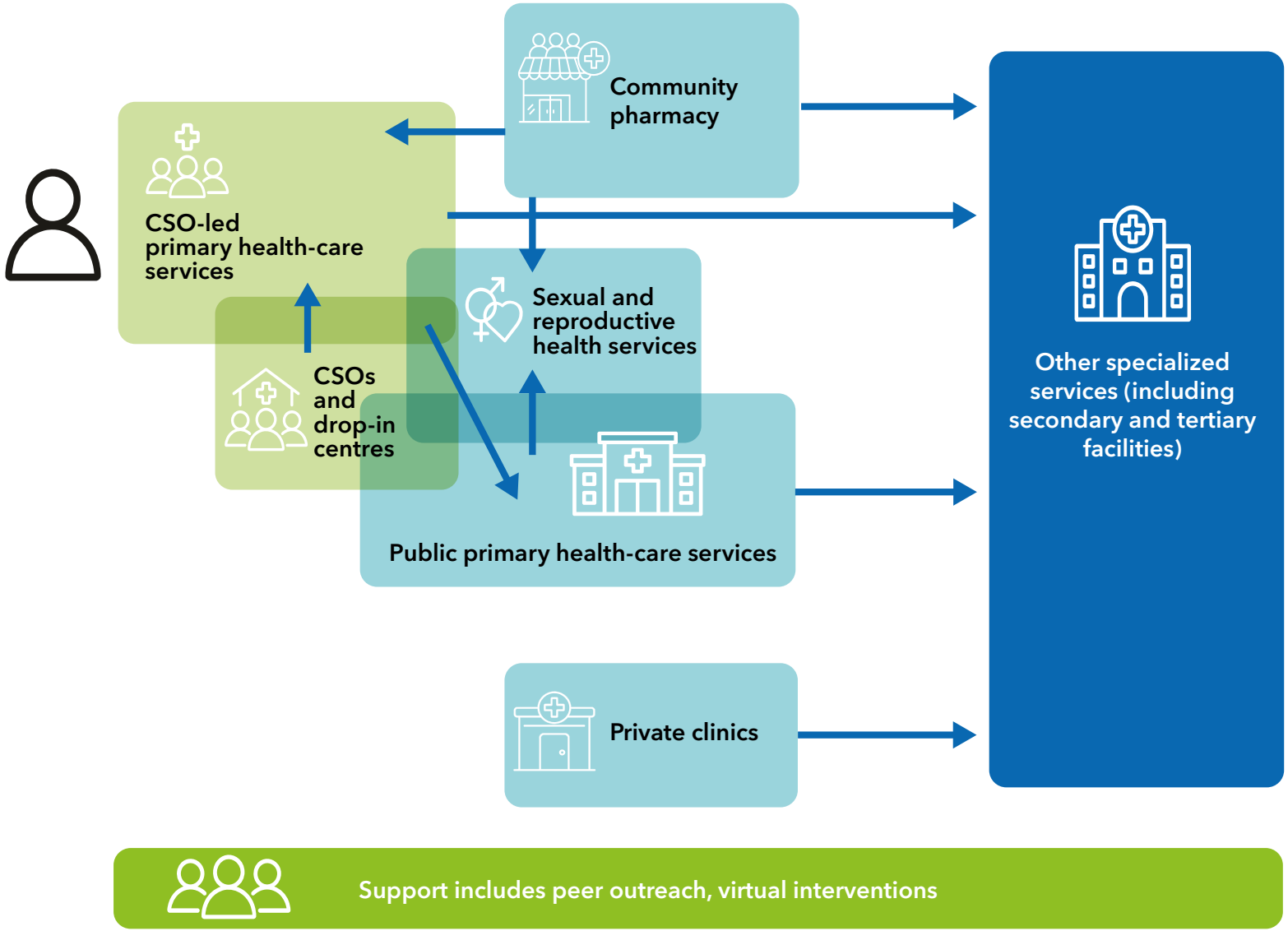


Figure 5. Service delivery typologies for HIV prevention for members of key populations (overlapping boxes indicate co-location; arrows refer to potential referral pathways; not all scenarios are shown)

These typologies describe the main components of primary HIV prevention service delivery for people from key populations in the surveyed countries. However, not every component is present in every country.

Public, community-based primary healthcare facilities are most prevalent and serve all sectors of a community in a defined catchment area. These facilities tend to be mainly or entirely funded by domestic resources. However, they are often not key population friendly, and fears or experiences of stigma and discrimination may deter members of key populations from using them. When people from key populations do attend these facilities, concerns about confidentiality, stigma and discrimination may limit their ability to fully utilize the available services. Financial barriers may further influence health-seeking behaviours, for example when informal fees are charged even though services are nominally free.

