

Join us for the 12<sup>th</sup> GPC KP COP

# Sustainable and Scalable Primary Prevention Programmes for Key Populations



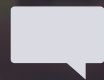
Thursday, 3<sup>rd</sup> July 2025



**Session 1:** 11h00 – 12h30 GMT+2 | **Session 2:** 16h00 – 17h30 GMT+2



**Countries Examples From:** Australia, Thailand, Zimbabwe, Brazil, Nigeria, Moldova










English, French, Portuguese, Spanish, Russian




Register here: [Session 1](#) | [Session 2](#)

# AGENDA | Sustainable and Scalable Primary Prevention Programmes for Key Populations

1	<b>Opening remarks:</b> Welcome and meeting objectives	Heather-Marie Ann Schmidt, GPC & WHO	
2	<b>Global evidence:</b> Analysis and evaluation of the evidence for scalable and sustainable HIV prevention service delivery models for key populations	Antons Mozalevskis, WHO	
3	<b>Sustainability roadmap:</b> Update on the sustainability roadmap and the inclusion of HIV prevention and key population programming	Iris Semini, UNAIDS	
4	<b>Country examples:</b> Sustainable and scalable models of HIV programming in Australia, Thailand, and Zimbabwe	<ul style="list-style-type: none"><li>• <b>Australia:</b> Phillip Read</li><li>• <b>Thailand</b> Surang Janyam</li><li>• <b>Zimbabwe:</b> Humphrey Ndondo</li></ul>	
5	<b>Community perspectives:</b> Community perspectives and recommendations on the topic	Ahmed Said, AfricaNPUD	
6	<b>Panel discussion:</b> Responses to questions from the audience	Heather-Marie Ann Schmidt, GPC & WHO	
7	<b>Closure:</b> Summary of actions and next steps	Heather-Marie Ann Schmidt, GPC & WHO	

# 1 | Opening remarks

Heather-Marie Ann Schmidt, GPC &   
WHO

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# 2 | Global evidence

Antons Mozalevskis, WHO 

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

## **Dr Heather-Marie Schmidt**

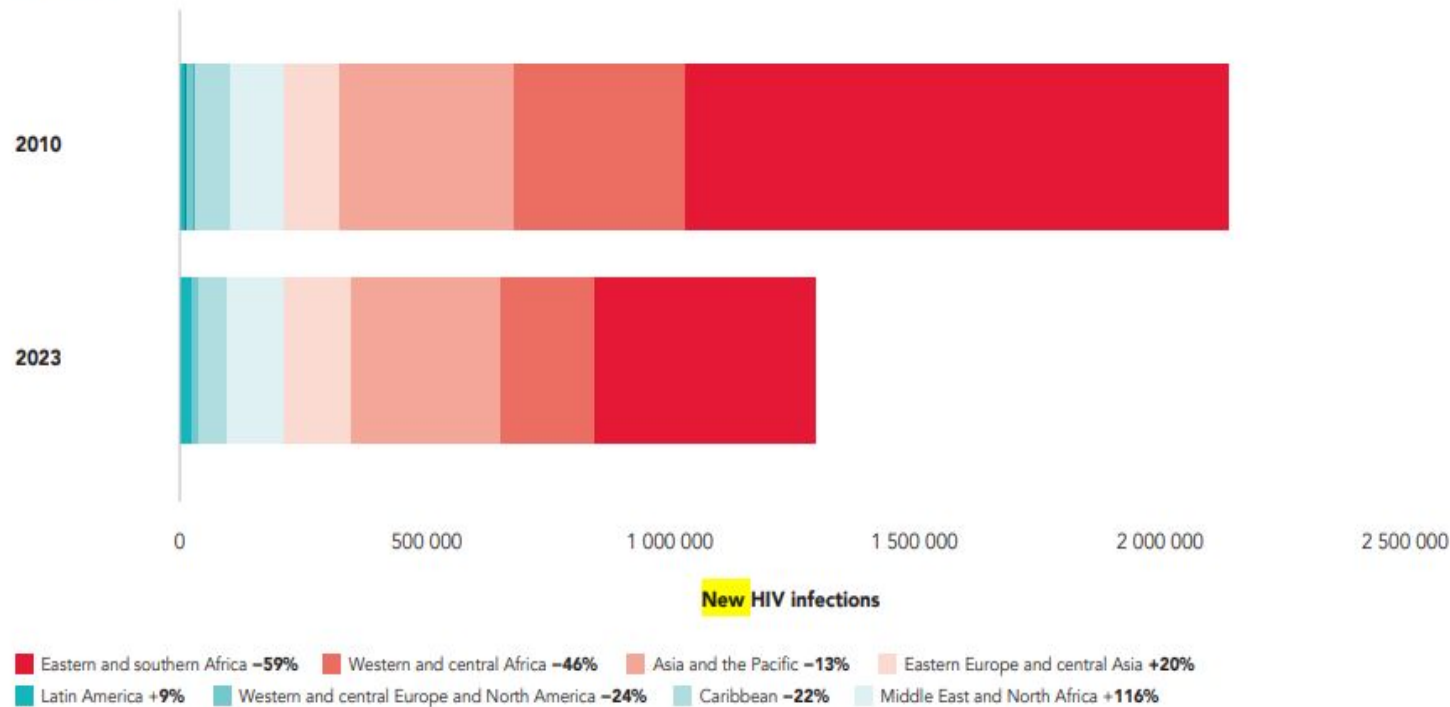
*Advisor – HIV Prevention Programme Implementation*  
Global HIV Prevention Coalition Secretariat, UNAIDS and  
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[schmidh@unaids.org](mailto:schmidh@unaids.org)

## **Dr Antons Mozalevskis**

*Technical Officer – Key Populations*  
WHO, Geneva  
[mozalevskisa@who.int](mailto:mozalevskisa@who.int)

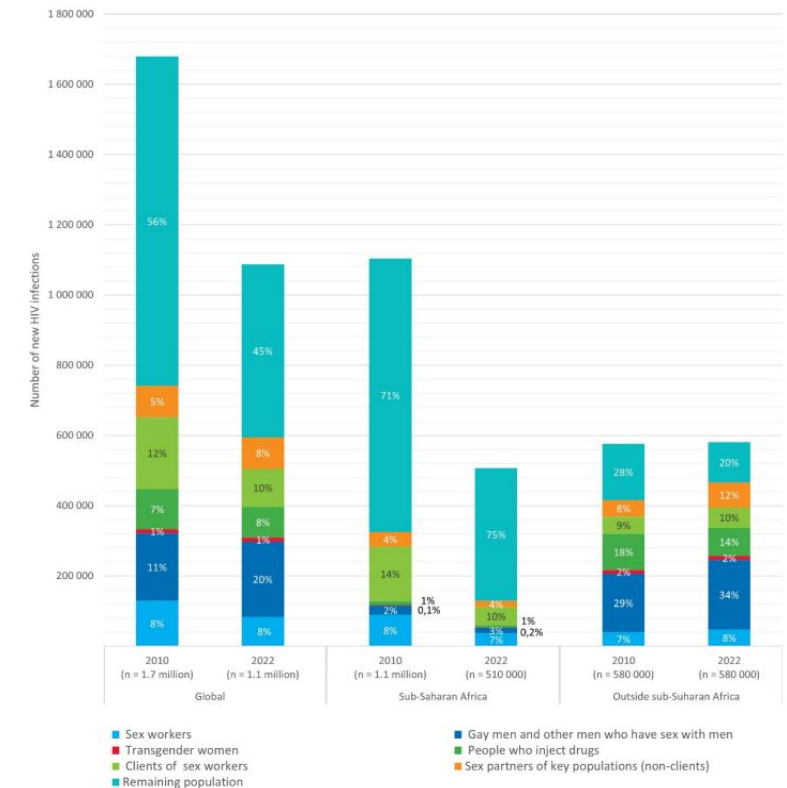
# Why sustainable and scalable key populations prevention programmes matter now?

There were an estimated **1.3 million new HIV infections** globally in 2023, unchanged from 2022 and more than **three times the 2025 target**. 55% of new HIV infections occur among key populations and their partners.



Source: UNAIDS epidemiological estimates, 2024 (<https://aidsinfo.unaids.org/>).

Figure 2. Distribution of adult new HIV infections, global and by region, 2010 and 2022



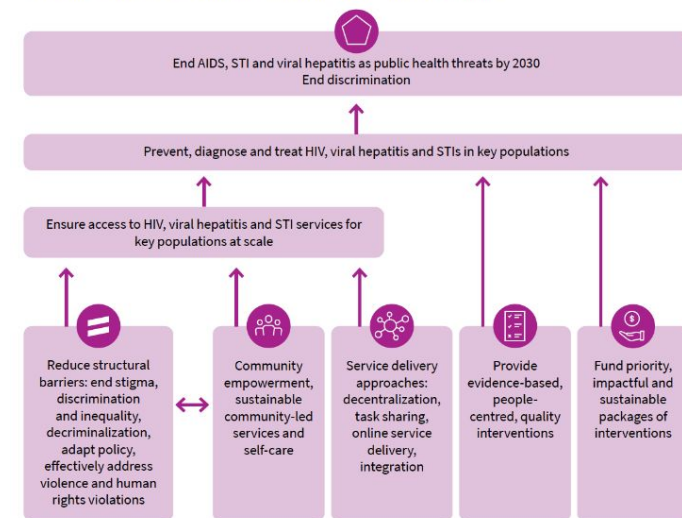
Source: Korenromp E, Sabin K, Stover J, et al. New HIV Infections Among Key Populations and Their Partners in 2010 and 2022, by World Region: A Multisources Estimation. JAIDS Journal of Acquired Immune Deficiency Syndromes. 2024;95(1S):e34–e45.

# Why sustainable and scalable key populations prevention programmes matter now?

- Key barriers include: underfunding, stigma and criminalization, and fragmented services.
- Funding cuts have had a profound impact on HIV prevention programs among key populations.
- Effective models that are sustainable and delivered at scale are essential for long-term impact and ensuring key populations are not left behind.



Fig. 2. Theory of change: addressing HIV, viral hepatitis and STIs in key populations

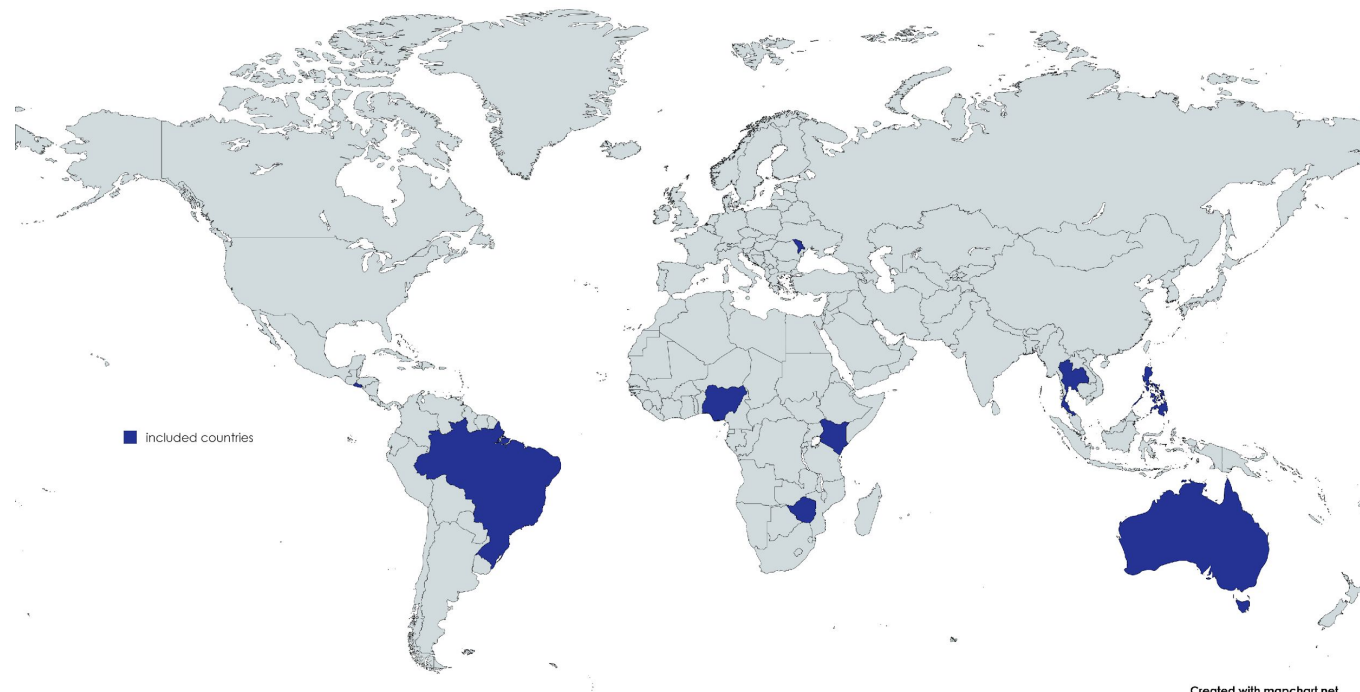


# Methodology overview

- Objectives: Analyze examples of scalable and sustainable HIV prevention service delivery models for people from key populations, and identify important features and lessons learned
- Desk review + global call for case studies (250+ informants contacted)
- Criteria: Sustainability, scalability, service quality and coverage, innovation, programs for: Gay men and other men who have sex with men; transgender people; sex workers; people who inject drugs

# Methodology overview

- Deep dive into 9 countries across regions and income levels
  - Collection of qualitative and quantitative data
- Stakeholder validation and standardized country case write-ups