Across the various funding models, public, community-based primary healthcare facilities may receive increased funding to provide services for people from key populations as rates of use rise. Increasing the accessibility, acceptability and use of those facilities for key populations requires targeted capacity building. The latter includes specialized training of healthcare providers and auxiliary staff, such as security and reception staff, alongside continuous monitoring and accountability mechanisms. Engaging key population peers as staff can also foster more key population-friendly environments.

Primary healthcare facilities of CSOs are typically staffed by healthcare workers who are contracted by governments (and/or external donors) and then hired and trained by CSOs with clearly defined minimum standards and quality of care requirements. A subset of CSO primary healthcare facilities is operated by CLOs, with staff drawn primarily from key population communities.

A key distinction between public and CSO primary healthcare facilities is the training of staff and ongoing service monitoring to ensure that services are safe, acceptable, key population friendly and of high quality. While CSO-led facilities do not necessarily employ staff who belong to key population communities, their service delivery models typically place greater emphasis on responsiveness to people, alongside the provision of broader primary healthcare services.

When people from key populations require support that is beyond the scope of public or CSO primary healthcare facilities, referrals to secondary or tertiary hospitals are required. Referrals can be challenging in contexts of criminalization, stigma and discrimination unless the referral pathways are supported and facilitated by trained peers from key population communities. Funding of specialized care and treatment can also be a challenge if people lack health insurance that covers the required services. In general, access tends to be more assured in countries where healthcare services are fully funded from domestic resources (Funding Model 3), including through health insurance, though gaps persist.

There can be an overlap between services provided by CSOs and government-run primary healthcare facilities—such as in Zimbabwe, where many CSO healthcare sites are located next to or near government-run clinics *(52)*—though this also allows for easier and more convenient referrals. Overlapping public and CSO primary healthcare services are particularly effective when staff of a government facility include trained individuals from key population communities (e.g. in Brazil, Nigeria and some countries of Asia) who can facilitate patient pathways.

Sexual and reproductive health services can be delivered as stand-alone services or at public or CSO primary healthcare facilities. However, people from key populations who seek those services often face the same barriers that hinder their use of other health interventions. As a result, the services are generally provided as an integrated component of broader HIV prevention and health interventions, through service providers that are either community-led or that have developed key population-friendly approaches (e.g. in Brazil, the Philippines and Thailand).

Under **Funding Model 1** (primarily funded by external donors), donors may allocate resources to support improvements in the quality and availability of sexual and reproductive health services, including making them key population friendly (e.g. in Kenya, Nigeria and Zimbabwe). With **Funding Model 2** (funded primarily by domestic resources), the services can be part of a package of contracted or reimbursable services (e.g. in the Philippines and Thailand). In **Funding Model 3** (fully funded from domestic resources), the services are often integrated with other services, or they benefit from state funding for specific clinics (e.g. in Australia).

In many communities, there is a strong link between community pharmacies and primary healthcare facilities and sexual and reproductive health services. Community pharmacies can play important roles in all primary HIV prevention service delivery typologies. Pharmacies providing sexual and reproductive health services can increase access, acceptability and convenience for individuals. As shown in studies, it is important to train pharmacy staff to work with people from key populations for the effective provision of HIV prevention services, including PrEP, non-prescription needles and syringes, and naloxone for the management of opioid overdoses *(59, 60)*.

Private healthcare services are a further option, but fee payments can be a significant barrier. People with sufficient resources may prefer to use private services that offer greater confidentiality and privacy.

CLOs are particularly suited for serving the needs of people from key populations, as staff are drawn from those communities (e.g. in Nigeria and Thailand) *(61, 62)*. Peer-led services tend to show greater concern for people's problems, privacy, confidentiality and rights. The effectiveness of CLOs is recognized in the 2021 Political Declaration on HIV and AIDS, which specifies that CLOs should deliver 80% of HIV prevention services for populations at high risk of HIV infection, including for women within those populations by 2025 *(6)*.

Photo: UNAIDS Cambodia/2019/Todd Brown

Drop-in centres run by CSOs, especially CLOs, provide basic support for the provision of primary HIV prevention services, especially commodities. Such centres are usually linked to CSO run or key population-friendly primary healthcare facilities (e.g. in Nigeria, the Philippines and Thailand). Drop-in centres or CSO primary healthcare facilities often serve as platforms for outreach, including mobile outreach, into key population communities to provide regular and convenient services across multiple locations *(63–68)*. Such services are especially prominent in countries where primary HIV prevention is funded mainly by external donors (**Funding Model 1**); they are less common where funding is mainly from domestic resources (**Funding Model 2**), e.g. in the Philippines and Thailand. Under **Funding Model 3** (fully funded from domestic resources), drop-in centres and outreach activities tend to be part of a package of services that is financed with grants or other contractual arrangements between the government and CSOs.

The use of virtual interventions is increasingly common. They include phone-based options (e.g. voice calls and text messages) and internet-based possibilities (e.g. messenger apps, social media, chatbots, online marketing and advertising platforms, and websites). Virtual case management can support DSD models such as community- or home-based services, including PrEP initiation and refills, through virtual consultations and support, automated or provider-led client reminders, and chatbots. Online consultations, virtual outreach through websites with targeted messaging, social media and smartphone applications offer anonymity as well as opportunities to reach people at times and locations of their choosing. However, these approaches require that individuals have suitable electronic devices and access to the internet.

Key findings

Common features of funding and service delivery models

1. **Enabling environments.** Primary HIV prevention services are more available and accessible for people from key populations in countries that have a supportive legislative and policy environment, or where there is a flexible approach at local/community level that allows the services to be provided without significant interference from government authorities, including law enforcement agencies. Accessibility and utilization of the services are affected by the levels of stigma and discrimination which individuals experience when interacting with facility staff (healthcare professionals and administrative and security staff). Government mandated actions that target specific key populations can inhibit or prevent organizations from providing services and lead to those populations avoiding the services.

2. **Stigma and discrimination**. A variety of approaches to key population-friendly public health facilities (whether run by government healthcare staff with support from CSO counterparts, or vice versa) have proved effective for attracting people from key populations. These approaches generally are associated with much lower levels of stigma and discrimination towards people from key populations.

3. **Registration and/or accreditation.** As with other aspects of the HIV response and the broader provision of health services, registration and/or accreditation of HIV prevention service delivery organizations—both public sector and CSOs—and their staff with a relevant government agency (e.g. the Ministry of Health) is usually required. However, registration and/or accreditation of CSOs can be a barrier in countries where there is criminalization and/or significant stigma or discrimination towards key populations and/or where the services being provided are discouraged or considered illegal.

4. **Maintaining minimum standards.** Accredited entities are required to maintain minimum standards in order to retain accreditation and funding. This includes operational audits, individual training and examinations, and the integration or regular provision of data to national reporting systems.

5 **Use of evidence-based good practices/guidelines.** HIV prevention services for people from key populations are often based on guidance from WHO and/or evidence-based best practices to support quality and safety.

6 **Basic service package**. A minimum package of services for funding is defined and is usually tailored for key populations. Staff salaries may be excluded or funded separately.

7 **Costings.** Unit costs for services and/or commodities are often agreed in advance. Since the actual costs may change over time (typically increasing), reimbursement from the funding agency can result in a deficit for the service delivery organization. This can compromise sustainability. Allowing contracted organizations to access the government's pooled procurement mechanism for commodities, including medicines, can avoid that risk and can support improved integration and sustainability.

8 **Data collection and sharing**. Data collection and sharing between governments and CSOs, as part of national health information systems, is a challenge in many countries, especially when it comes to the inclusion of data from CLOs. Accurate data are vital for understanding the realities and HIV-related needs of key populations and the extent to which those needs are being met. While significant progress has been made on community-led monitoring, the limited availability and the heterogeneity of data for key populations hinder precise estimates for key population programming and monitoring. There is much to be gained from ensuring that routine data are available to, and within, national HIV strategic information systems to guide HIV prevention for people from key populations.

9 **Scaling up service availability.** The decentralization of decision-making from national level to provincial, municipal and community levels can help ensure that primary HIV prevention services meet the needs of key population communities. Health services that are accessible to key populations tend to be concentrated in urban areas, leaving rural and remote areas underserved. Small pilot projects have been used (e.g. in Kenya, Nigeria and Zimbabwe) to demonstrate the viability of HIV services for people from key populations and have led to the scaling-up of such services.

10 **Differentiated service delivery.** A variety of service locations and types, providers and service packages are used to complement traditional service models to better meet the needs of people from key populations for primary HIV prevention. Several countries are using a variable mix of community-based and/or community-led models to supplement traditional facility-based models. Virtual interventions are increasingly available and

used, providing increased confidentiality (and potentially anonymity) and convenience for individuals. They can also support service efficiencies.