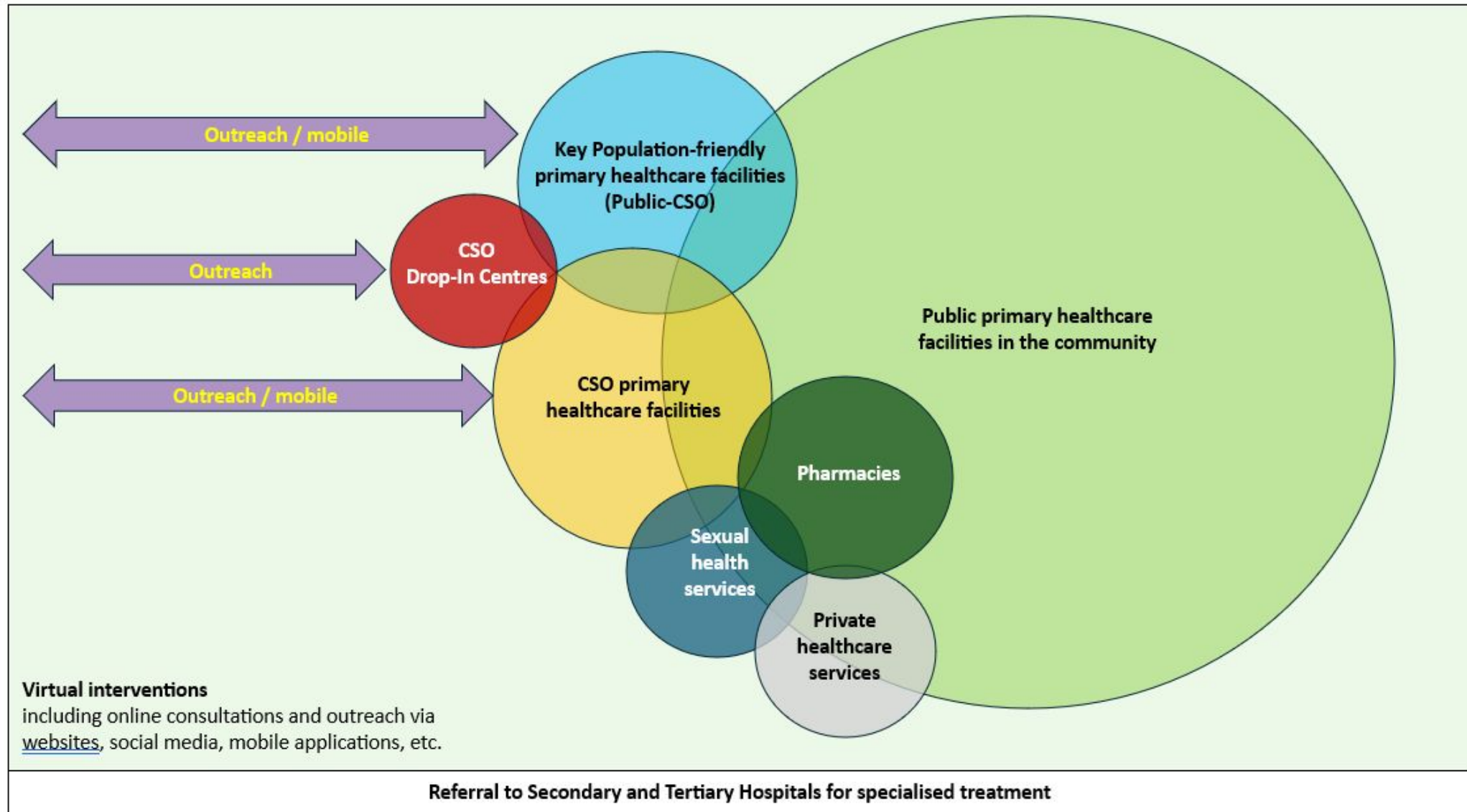


*Note: review was undertaken before January 2025*

# Three overarching funding models identified for HIV prevention among key populations

- **Model 1:** Mainly donor-funded; may provide direct or indirect support to service providers (public, private and/or CSO); often donor-supported procurement (e.g. Kenya, Nigeria, Zimbabwe)
- **Model 2:** Significant domestic funding; often (but not always) managed through a semi-autonomous agency (e.g. Republic of Moldova, Brazil, Thailand, El Salvador, Philippines)
  - For example: bulk procurement of services by governments, reimbursement to CSOs via national insurance agencies, social security funded services at specific facilities
- **Model 3:** Fully domestically funded; registered service providers (public, private and/or CSO) may be reimbursed and/or contracted (e.g. Australia)

# Service delivery typologies



# Common features of sustainable & scalable models

Common features are on a continuum, but there is currently no **perfect** model.

- Domestic financing and national ownership
- Integration into primary healthcare and social insurance
- Enabling legal/policy environments
- Community-led and person-centred services across all models are vital
  - CSOs are trusted, embedded in communities, innovative, require adequate funding
- Use of differentiated service delivery (DSD)
  - Variety of models: outreach, drop-in centres, fixed clinics, mobile clinics, pharmacies and vending machines
  - Co-location and/or strong linkages of CSO and public services
  - Task sharing, peer-led navigation and secondary distribution (e.g. HIVST kits)
  - Innovations including virtual interventions: apps, chatbots, telemedicine, e-prescriptions

# Lessons learned and way forward

- 1. Prioritize domestic financing for prevention in HIV sustainability planning**
  - Global Fund and PEPFAR have played a significant role in funding HIV prevention services for key populations, especially staff salaries within CSOs.
- 2. Establish or strengthen evidence-based mechanisms that have propensity for sustainability and scalability to include HIV prevention**
  - For example: social contracting, national program / national health insurance reimbursement, and/or pooled procurement.
- 3. Institutionalize CSOs and peers within the health system e.g. task-shifting and peer provider certification**
  - Engage communities in planning and delivery
  - Undertake necessary legal and policy reform
  - Invest in community-led monitoring and capacity
- 4. Leverage real-world evidence to inform country and investments, and to advocate for integration, innovation and scale-up**
- 5. Remember: there is no “one-size-fits-all” approach**

# WHO statement on potential global threat to people living with HIV

العربية 中文 Français Русский Español

28 January 2025 | Statement | Reading time: 1 min (375 words)

The World Health Organization (WHO) expresses deep concern about the implications of the immediate funding pa... to life-savin... with HIV at

A funding h... death and u... prolonged, taking the v... the United :  
For the glot... in scientific... innovative c...  
We call on t... HIV treatm...  
**PEPFAR**  
The United... global HIV r... a direct imp... treatment.

## Media Contacts



## Protecting key populations from abrupt disruptions to essential HIV services

27 February 2025 | Departmental update | Reading time: 2 min (621 words)

Prevention, testing and treatment services for HIV, viral hepatitis and sexually transmitted infections (STI) have driven unprecedented progress in improving population health over the past two decades, with millions of new HIV infections and AIDS-related deaths averted.

Foreign aid investments in the global HIV response, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund on AIDS, TB and Malaria, have been pivotal to this success, along



### Drastic cuts to global health funding will leave millions without essential HIV and STI services

#ZERODISCRIMINATION



UNAIDS Impact of US funding cuts on the global AIDS response

## Estimating the Potential Impact of HIV Response Disruptions

LATEST UPDATES

05 JUNE 2025

"We want to build a future where everyone—regardless of gender, health status, or identity—can live...  
READ MORE

29 MAY 2025

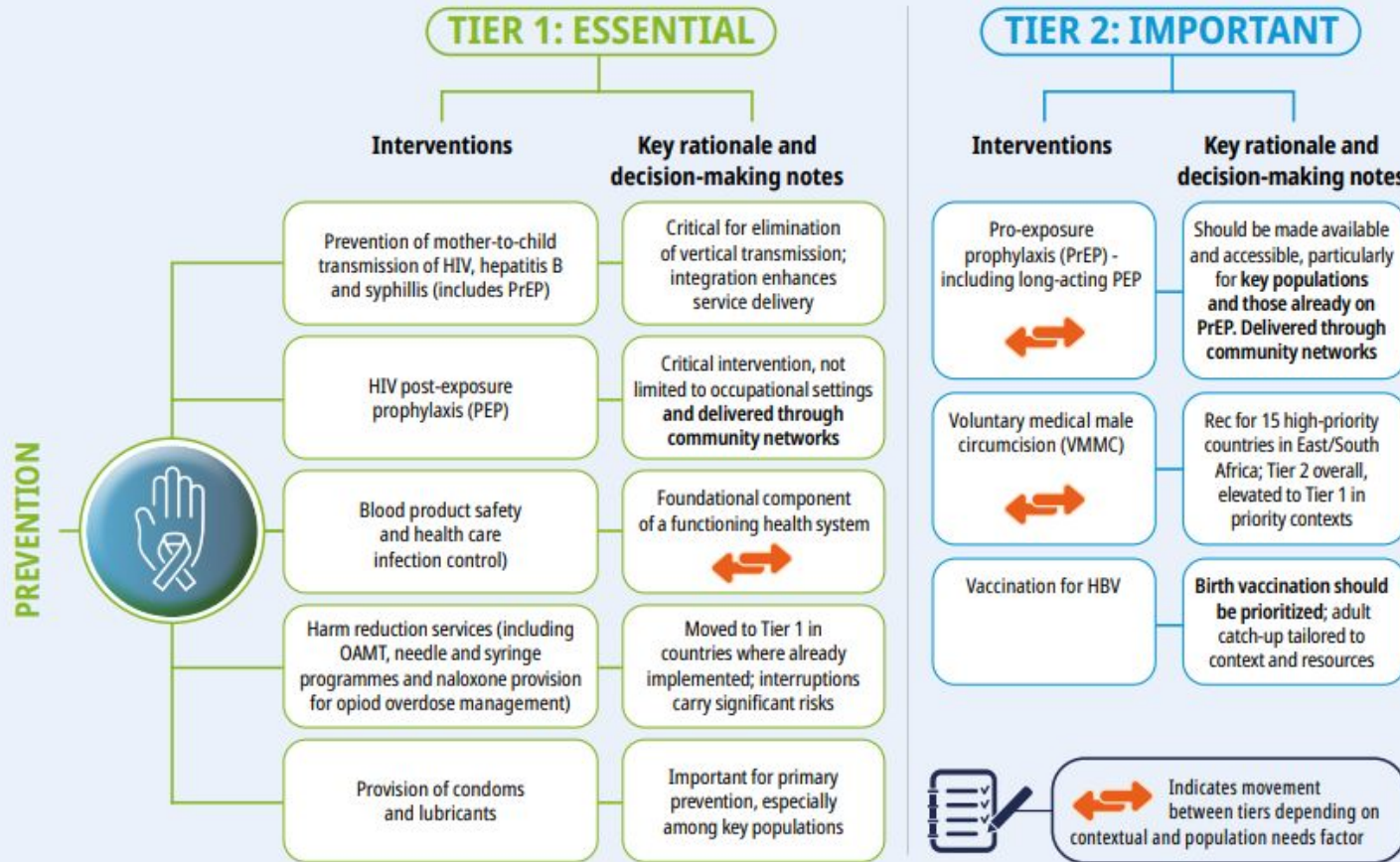
"If funding is not restored or replaced, our progress will be lost" - UNAIDS Country Director in...  
READ MORE

# Adapting to abrupt reductions in donor funding

- HIV prevention for key populations is disproportionately affected by sudden cuts in donor funding.
- CSO-led services often rely heavily on external support, especially in low- and middle-income countries.
- Reduced funding jeopardizes access to PrEP, harm reduction, peer navigation, and community-based services.
- Immediate adaptation is needed through:
  - Domestic resource mobilization and inclusion in health insurance schemes
  - Emergency transition plans to maintain critical services
  - Greater support from multilateral partners for short-term gaps
  - Advocacy to protect and prioritize KP services in national budgets
- Now more than ever, we must invest in resilient, country-owned systems.

# New guidance from WHO on prioritisation

Fig. 6. Prevention: Results from the rapid global assessment exercise



**Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: operational guidance**

Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes

World Health Organization  
Updated June 2025

# Thank you!

Thank you to **Graham Shaw** who led this work on behalf of the GPC.

Thank you to the contributors from Australia, Brazil, El Salvador, Kenya, Nigeria, Philippines, Thailand and Zimbabwe, UNAIDS country and regional offices, and global communities and partners who contributed to the data collection, and to the working group who oversaw it. Thank you to the Gates Foundation for funding the GPC.

Thanks also to the **UNAIDS Prevention and Global Prevention Coalition Secretariat team** and to the **WHO HHS Testing, Prevention, and Populations team** for contributions to this presentation.

**NEW Global Prevention Coalition Resource Hub:**

<https://hivpreventioncoalition.unaids.org/>

**WHO's global work on key populations:**

<https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/prevention/pre-exposure-prophylaxis>



# 3 | Sustainability roadmap

Iris Semini, UNAIDS 

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# Sustainable and Scalable Programmes for Key Populations

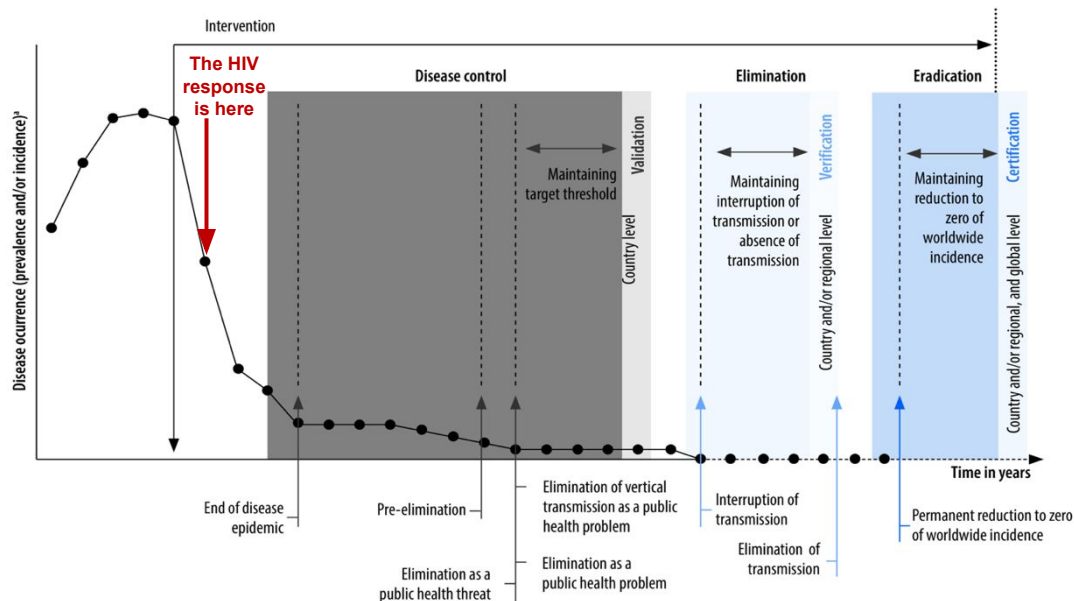
## *The HIV Response Sustainability Roadmaps*

Iris Semini (UNAIDS)

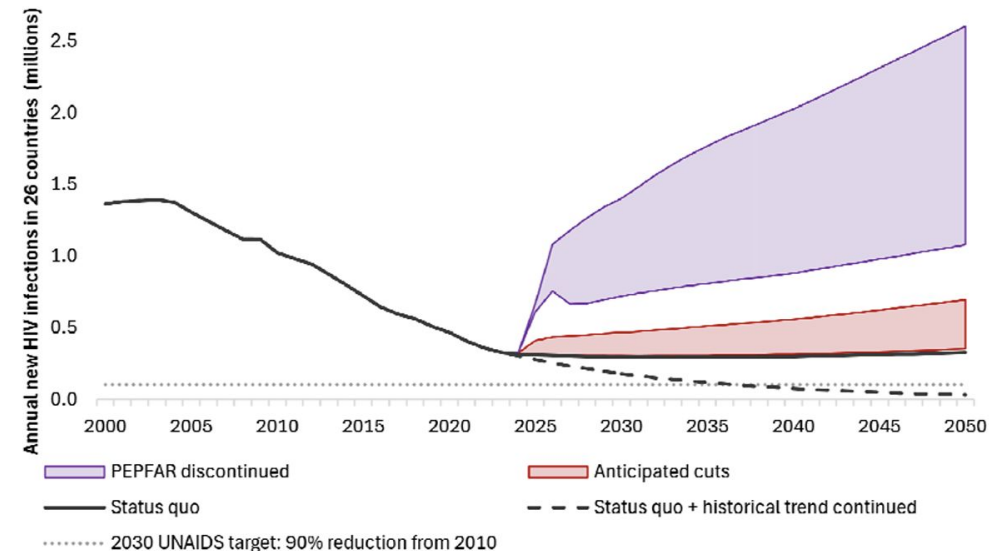
Gemma Oberth (Consultant)

# Context

- New Global AIDS Strategy, Targets to get us to 2030, Sustaining HIV response impact by and beyond 2030
- Estimates project a growing number of people living with HIV until 2039, all of whom will require life-long treatment (Carter et al., 2024)
- Recent changes to the global HIV funding landscape require accelerated **prioritization, optimisation, sustainability and transition planning**

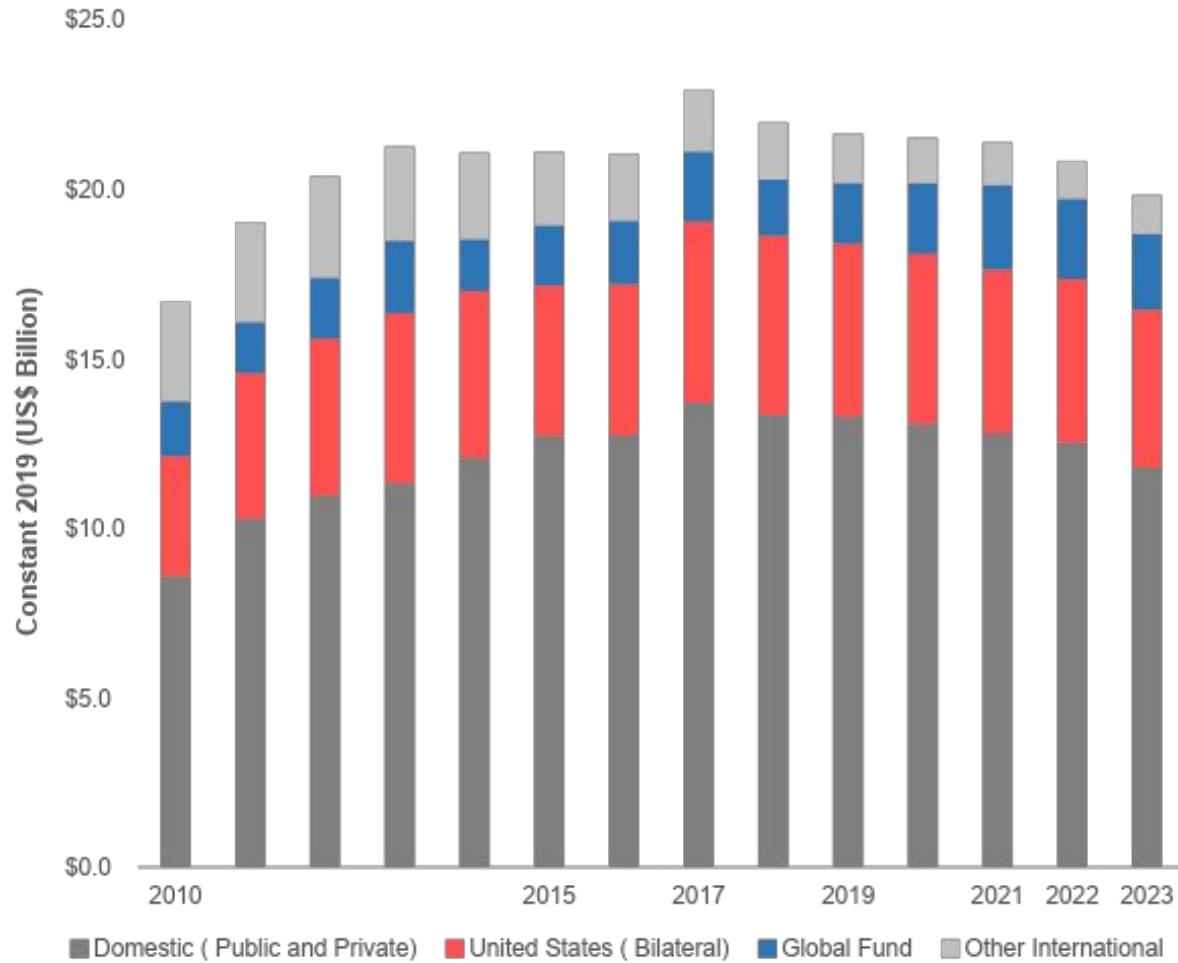


**FIGURE 1.** Time horizon for HIV eradication and estimated position on epidemic curve (Source: Khawar et al., 2023)

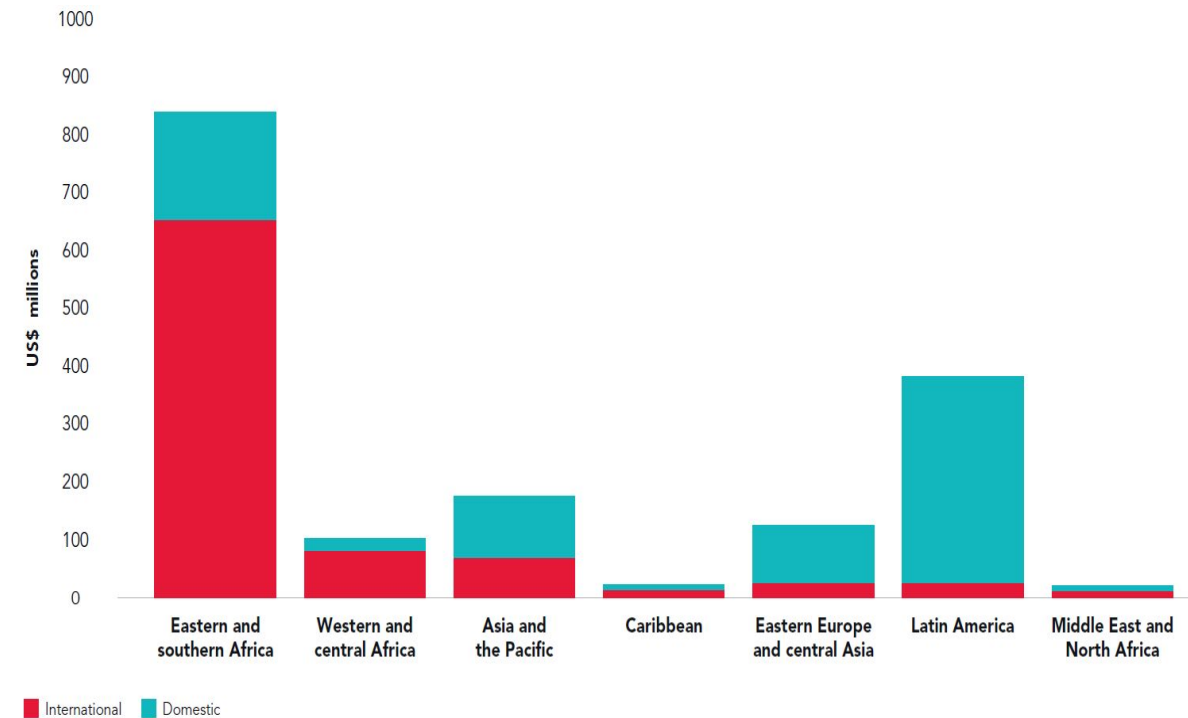


**FIGURE 2.** Projected impact of HIV program funding cuts in 26 countries from 2000 to 2050, on new HIV infections (ten Brink et al., 2025)

# Resource availability for the HIV responsibility in low-middle income countries, 2000-2023

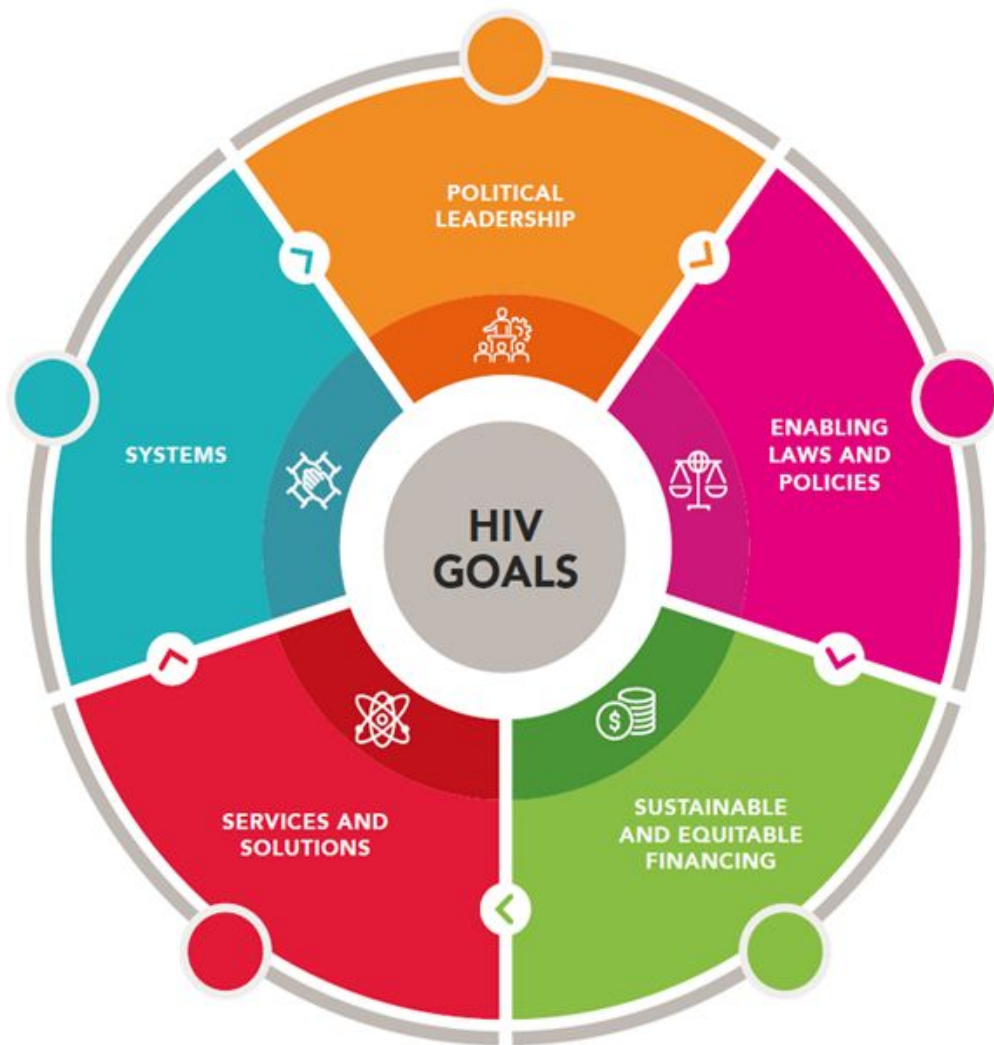


## Amount and source of HIV prevention spending, 2023



Source: UNAIDS financial estimates, July 2024 (<http://hivfinancial.unaids.org/hivfinancialdashboards.html>).

# HIV response sustainability



- **Holistic framework** to sustain impact of a transformed HIV Response by and beyond 2030
- **Five Domains** to guide identifying transformations required to sustain impact
  - Sustained VL Suppression
  - Prevent, detect and respond to new HIV infections
  - End or reduce inequities and inequalities that drive the HIV epidemic
- Sustainability approach starts by **knowing your epidemic**
- **Country-led**, participatory with communities and people living with HIV at the center of design and implementation
- **All countries** engage in sustainability discussions – transformations take time and resources

# HIV response sustainability roadmaps: From vision to results

## Phase 2: Sustainability Assessment

- Data-backed current state assessment
- Future state delineated
- Identify high-level outcomes



## Phase 4: Roadmap Part B – Create a Transformation Plan

- Strategies
- M&E plan w/milestones, benchmarks, & indicators
- Quality management plan
- Timeline and responsibilities
- Risk mitigation plan

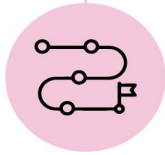
Roadmap Part B finalized



## Phase 3: Design Roadmap Part A

- Prioritize high-level outcomes
- Identify pathways of change
- Begin to discuss how to sustain progress beyond 2030

Roadmap Part A finalized



## Phase 5: Implement and Monitor

- Implementation of Roadmap
- Program data
- QA/QI recommendations
- Updated Roadmap



## Phase 1: Plan/Adapt the sustainability journey: Country engagement

- Country leadership: Technical working group on HIV Response Sustainability
- Sustainability Dialogue: Goal, vision, Roadmap timeline



**Country-led Roadmaps:** Outline concrete, quantifiable plan for programmatic and financial sustainability to sustain impact

**Part A:** Country's visions, Political Commitment, High-Level Outcomes for five domains to achieve and sustain impact by and beyond 2030



**Part B:** Prioritized, two and five-year benchmarks, Evidence-driven two year costed Transformation Plan translating commitments into

Actions to transition from donor funding, advance policies, programmes, and systems sustainability

Mechanisms, functions, response components that will transition to fully national ownership

**Integrated financing framework:** increasing domestic financing, aligning donor investments (e.g. GF, PEPFAR)

# HIV response sustainability roadmaps: From vision to results

- 30+ countries engaged in developing the SRM Part A (UNAIDS, WHO, PEPFAR and partners' support)
- HIV SRM Part A integrated into national multi-disease requests (e.g. Ethiopia, Nigeria)
- 15 countries have (so far) requested support to develop Part B

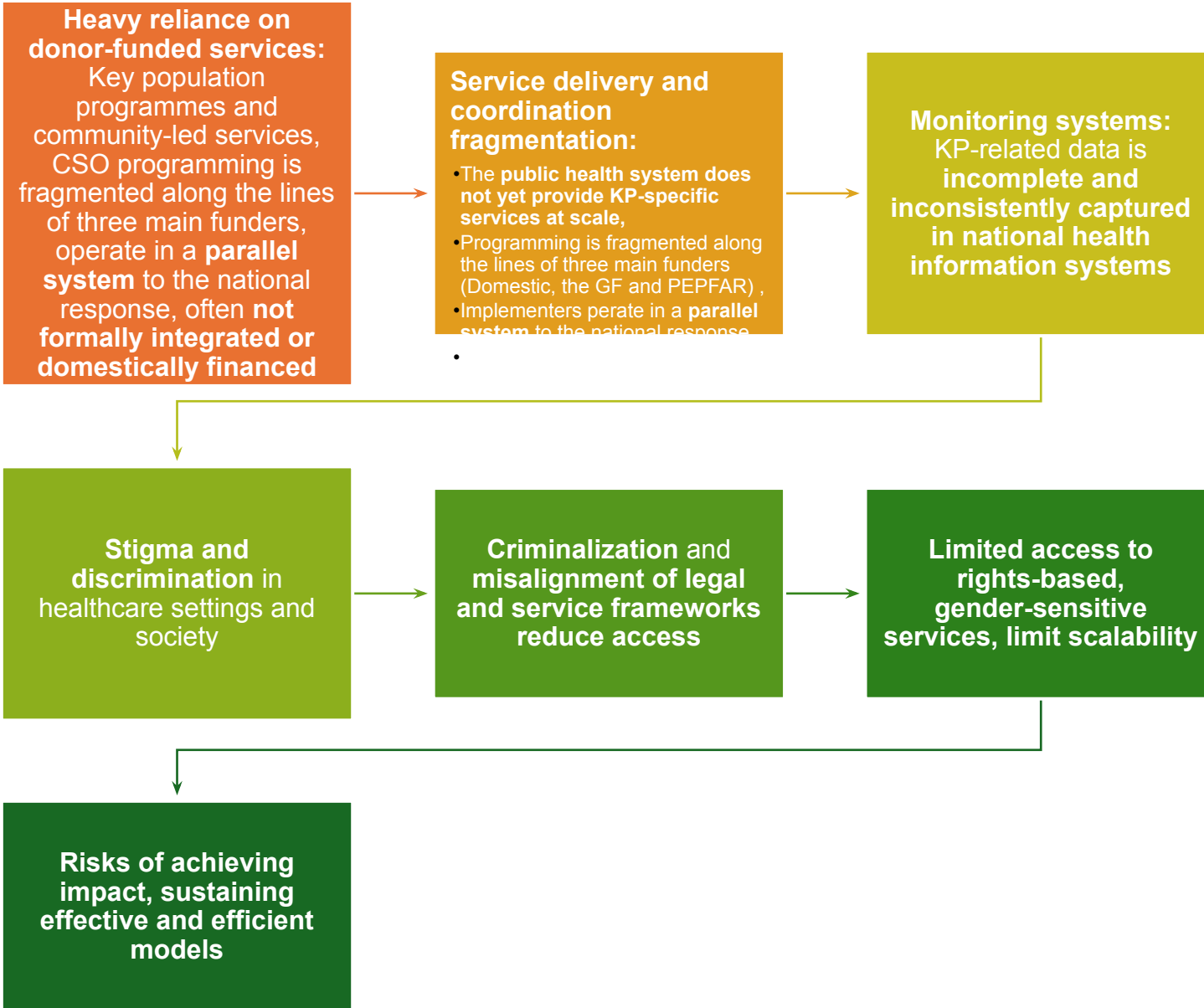
## All SRMs Part A:

- Reinvigorated Political Leadership, vision of the HIV response sustainability
- Achieve and Sustain epidemic control: HLOs and pathways for governance, programme sustainability, multisectoriality
- Domestic financing targets and strategies for their journey to self-reliance
- Community involvement and social contracting
- **Centrality of key populations in the national HIV response** (including in countries that have reached 95-95-95)
- **Key populations: priority groups** requiring tailored interventions that are at a **critical intersection** of sustainability and risk
- Indicate (not limited to) targeted programs like:
  - Peer-led education and service delivery; Condom distribution
  - PrEP and PEP access; harm reduction for PWID
  - Voluntary medical male circumcision (VMMC)

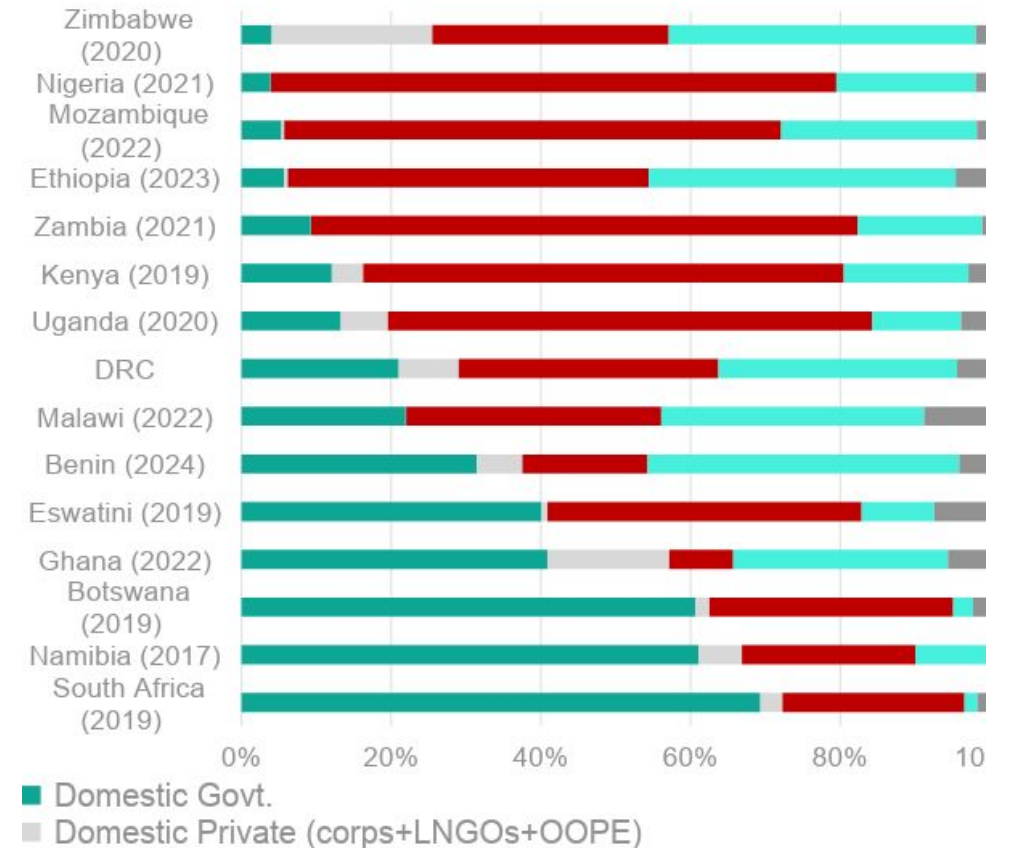
TABLE 1. Country-led Progress Developing National HIV Sustainability Roadmaps

Countries with an endorsed Roadmap Part A by December 2024	Countries with a draft with a completed sustainability assessment and/or Roadmap Part A
▶ Botswana	▶ Benin
▶ Cambodia	▶ Cameroon
▶ Eswatini	▶ DRC
▶ Ghana	▶ Dominican Republic
▶ Kenya	▶ Senegal
▶ Lesotho	▶ Belarus
▶ Namibia	▶ Burkina Faso
▶ Malawi	▶ Burundi
▶ South Africa	▶ Cote d'Ivoire
▶ Tajikistan	▶ Indonesia
▶ Tanzania	▶ Liberia
▶ Togo	▶ Mali
▶ Uganda	▶ Nepal
▶ Viet Nam	▶ Mozambique
▶ Zambia	▶ Rwanda
▶ Zanzibar	▶ Sierra Leone
▶ Zimbabwe	▶ Thaila

# Review of risks and challenges related to key populations programmes



## National AIDS Spending in Africa - % financing contribution



# Roadmaps strategies to sustain key populations programmes and impact



**Social contracting:** mechanisms to institutionalize public financing of CSO-led key population services



**Increased KP representation:** HIV and health decision-making and accountability platforms, inclusive planning and implementation



**Dedicated budget line/Government allocations:** for KP-focused interventions within national health financing,



**Institutionalize KP programming:** within national HIV planning and budgeting processes



**Strengthen KP-specific data and M&E systems:** disaggregation and size estimation, surveillance



Scale up **human rights and stigma-reduction initiatives**

Stigma-free environments

Rights-based and inclusive service delivery

Gender equitable norms

Expanded social protection for KPs

Promote equity-driven financing and governance reforms.

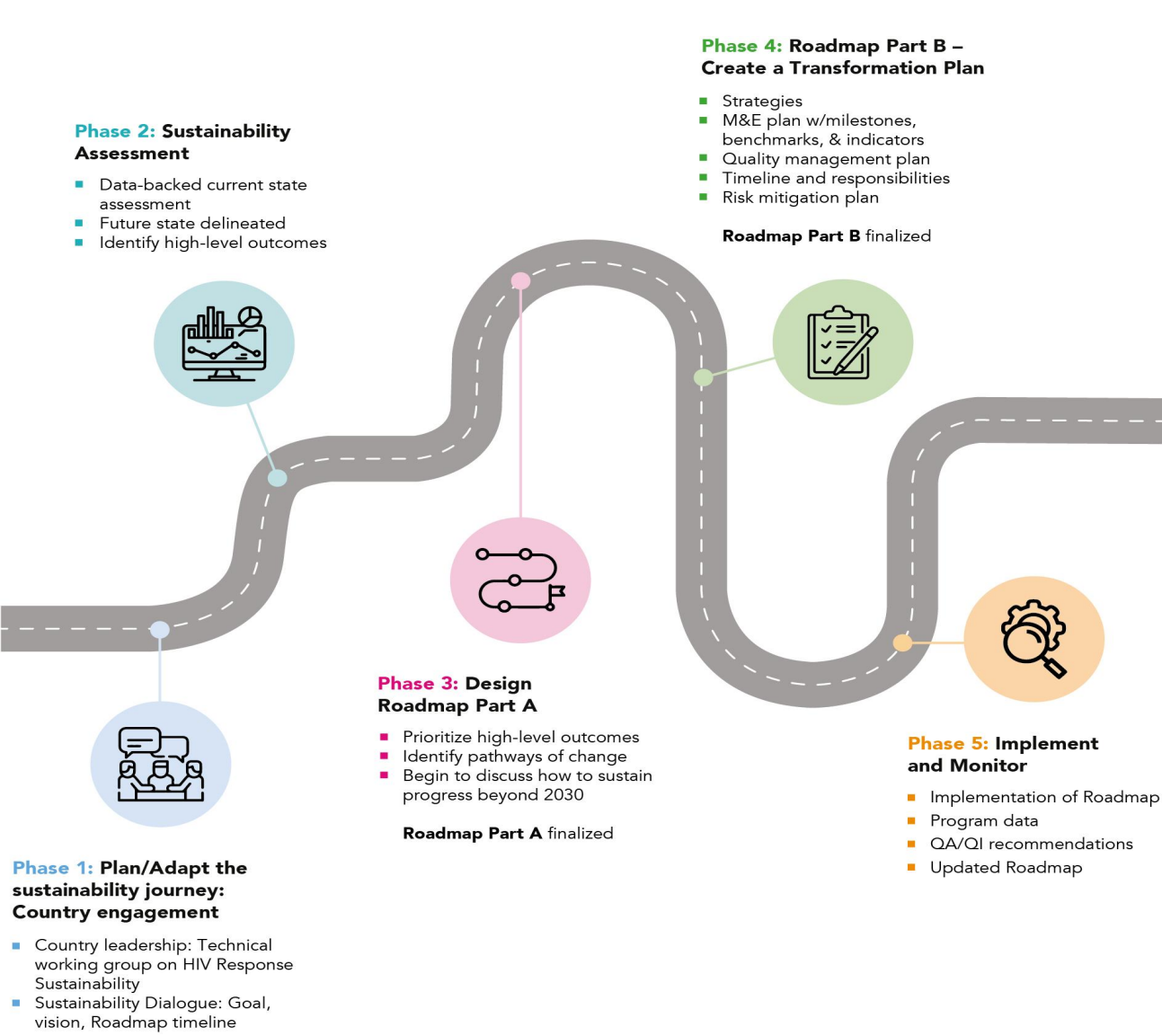
# SRMS high-level outcomes and actions: Opportunities for advancing the roadmaps in countries

- **Ghana:** In Oct. 2024, NAC shared that the Ghana AIDS Commission Act (Act 938) will be reformed to sustain political leadership community engagement.
- **Cambodia:** In June 2023, the government expanded access to free publicly-funded HIV services for key populations, including sex workers.
- **Early, 2025 Significant Reduced Funding** for HIV prevention services, community-led interventions, key populations, structural enablers
- In many countries, integration of key population services into public health facilities occurred with limited measures to reduce stigma and discrimination
- **Uganda:** In February 2025, the government issued a circular with new guidance that standalone HIV/TB clinics will be phased out and integrated into general outpatient services.
- **South Africa:** The 2025 Budget Review includes a 5.9% annual increase over three years for health expenditure, including a 3.3% annual increase for HIV and TB, with specific commitments for National Health Insurance preparation.

## BOX 1. Example High-Level Outcomes from Sustainability Roadmaps Part A

- ▶ **GHANA:** User fees (including unofficial charges) and other out-of-pocket spending are reduced, leading to wider and more equitable access to HIV care for all.
- ▶ **Botswana:** Sustain KP services post-donor through government financing and CSO integration
- ▶ **Eswatini:** Institutionalize KP programming via social contracting and legal reform
- ▶ **KENYA:** There is Zero tolerance for stigma and discrimination in healthcare settings.
- ▶ **LESOTHO:** Community-led organisations independently drive progress toward the 30-80-60 targets, delivering testing, prevention, and support services with sustained resources and capacity, empowered by formalized funding, training, and robust, meaningful partnerships
- ▶ **TOGO:** 50% of key interventions in the fight against HIV/AIDS are financed by public resources, with a substantial contribution from insurance systems and are complemented by external financing and maintained throughout the response period
- ▶ **Zambia:** Establish social contracting to enable public financing of community-led services and integration into the health care delivery system (strategic purchasing)
- ▶ **Tanzania:** Integrate HIV-related interventions into national health insurance

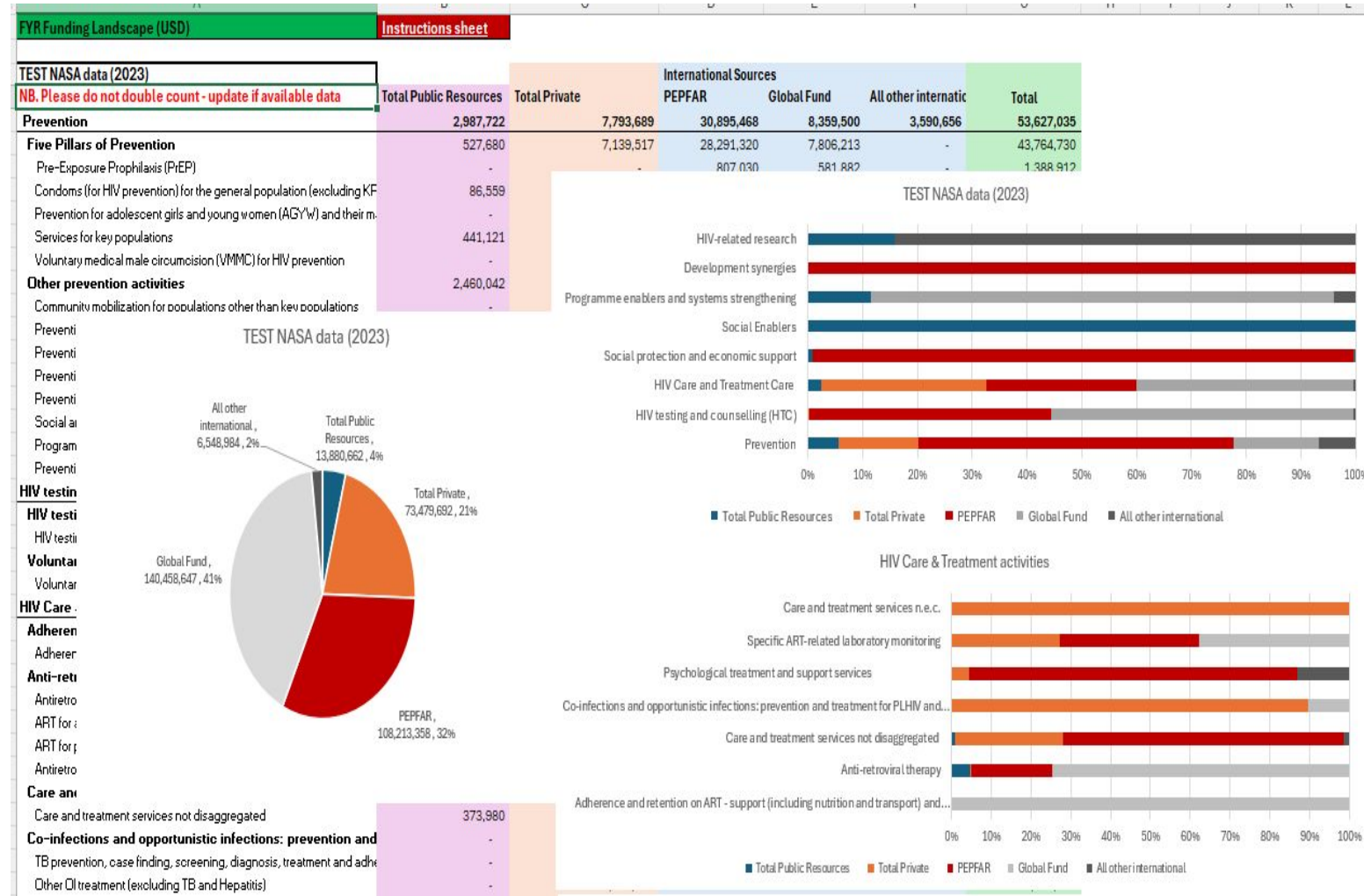
# HIV response sustainability roadmaps: Opportunities to engage



- The Companion Guide to develop the second part (Part B); the two-year Transformation Plan shared on July 1<sup>st</sup>, 2025
- **One country sustainability Roadmap** : Countries are advancing the design to guide domestic and donor financing, transition and sustainability
- Participate in the Sustainability Working Group, dialogues and planning to influence decisions and advocate
- Mapp, document service interruptions, the funding gaps, and potential impact
- Organize, prepare data and proposals of programme interventions, service delivery modalities, potential integration and safeguards to be in place
- Define and assess the capacity development needs
- Leverage partnerships and alliances to make the case and increase awareness regarding gaps, shortfalls, and violations.