However, virtual interventions cannot replace fundamental components of HIV prevention, such as health workforces, financing, leadership and governance, and access to essential commodities. To be effective and ethical, all DSD models, including virtual interventions, require trust and strong community engagement, protection for service users and providers, confidentiality, and other safeguards. They also require ongoing capacity building for service providers and funding for hosting and regularly updating the services so they reflect new information and guidance *(66–68)*.

Kampus Liberty Uganda, Kampala, 25 October 2019.
Photo: UNAIDS/E.Museruka

Government use of semi-autonomous agencies for increased, sustainable domestic funding of services

The use of semi-autonomous agencies to fund primary HIV prevention services for people from key populations can support sustainable scale-up (see **Funding Model 2** in the previous chapter). These agencies receive and allocate domestic funds from the central government to entities that provide HIV prevention services

for key populations. In some cases, the agencies act as a health insurance company (e.g. the National Health Insurance Company in the Republic of Moldova, PhilHealth in the Philippines, and the National Health Security Office in Thailand).

Risks of relying on external donor support

Except for **Funding Model 3**, all the funding models identified in this report rely on external donor support to some extent. Both the Global Fund and PEPFAR have provided vital support for primary HIV prevention services for people from key populations in most of the countries reviewed in the report, especially for staff salaries and for managing innovative service delivery mechanisms for HIV prevention. The sudden freeze of much of the United States Government's HIV funding through PEPFAR in early 2025 significantly disrupted both government and community-led HIV prevention efforts in many countries, highlighting the risk of dependency on external donors *(69)*.

Crucial roles of civil society organizations in HIV service provision for people from key populations and benefits for the public primary healthcare sector

CSOs, especially key population-led organizations, play crucial roles in making HIV services accessible to people from key populations. These CSOs are linked to, co-located with, or integrated into the public primary healthcare infrastructure and systems in some of the countries reviewed in this report. In Thailand, for example, doing so is a requirement to receive government funding, while in Brazil and Nigeria, CSOs bridge access to mainstream health services. Physical and virtual outreach activities can be highly effective when performed by peers from target communities and linked with assisted referrals (involving 'peer navigators') to help individuals navigate complicated or unfamiliar systems (e.g. in Australia).

Good practices for sustainable and scalable primary HIV prevention programmes for people from key populations

The following good practices can guide countries as they move towards achieving sustainable and scalable primary HIV prevention programmes for people from key populations.

Sustainability of the HIV prevention response will require governments to invest more domestic resources in primary HIV prevention programmes, including for people from key populations

Volatile and decreasing funding for HIV underscores the risk of relying on external donors to finance primary HIV prevention programmes. There is a strong economic and social case for greater domestic investment in prevention to prevent new HIV infections and avert future costs of treatment and care. It is also evident that CSOs, especially CLOs, are highly effective for reaching people from key populations and engaging them in HIV prevention *(62, 65, 70–73)*.

However, in addition to the PEPFAR freeze in 2025, many other external donors have signaled an intention to reduce contributions to HIV responses. Yet it is also widely acknowledged that rapid and large increases in domestic funding for HIV programmes will be difficult to achieve for many low- and middle-income countries and that gradual transitions are needed *(69)*. Nonetheless, in the current global health funding landscape, governments need to prioritize the use of domestic resources to fund HIV prevention programmes, with a focus on interventions that serve people from key populations and that make best use of the expertise and capacity of CLOs.

External partners can assist governments to establish sustainable domestic funding mechanisms

Given the global health funding landscape, it is important for donors, the United Nations and other technical entities to advocate for, and provide, technical assistance to governments to establish and manage domestic funding mechanisms through health insurance entities for the delivery of primary prevention services for key populations. That support should form an integral part of detailed, costed and realistic plans for countries to transition from donor to domestic funding.

Governments can choose the sustainable funding models that suit their economic and policy environments

Governments can choose among different options to allocate domestic funds to primary HIV prevention for people from key populations according to their context. **Funding Model 2**, for example, involves the creation or use of a semi-autonomous agency that receives funds from the central government (e.g. in the Republic of Moldova, the Philippines and Thailand) and then either issues contracts to designated service providers or reimburses them for service delivery. There are also additional, temporary funding opportunities which governments can consider in collaboration with CSOs, including *(73, 74)*:

- Social contracting (including social health insurance reimbursement schemes),
- Social enterprises and earned income,
- Equity investment (impact investment),
- Impact bonds (impact investment),
- Loans and bonds (impact investment),
- Individual donations (especially from high-net-worth individuals),
- Corporate funding,
- Foundation funding, and
- Crowdfunding,

Domestic resource mobilization and innovative procurement mechanisms, such as pooled procurement and social contracting, are critical for achieving greater national self-reliance in health financing and service delivery *(69)*. Social contracting—a legal mechanism whereby a government entity can commission CSOs to deliver health and other services—is already being used in some countries and shows significant returns on investment *(75, 76)*. Several low- and middle-income countries have been generating useful lessons for transitioning from donor funding. Those lessons emphasize the value of robust investment cases for primary HIV prevention, strengthened advocacy, operational support for integration efforts and strong political will *(77)*.

Proactive engagement with government agencies can identify opportunities for sustainable and scalable HIV prevention approaches

CSOs engaging directly with relevant government agencies to identify opportunities for accessing domestic funding for HIV prevention services for key populations has been an effective approach in some settings. This can include briefing key decision-makers on approaches used in other countries, particularly those with

similar governance structures and socioeconomic profiles, as well as on available non-traditional funding approaches.

In addition, CSOs can develop detailed costings, including salaries, for the delivery of HIV prevention services for key populations, for use in negotiations with government departments to establish allowable and unit costs for future contracting or reimbursement.

Integration of CSO services with government primary healthcare infrastructure and services can reduce costs and increase access

Effective referral systems between public and CSO-led HIV prevention services can enhance access for people from key populations. The integration of CSO services into existing public primary healthcare infrastructure and systems, including referral mechanisms and pooled procurement systems, can also increase services access and uptake, as well as reduce infrastructure and operational costs. These approaches work best when they closely involve trained and accredited CSO staff who are from or linked to key populations.

Service efficiencies and cost savings can support the further scale-up of services, based on feedback and other input from communities of key populations.

Revised policies can facilitate DSD to increase uptake of primary HIV prevention services, including PrEP and PEP

A useful practice in some settings has been the revision of policies and guidelines, where needed, to support DSD options. That includes the use of community-based sites and virtual interventions, as well as shifting tasks to peers and community-based pharmacists who can increase access to, and use of, primary HIV prevention services by people from key populations while maintaining service quality standards. Virtual interventions, for example, can provide greater confidentiality and convenience while lowering costs, improving reach and maintaining quality *(66)*. Seizing those opportunities requires ongoing efforts to bring about and protect enabling environments, including having regulatory arrangements that allow CLOs to operate, receive funding and provide clearly defined services.

Government and CSO collaboration can establish appropriate costs for sustainable HIV prevention services for key populations

An effective practice in some settings has been collaboration between governments and CSOs to identify, negotiate and standardize allowable and unit costs for HIV prevention services for key populations. That can help ensure that price inflation is reflected in multiyear contracting or reimbursement arrangements with CSOs. Nationally operated pooling of procurement is being used successfully (e.g. in Australia and Nigeria) to reduce individual unit costs.

The arrangements should also consider the salaries of staff who are hired by CSOs to deliver services, costs which often are omitted from government contracting or reimbursement mechanisms *(78)*. For a more sustainable approach, CSOs and governments should work together to align remuneration for CSO and public sector staff with *equivalent* job responsibilities and technical skills (as seen, for example, in the Australia-wide Social, Community, Home Care and Disability Services Industry Award). This could also help reduce the loss of talent from the public sector to NGOs and the private sector due to large salary disparities.

Revisions to legislation and policies can enhance primary HIV prevention access and use

An enabling practice has been the revision of legislation and policies to facilitate access for people from key populations to health services broadly, and to HIV prevention services specifically. As needed, they can engage with relevant stakeholders to protect HIV prevention service providers against potential prosecution for delivering HIV prevention interventions that may be considered to violate existing laws, for example regarding drug use, sex work and same-sex relations.

Alejandra Fang (middle), defender of the TLGBIQ+ community in Peru.

Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CBO	community-based organization
CDC	United States Centers for Disease Control and Prevention
CLO	community-led organization
CSO	civil society organization
GPC	Global HIV Prevention Coalition
NGO	nongovernmental organization
OAMT	opioid agonist maintenance therapy
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PhilHealth	Philippine Health Insurance Corporation
PrEP	pre-exposure prophylaxis
STI	sexually transmitted infection
TB	tuberculosis
USAID	United States Agency for International Development
WHO	World Health Organization

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