# Examples: Funding landscape analysis

- Detailed review of the funding landscape to identify funding gaps, prioritize elements for urgent and mid-term transition and/or be included in sustainability actions
- Less granular data and transparency on funding of key population programmes
- Challenges in **defining the funding gap and assess the impact of funding interruptions** for key populations and community-led services
- Country-level dialogue with implementers, partners, dedicated analysis to inform the funding landscape and prioritization



# Example: Development of the Transition and Transformation

## Plan


### The Transformation Plan: A two-three year costed sustainability and transition plan (narrative and workbook)

- The **funding landscape table** has been developed and included in the Plan
- Based on prioritization and modelling, include the agreed upon **evidence-driven activities in the excel workbook (per domain) that contribute to the benchmarks and the HLOs**

The companion guide proposes key questions per domain to assist with:

- Prioritization, identifying transition and sustainability actions
- Reflect on potential integration pathways
- Include references to the different technical guidance available per domain

Illustrative Examples	
Political Leadership	How to adapt the strategic positioning of multisectoral engagement structures, including communities in the current competitive context?
Services and Solutions	<ul style="list-style-type: none"> <li>• How to reach at sustain AGYW programmes? Is integration with SRH services and other community health outreach programmes reaching women and girls a potential pathway?</li> <li>• What opportunities to integrate VMMC into health service where still cost-effective</li> <li>• How to sustain effective KP programmes? Shall we map key functions and identify the different priority options (peer-led, virtual, KP-friendly service) ?</li> <li>• What are the mature primary HIV prevention models sustained through domestic resources in other countries?</li> <li>• What are the steps to prioritize and scale PrEP?</li> <li>• What are the simplified service delivery models</li> <li>• How can we leverage the WHO operational guidance to further prioritize services?</li> </ul>
Equitable and Sustainable Financing	<ul style="list-style-type: none"> <li>• Next steps to operationalize commitment on implementing social contracting (policies and regulation for public-financing of CSOs)</li> <li>• How to initiate the integration of the HIV services in health insurance package and ensure financial protection?</li> <li>• Shall we engage with MOH departments to advocate for sin taxes earmarked to health and HIV financing?</li> <li>• How does the decentralization of health care affect budget allocation decision-making?</li> </ul>
Enabling laws and policies	<ul style="list-style-type: none"> <li>• How can we prioritize actions to address criminalization, gender inequality, stigma and discrimination that are barriers to access ?</li> </ul>
Systems	<ul style="list-style-type: none"> <li>• What will the national data system look like given the reduced funding?</li> <li>• Steps for optimizing HRH, sustainable and equitable access to commodities</li> <li>• Supply chain</li> </ul>

- 
- <https://sustainability.unaids.org/>
  - The Companion Guide and tools to develop the first part (Part A)
  - Companion Guide to develop the second part (Part B); the two-year Transformation Plan shared on July 1<sup>st</sup>, 2025
  - **One country sustainability roadmap:** Countries are advancing the design to guide domestic and donor financing, transition and sustainability
  - Country roadmap, resource analytic tools, and other reference documents

# 4 | Country examples

Phillip Read, Australia  
Surang Janyam, Thailand  
Humphrey Nondo, Zimbabwe



**SOUTH TO SOUTH  
LEARNING NETWORK**  
*Reimagining HIV Prevention*

# Sustainable and Scalable Primary Prevention Programmes for Key Populations: Australia

**Dr Phillip Read**

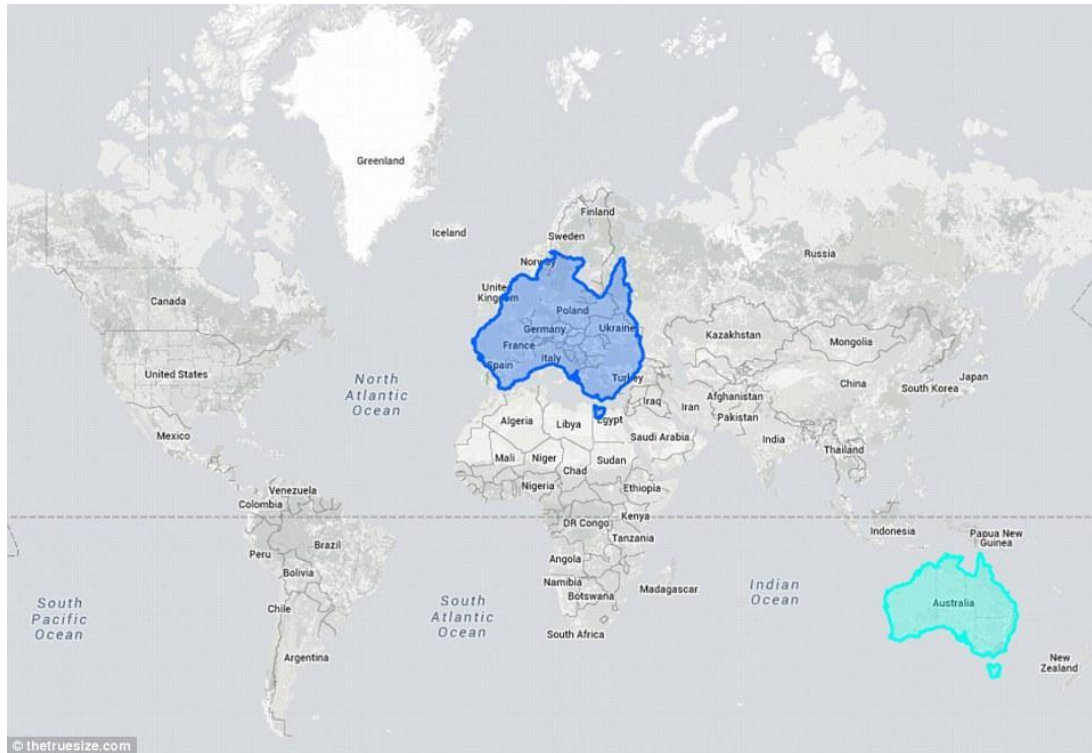
**Director- Sexual Health and Blood Borne Virus  
Services, SESLHD, NSW Health**

**Conjoint Professor, The Kirby Institute, UNSW Sydney**

Population and Community Health  
South Eastern Sydney Local Health District



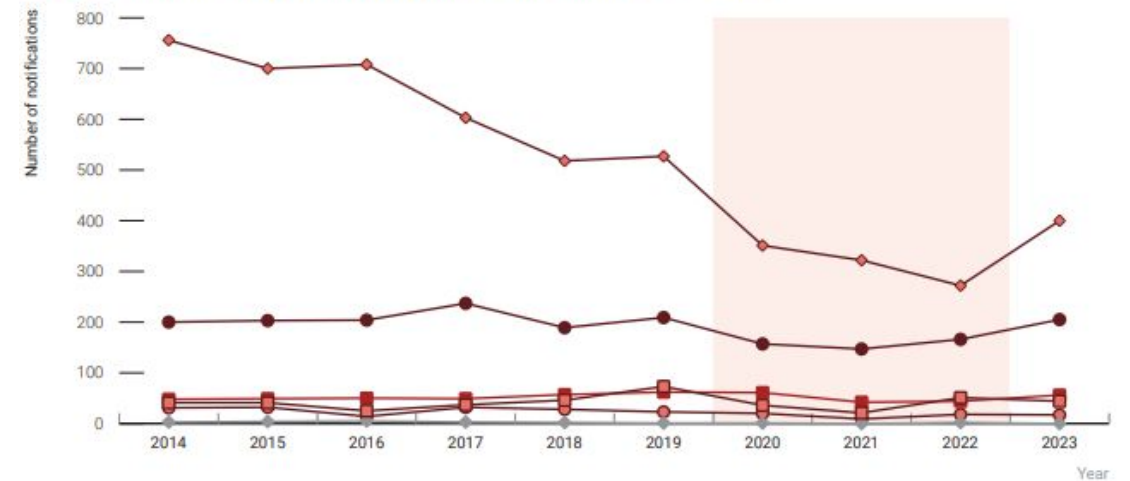
# HIV in Australia



Approximately 30,000 people living with HIV

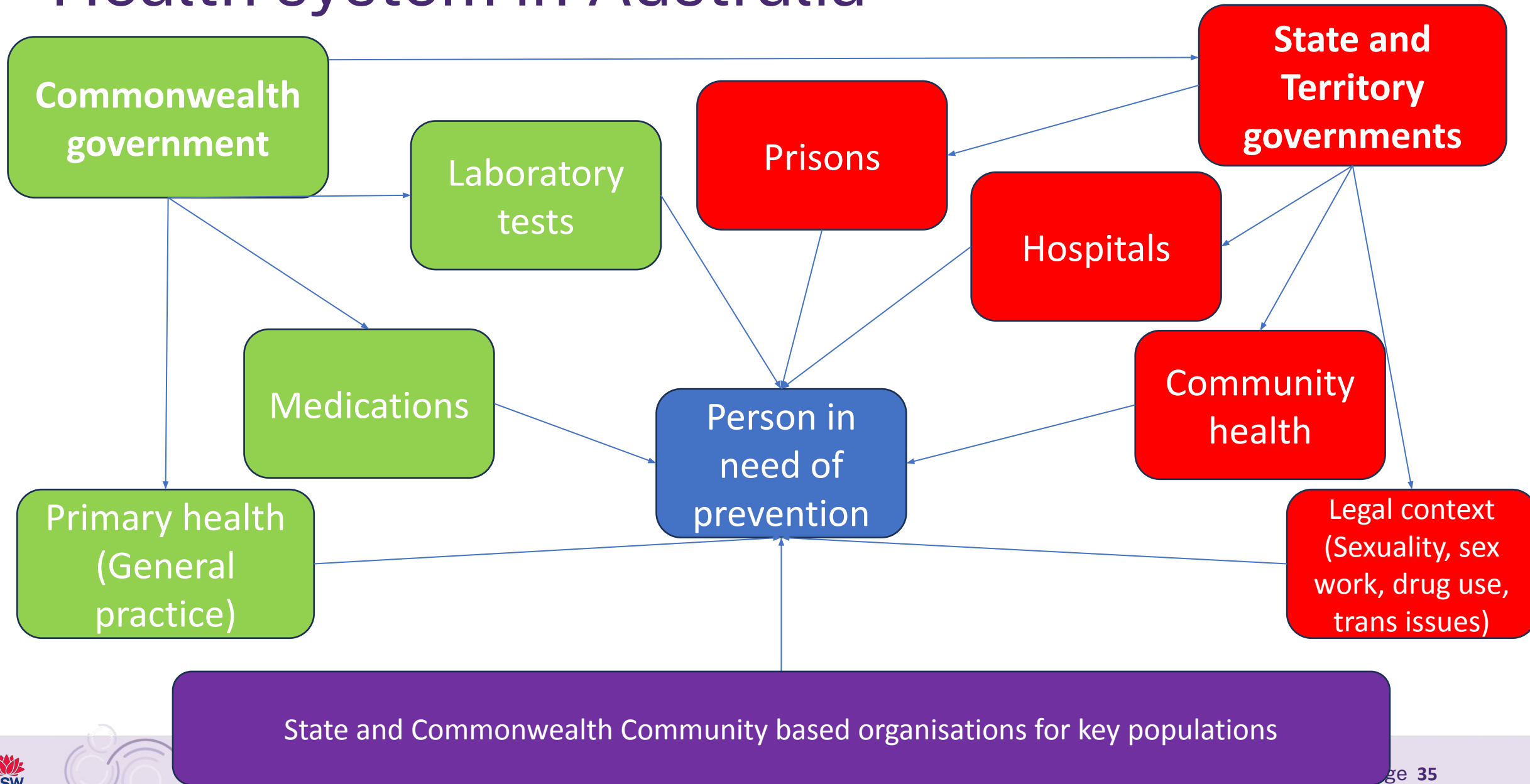
Population 28 million

**Figure 3** Number of HIV notifications by exposure category, 2014 – 2023

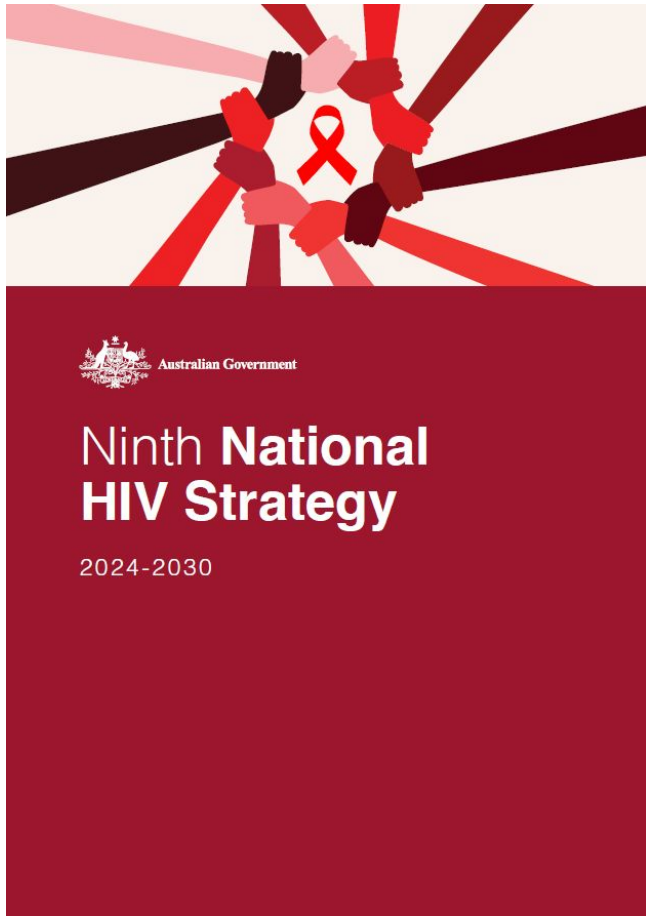


Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Male-to-male sex	756	700	708	603	518	527	351	322	272	400
Male-to-male sex and injection drug use	48	49	50	49	57	62	61	42	44	56
Heterosexual contact	200	203	204	237	189	209	157	147	166	205
Injection drug use	31	32	14	32	28	23	20	9	18	17
Vertical transmission	3	4	5	3	2	1	1	0	2	0
Other	41	41	25	37	46	73	36	21	51	44

# Health system in Australia



# Enabling policy settings for prevention



**Aim**  
The virtual elimination of HIV transmission in NSW for all

**Headline target**  
90% reduction in the rate of preventable HIV infection

**Goals**

**1. Prevent**  
Prevent HIV transmission by promoting safe behaviours and by expanding access to condoms, PrEP, PEP, and sterile injecting equipment.

**Targets**

- 1.i 90% of men who have sex with male casual partners report at least one form of HIV prevention.
- 1.ii 90% of HIV-negative men who have sex with male casual partners without a condom take PrEP.
- 1.iii Reduce sharing of injecting equipment among people who inject drugs.

**Initiatives**

- 1.1 New models of care for PrEP
- 1.2 PrEP prescribers expansion
- 1.3 PrEP Guidelines
- 1.4 GPs and primary care workforce
- 1.5 Community mobilisation and health promotion
- 1.6 Sex worker peer outreach
- 1.7 Needle and Syringe Program
- 1.8 Information and referral
- 1.9 Aboriginal services
- 1.10 Research and surveillance

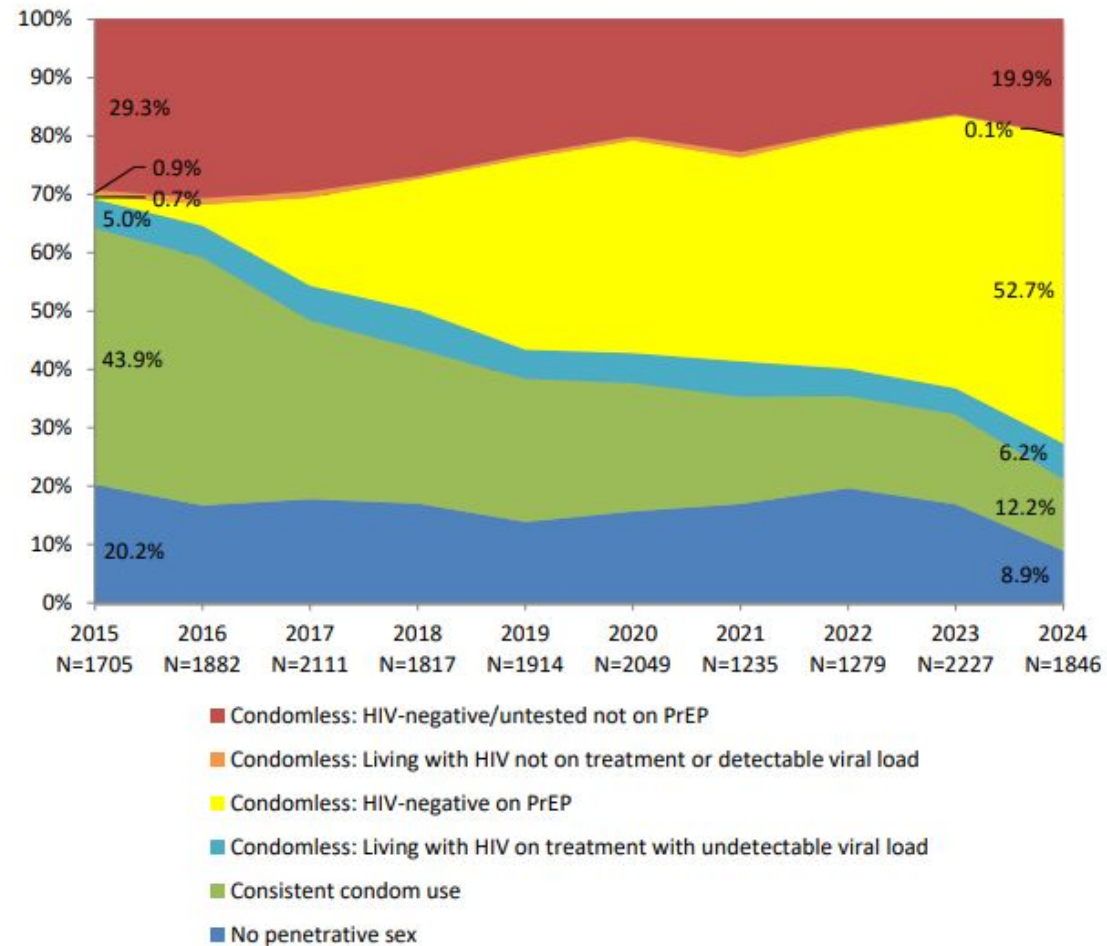
## PRIORITY POPULATIONS

This Strategy prioritises meaningful participation of people living with HIV along with other priority populations as essential to its development, implementation, monitoring and evaluation.  
People including those with diverse cultural, sexual and gender identities may belong to more than one priority population.

<p><b>People living with HIV</b></p>	<p><b>Men who have sex with men (MSM), including:</b></p> <ul style="list-style-type: none"> <li>- culturally and linguistically diverse (CALD)</li> <li>- recently arrived (four years or less) overseas-born</li> <li>- under 25 years old</li> </ul>
<p><b>People from or who travel to countries with high HIV prevalence</b></p>	<p><b>Aboriginal people</b></p>
<p><b>People who inject drugs</b></p>	<p><b>Sex workers and their clients</b></p>
<p><b>People who are in or have recently been in custodial settings</b></p>	<p><b>Sexual partners of members of priority populations</b></p>

# Prevention key populations: MSM

Figure 10. Proportion of GBQ+ men and non-binary people with casual partners reporting condom use, biomedical prevention and any condomless anal intercourse in the previous six months, 2015 to 2024



Source: Sydney GBQ+ Community Periodic Survey, Centre for Social Research in Health, UNSW Sydney.

## PrEP

- Primary care, specialist clinics
- Nurse initiated
- Free for non-citizens/low cost
- Community promotion/resources
- Online models

## TaSP

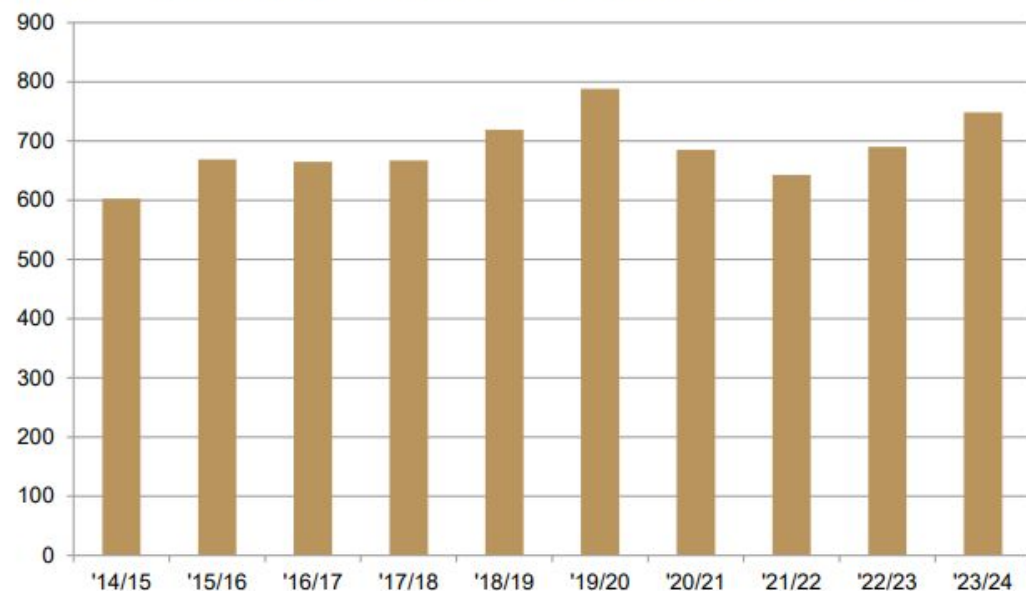
- Primary care, specialist clinics
- Free for non-citizens
- Rapid initiation/ high treatment targets
- Loss to f/up processes
- Public health requirements

## Condoms

- Continue to be promoted
- Free in clinics and many community sites

# Prevention key populations: People who inject drugs

Figure 4.4 National syringe coverage per PWID\* per year, 2014/15-2023/24



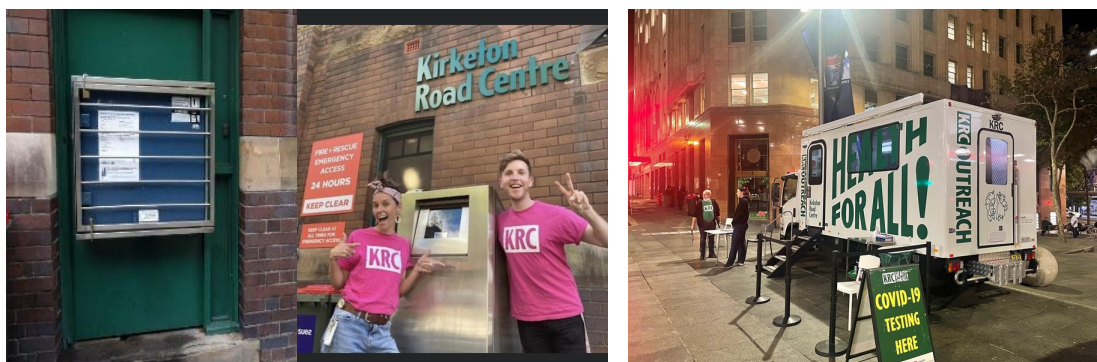
Note: \* Syringes per PWID includes people who inject on a regular basis and excludes those who inject occasionally

## Model:

- Anonymous, confidential needle programs
- Multiple locations/access points
- Often staffed by people with lived experience
- Online options
- Peer based organisation involvement
- Memorandum with police/drug law reform
- Peer/secondary supply
- Integrated with primary health services/health access and other harm reduction measures

## Targets:

- Reduce receptive syringe sharing (20%)
- Increase distribution
- Pilot NSP in prison setting



# Prevention key populations: Sex workers

First Tuesday of each month  
2:00-4:30pm

**SWOP NSW will be at KRC  
WITH OUR SWOP NSW INDEPENDENT  
OUTREACH WORKER ROSIE**

- **OPTIONS FOR WHEN, WHERE, AND HOW YOU WORK**
- **REFERRALS TO LEGAL AND FINANCIAL SERVICES**
- **STAYING PHYSICALLY AND EMOTIONALLY SAFE**
- **FREE SAFER SEX SUPPLIES AND MORE**
- **FREE MPOX VACCINE AND SEXUAL HEALTH CHECKS WITH NO MEDICARE CARD**

**12 KELLET ST, POTTS POINT  
DROP IN OR CALL 9360 2766 TO BOOK AN APPOINTMENT**

- Legal status varies state to state
- Decriminalisation in NSW and ACT
- High rates of condom use
- Clinical and outreach partnerships with sex worker organisations
- Advocacy and human rights approach
- Specific clinics for cultural and first nations groups
- Nuanced approach for male and gender workers

# Summary

## **HIV prevention models for key populations in Australia are:**

- Supported by government policies and strategies
- Enabled by human rights and pragmatic harm reduction approach
- Delivered in partnership with affected community
- Distributed and decentralised through the system where possible
- Focussed on access and minimising gaps/disadvantage
- Data driven and evaluated



Thank you

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# The sustainable and scalable models of HIV programming with key populations: **Thailand's experiences**

**Surang Janyam**

Executive Director  
SWING Foundation



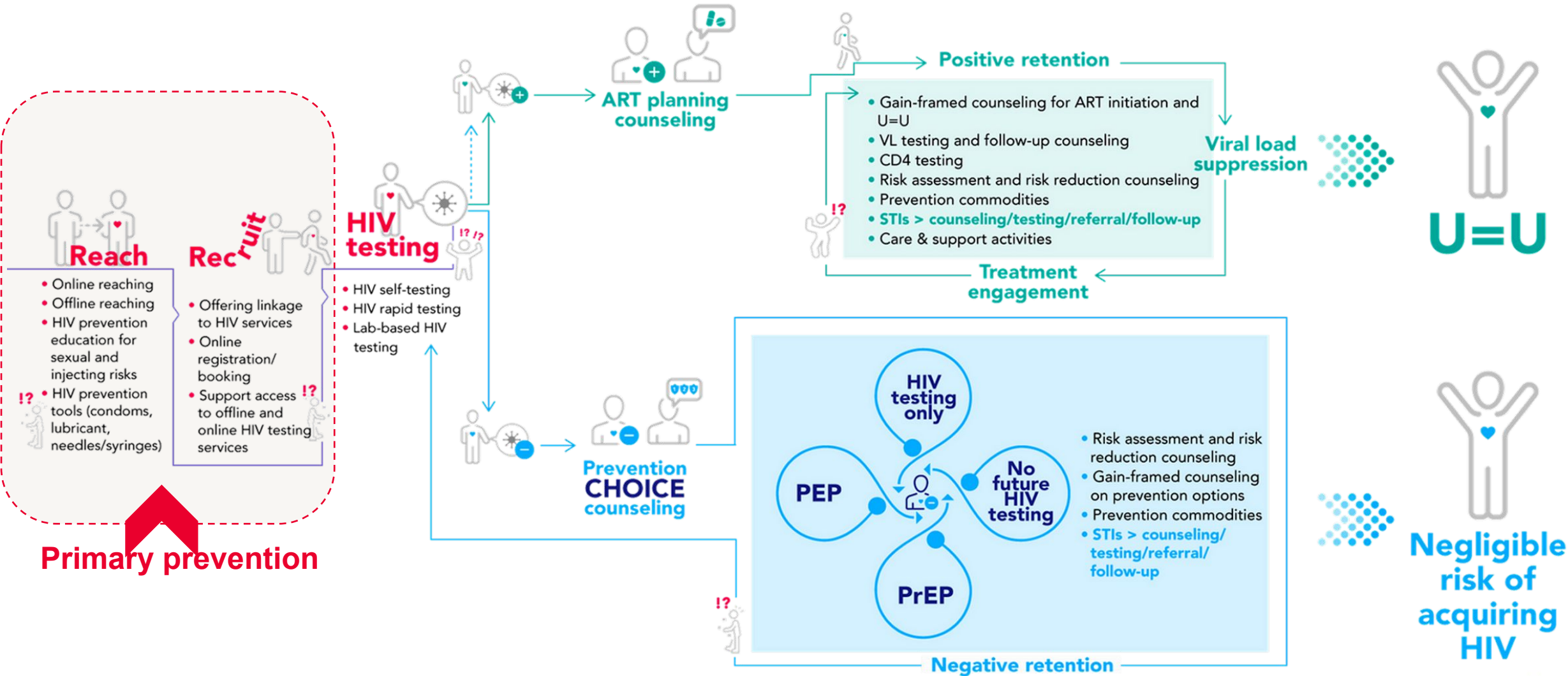
Visit Our Website  
[www.swingthailand.org](http://www.swingthailand.org)

# BACKGROUND



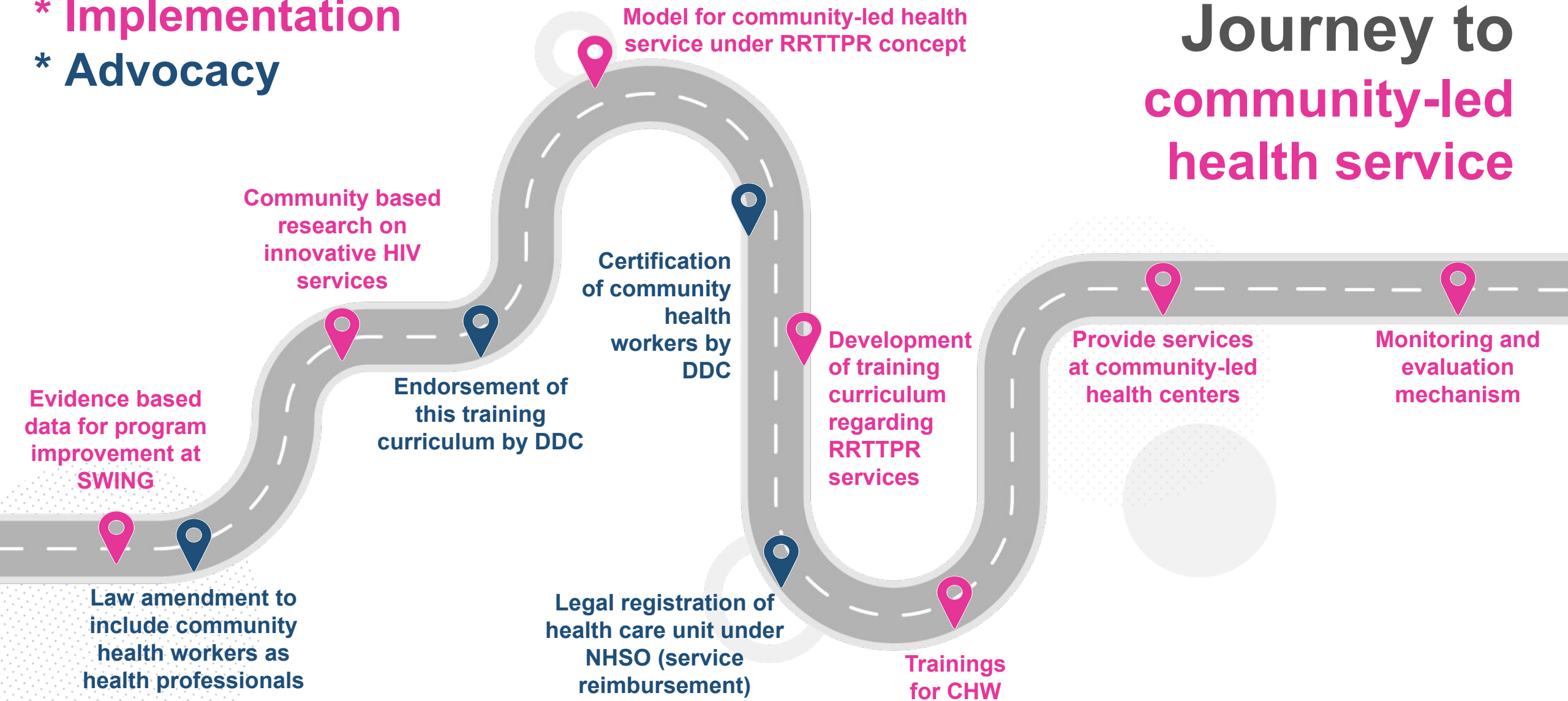
- 1 HIV movement in Thailand initiated by civil society organizations and HIV communities more than 30 years ago
- 2 Establishment of Thai NGOs coalition on AIDS (TNCA)
- 3 Equal partnership and meaningful representation at national HIV committee for developing the national HIV strategies
- 4 Innovative services at pilot community-based organizations
- 5 Community-led health service model as a game changing initiative for ending AIDS

# Community-led health service model (RRTTPR)



**\* Implementation**  
**\* Advocacy**

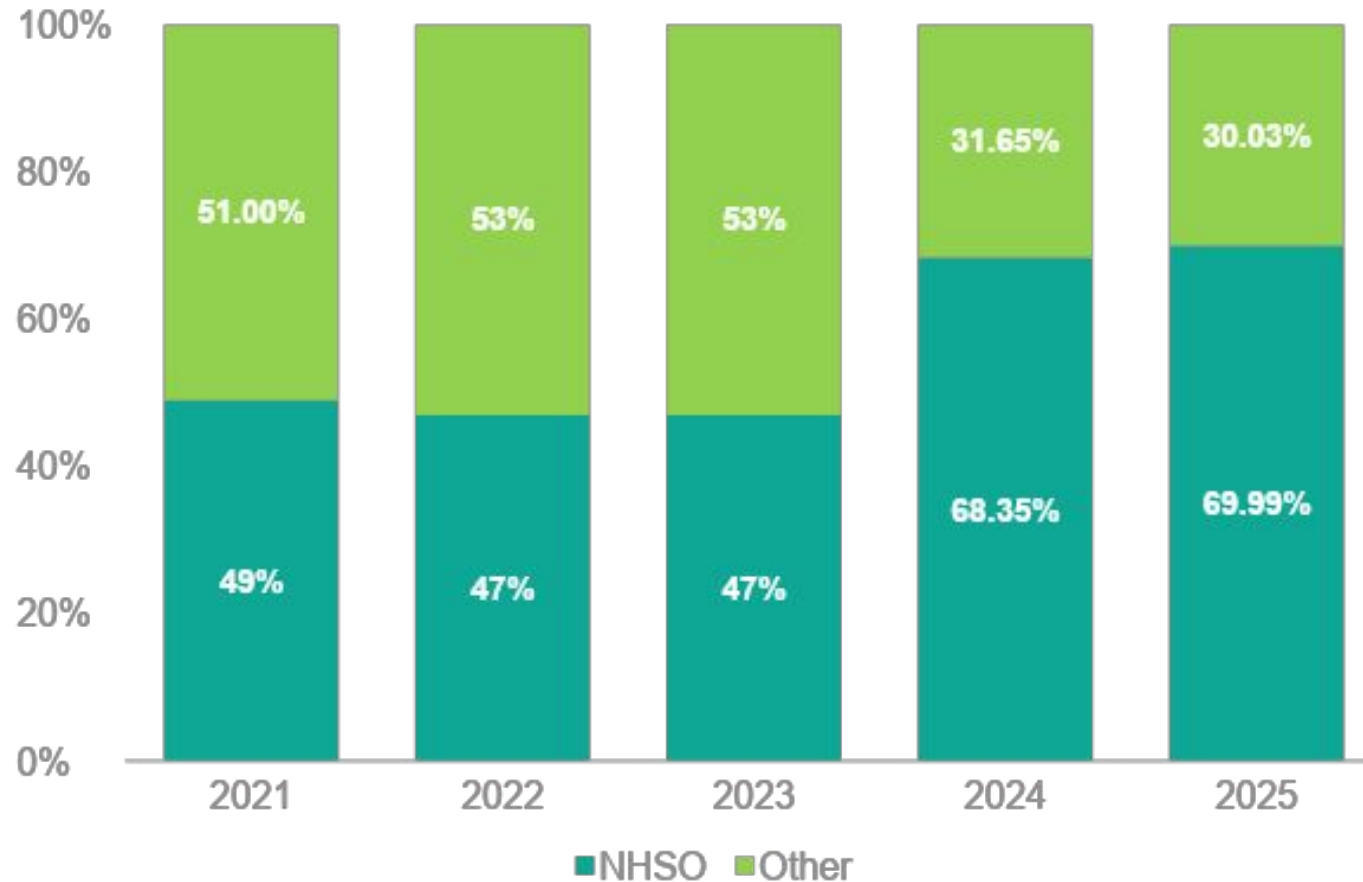
# Journey to community-led health service



# Proportion of HIV clients served by SWING compared to the national total



# Funding Landscape



Percentage of operating costs supported by international donors USAID, GFATM and domestic financing NHSO to USAID supported KPLHS organization in Thailand from 2021 - 2025



Thank you



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# Scalable and Sustainable HIV Prevention Programmes for Key Populations in Zimbabwe

*Presented Virtually at the 12<sup>th</sup> Global HIV Prevention KP Community of Practice*

**Equity | Differentiation | Integration | Scale | Sustainability**



**Humphrey M. Ndondo | MPH**

Senior Technical Advisor- Key Populations

National AIDS Council- Zimbabwe

03 July 2025

# Presentation outline

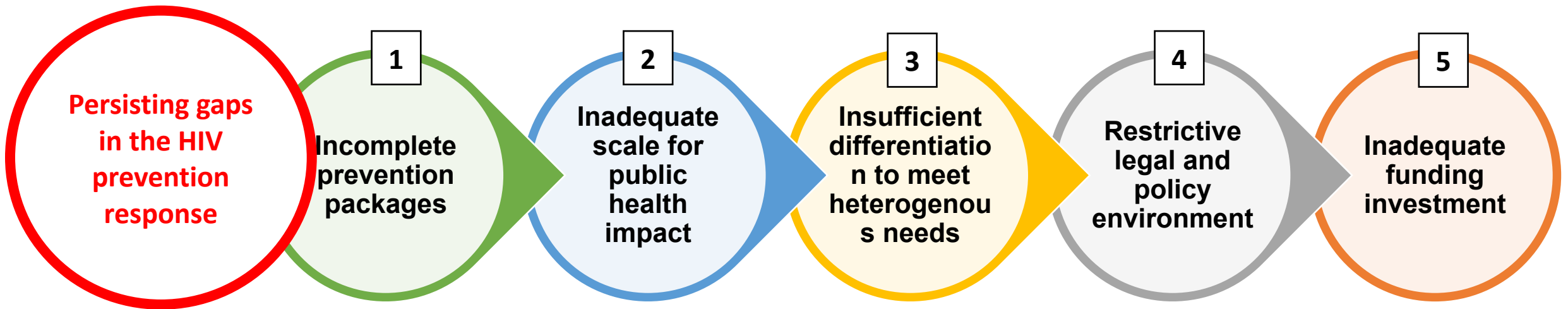
- Overview of the HIV response for Key Populations in Zimbabwe
- The Zimbabwe HIV Prevention Landscape
- Integrating KP focused HIV service delivery in the public sector
- Lessons Learned: Differentiation, **Integration**, Scale and Sustainability
- Opportunities to optimize integration of HIV prevention response for KPs
- Conclusion



# Overview of the HIV response

- As we achieve HIV epidemic control there is a need to build **community resilience** and **stronger, sustainable, public sector facilities** that will provide equitable, KP friendly and competent health care services.

✓ Government ownership & Community leadership



- Centre government duty and responsibility to provide **Universal Health Care** and nimble transition programme implementation to:

**Country-led programmes**

**Reduce operating costs**

**Expanding partnership approaches**

**Activate robust financing strategies**

# HIV prevention landscape

Before 20 Jan 2025

## The Light

- Strong political will for HIV control from government, funding and technical partners and communities
- Robust combination prevention programme resulting in 50% decline in new HIV infections in the past 10 years
- Early adoption and adaptation of prevention innovations- CAB LA
- Active, government led HIV prevention working groups, development of guidelines, sustainability plans, and HIV prevention roadmap
- Evidence driven implementation of HIV prevention
- HIV prevention leadership and astute technical support
- Donor support for differentiated HIV prevention service delivery
- Active KP peer footprint central to delivery of differentiated HIV prevention

## The Shadow

- Incomplete prevention packages for other KP groups- harm reduction for PWID, young people
- Disparities in access across urban and rural communities
- Insufficient access- demand creation carefully controlled to match limited supplies
- Extensively donor reliant prevention program
- Slow progress in addressing criminalization, stigma and discrimination
- Shrinking donor funding

Significant policy shifts on External Assistance

## The Light

- Evidence based adaptation of HIV prevention following US government SWO
- Active Civil Society engagement
- Steady supply of HIV prevention commodities (challenges with CAB LA and dapivirine ring supply)
- Accelerated public sector integration for KPs

## The Shadow

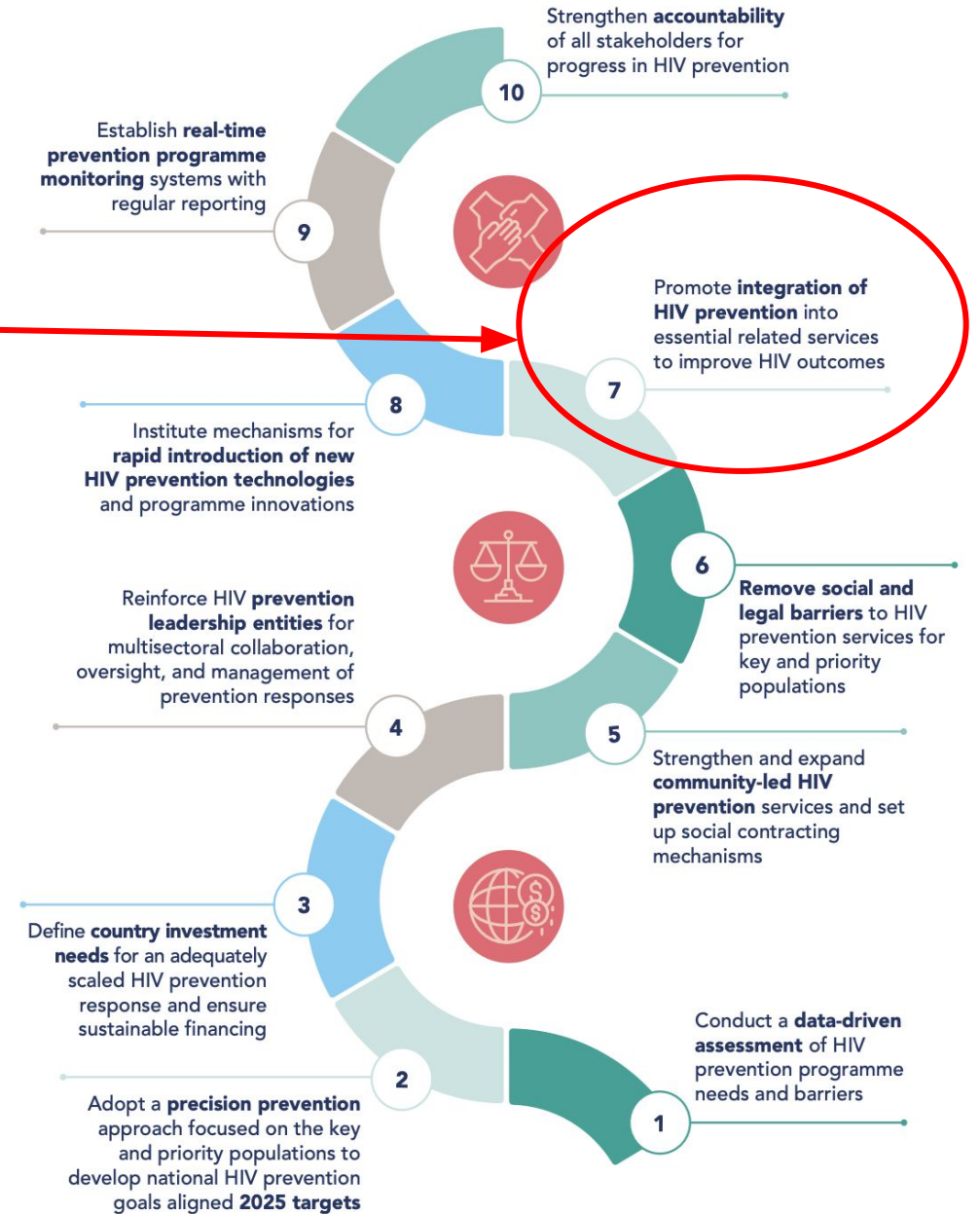
- Significant disruption of PEPFAR supported KP prevention program
- Defunding of KP Technical Support to NAC and MoHCC
- Loss of dedicated KP peer footprint and DSD
- Language casting DEI programmes as wasteful
- Research terminated including KP bio-behavioural survey and CATALYST (PrEP CHOICE)
- Loss of significant funding for KP CLM
- Disruption in country M&E systems

**IMPERATIVE**

Promote **integration of HIV prevention** into essential related services to improve HIV outcomes

Integrating KP focused HIV/ SRHR service delivery should be nuanced to address needs of communities.

*The 'one-size-fits-all' approach to delivery of life-saving interventions defies science and evidence of the merits of precision interventions and differentiated service delivery to enhance person centred care. Human Centred Design based approaches used to target and tailor HIV interventions for Key Populations have been conflated for "preferencing" in a wave of anti-Diversity, Equity and Inclusion (DEI) purges that have negatively impacted access to health-care services for marginalized communities.*

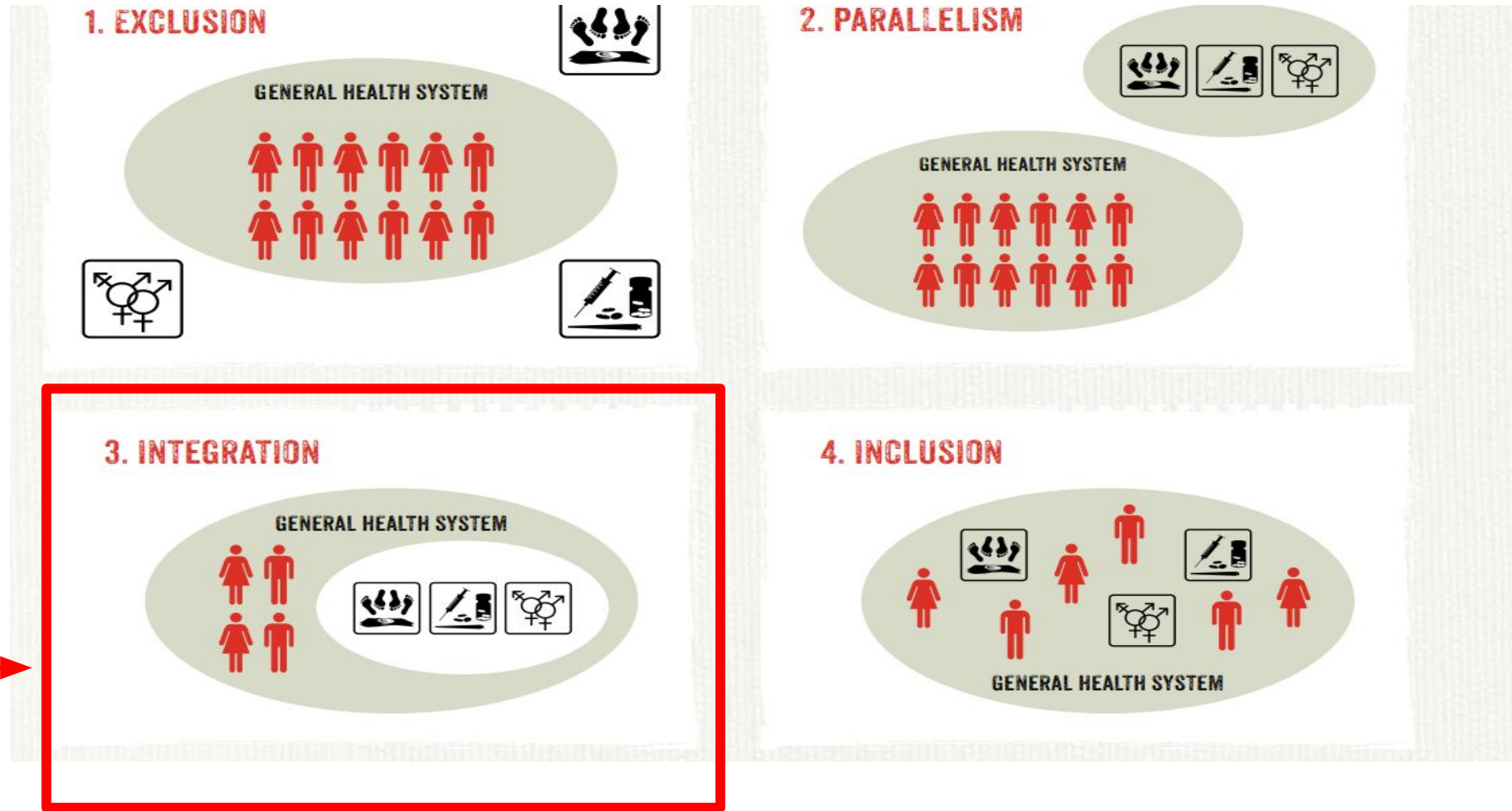


# Strong integration is anchored in diversity, equity and inclusion

## Integration:

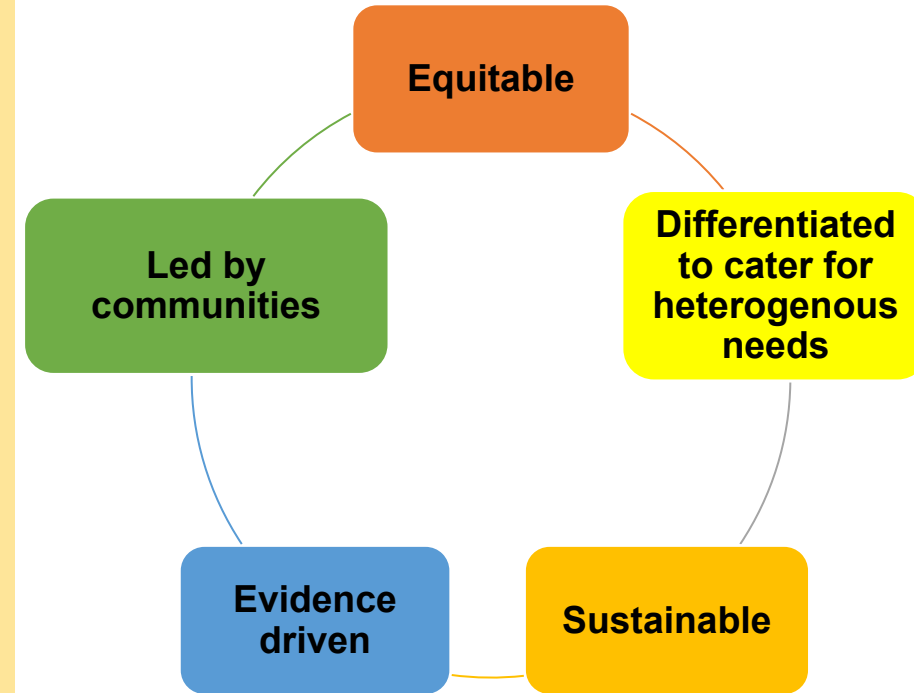
“The organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.”

~ WHO 2017



# Considerations for successful integration of KP focused HIV/SRHR services

## Principles



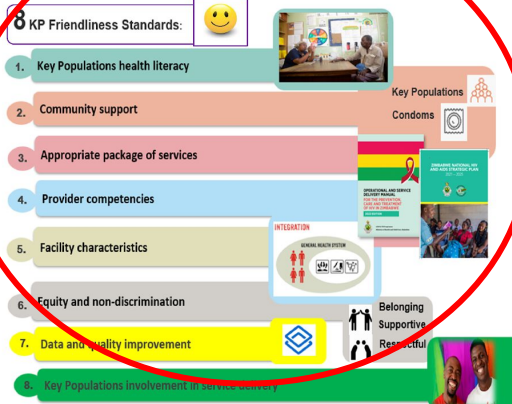
*Integration that looks like salad not yoghurt*



- ### 8 KP Friendliness Quality Standards
1. KP health literacy
  2. Community support
  3. Appropriate package of services
  4. Provider competencies
  5. Facility characteristics (public, private, community)
  6. Equity and non-discrimination
  7. Data and quality improvement
  8. KP involvement in service delivery

**Metrics that matter:** Developing quality standards to measure friendliness of integrated Key Populations focused HIV service delivery in the public health sector in Zimbabwe.

**AUTHORS**  
**Humphrey M. Ndondo**<sup>1</sup>, R. Bako<sup>1</sup>, B. Madzima<sup>1</sup>, R. Yekeye<sup>1</sup>, A. Mpofu<sup>1</sup>, C. Goshu<sup>1</sup>, G. Ncube<sup>2</sup>, O. Mugurungi<sup>2</sup>, U. Tenga<sup>2</sup>, B. Mutede<sup>3</sup>, J. Mavudze<sup>3</sup>, N. Taruherera<sup>3</sup>, I. Soko<sup>4</sup>  
<sup>1</sup>National AIDS Council, Zimbabwe | <sup>2</sup>Ministry of Health and Child Care, Zimbabwe  
<sup>3</sup>Population Solutions for Health | <sup>4</sup>Zimbabwe Technical Assistance, Training and Education Centre



### BACKGROUND

- Zimbabwe has reached epidemic control, surpassing the UNAIDS 95-95-95 targets among the general adult population.
- Key populations in Zimbabwe, however, perform dismally against these targets and contend with disparate health equity gaps that preclude access to friendly, and comprehensive HIV services.
- With a paucity of programmatic monitoring and evaluation tools to measure the impact of structural barriers to HIV service access, we set out to develop a KP friendliness tool and to determine domains that measure facility KP friendliness in the public sector.

### DESCRIPTION

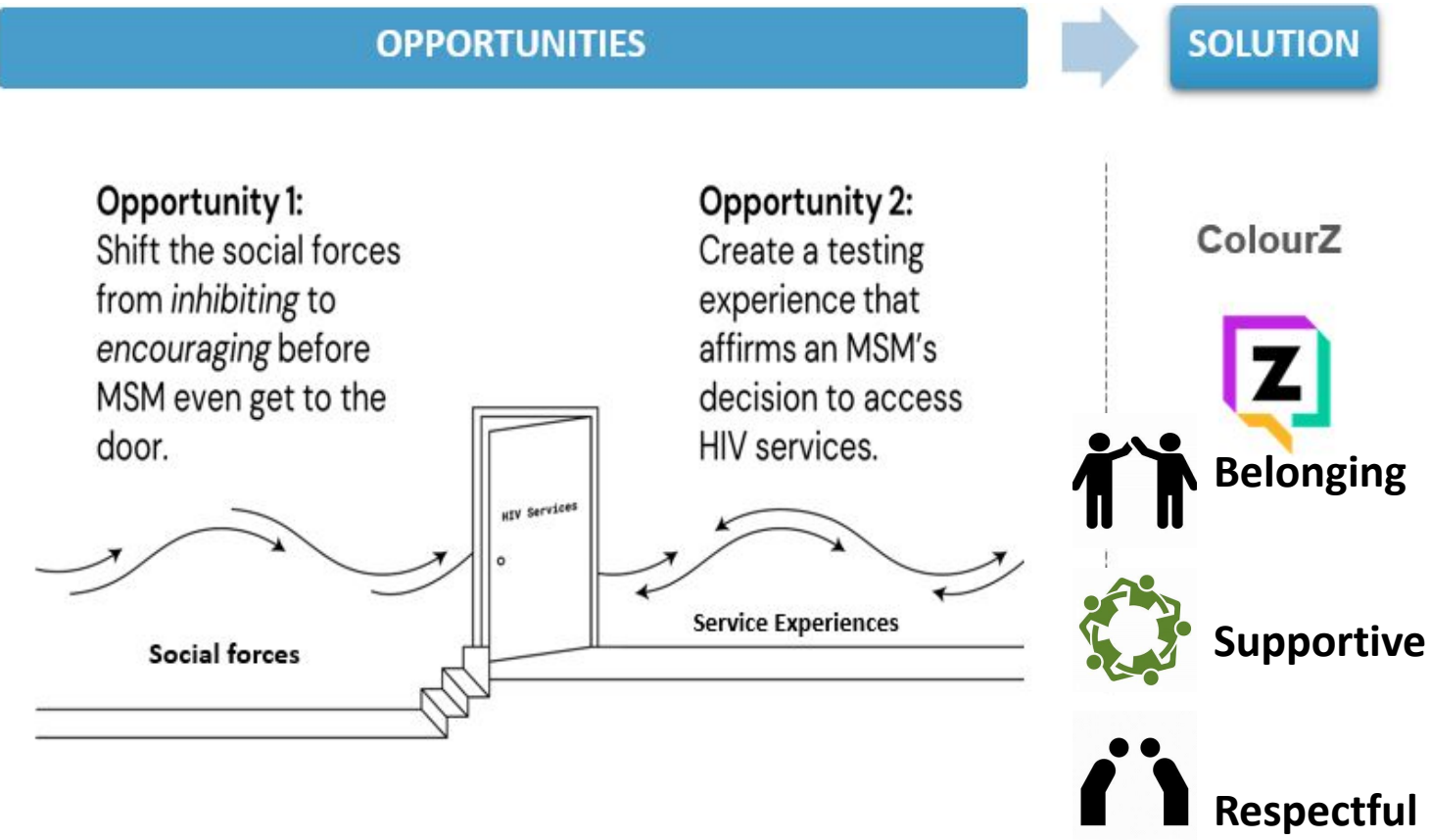
- We developed a KP friendliness tool anchored in the World Health Organizations' quality standards.

*Accessibility | community participation and linkages | provision of an appropriate package of services | provider competencies | facility characteristics | equity and non-discrimination | data quality.*

- We piloted the tool across 10 public sector facilities among men who have sex with men, sex workers, and transgender persons in Mutare, Masvingo, Bulawayo, Chitungwiza and Gweru districts in Zimbabwe.
- The tool was administered with 10-15 members of health facility monitoring committees (HFMC) from each of the sites.
- Each rating was discussed, and overall facility performance was scored as bronze (<60%), silver (60-79%), gold (80-94%) and platinum (95-100%).

- The tool provides reliable measures to monitor "KP friendliness". Its domains are critical in improving quality of care and provide a yardstick for incremental progress in addressing structural barriers to equitable access to differentiated HIV services for KPs in the public health sector. Triaging data from the KP friendliness tool with KP CLM feedback provides rich data for evidence informed quality improvement efforts.

# Differentiated care | Reaching and serving key populations using human-centred design approaches



- HCD driven approaches to better understand the heterogenous needs of KPs
- Differentiated Service Delivery tailored to meet specific needs e.g ColourZ Initiative
- Capacity building of health care workers to provide comprehensive, friendly and affirming care

- Engaging KP communities in the design, implementation, monitoring and evaluation of HIV/SRHR services
- Community led monitoring to strengthen the community feedback loop on the quality of Integrated HIV services delivery for KPs

# Remove social and legal barriers to HIV services for KPs

- Continue to provide a platform for KVP Civil Society engagements
- Conduct a KP focused Legal & Environmental Assessment
- Sensitization of parliamentarians
- Growing a network of KVP, SOGIESC advocacy allies
- Building stronger coalitions with unusual allies
- KP risk management and mitigation
- Long term, consistent engagement with KVP CSOs and communities disproportionately affected by HIV
- Elevating KVP community leadership to champion advocacy efforts and lead implementation of CLM initiatives

## Cross-Cutting Activities

- Set up **inclusive, multi-sectoral governance structures and processes**
  - Key Population Forums
  - **Human Rights Working Group**
  - Key population representation on other structures (e.g. CCMs, prevention forums)
  - Support platforms to facilitate dialogue between communities and decision-makers
- Work with **leaders, decision-makers to reduce S&D, remove punitive laws, increase access to justice**
  - Sensitizing judiciary, parliamentarians, executive
  - Work with law enforcers
  - Work with religious and corporate leaders
  - Increasing access to legal support services
- Provide TA and **capacity strengthening to communities**
- Support activities to **build evidence** base
  - Strengthen KP leadership in CLM
  - Regular updating of Stigma Index Studies
  - Legal Environment Assessments
  - Human Rights Assessments
  - Inequalities Assessments

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JULY 2018

**Zimbabwe**  
Legal Environment Assessment  
for HIV, TB, Sexual and  
Reproductive Health & Rights

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# Opportunities to optimize integration of KP focused HIV service delivery



- Reinforce government ownership and community leadership for the HIV response
- Continue to improve **donor coordination** to ensure maximize efficiency and mitigate against shocks.
- Fast Track implementation of innovative and novel prevention interventions for KPs
- Right size role of donor funded implementation and consider what “**maintenance**” programming may look like in mature KP groups/geographies.
  - Formalize **task shifting** – make policy adjustments and strengthen the skills and abilities of community cadres to deliver HIV prevention, care and support.
  - This would include improving the employability of KPs within the public sector.
- Move from criminalization to **harm reduction** for KPs



**Thank You**



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# 5 | Community perspectives

Ahmed Said, AfricaNPUD 

- 1
- 2
- 3
- 4
- 5
- 6
- 7



# 6 | Panel discussion

Heather-Marie Ann Schmidt, GPC & WHO 



# 7 | Closure

Heather-Marie Ann Schmidt, GPC & WHO 



# Thank you for joining us today!

## Reach out to us

South-South Learning Network

<https://www.hivinterchange.com/contact-us>

GPC

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