

Transformations driving sustainability and impact

Integrating HIV services into national health insurance schemes





Table of contents

Overview	3
Summary of Findings	6
Country Case Studies	8
● Thailand	9
Background	9
Systems Innovation and Structural Design	10
Political Leadership and Commitment	11
Transformation in Action	12
Financing	12
Capacity Building	13
● Viet Nam	14
Background	14
Systems Innovation and Structural Design	15
Political Leadership and Commitment	16
Transformation in Action	16
Financing	17
Capacity Building	17
● Rwanda	19
Background	19
Systems Innovation and Structural Design	19
Political Leadership and Commitment	20
Transformation in Action	21
Financing	21
Capacity Building	21
● Kenya	22
Background	22
Systems Innovation and Structural Design	23
Political Leadership and Commitment	24
Transformation in Action	24
Financing	25
Capacity Building	25
Summary of findings and key recommendations	26
References	28

Overview



Sustaining the gains of the HIV response in low- and middle-income countries (LMICs) is becoming increasingly challenging due to the chronic nature of HIV and a noticeable decline in international donor support, as well as domestic macro-fiscal constraints (1). In the aftermath of the Covid pandemic, uneven economic recovery in LMICs, worsening inequity across and within countries and significant declines in development assistance for health have affected most of the population, risking a resurgence of HIV/AIDS, particularly among vulnerable people (2). While donor funding has historically been crucial in scaling up HIV services, its recent decrease highlights the urgent need for countries to transition toward more sustainable, domestically driven models of financing HIV programmes (3). This shift is particularly critical now to ensure that HIV responses remain effective and resilient in the long term. As countries pursue progress towards universal health coverage (UHC), mixed method

approaches are needed. One effective strategy for achieving this is through the integration of HIV services into national health insurance (NHI) (4). Here, integration broadly means incorporating a range of HIV prevention, treatment and care services within existing health and social systems (5). Specifically relating to NHI integration, it means that HIV-related services, such as testing, antiretroviral therapy (ART) and prevention (including pre-exposure prophylaxis (PrEP)), are delivered stigma-free to all populations in need and are included in the essential health benefits packages covered by a country's NHI scheme or other social protection mechanisms.

At the 78th World Health Assembly (WHA), held from 19 to 27 May 2025 in Geneva, Member States reiterated the need for increased domestic financing towards UHC. Global health institutions, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund),

the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO) and the World Bank, recommended integrating HIV services into broader health systems as a key strategy for achieving UHC and sustaining HIV responses. The Global AIDS Strategy 2021–2025 (GAS) identified UHC as a key component for ending AIDS as a public health threat by 2030. This includes supporting NHI schemes that have defined essential health service packages, including a comprehensive package of HIV services which are sensitive to the needs of diverse communities and provide financial risk protection and equitable access to health care. WHO's proposals regarding public compulsory health financing and health insurance plans are important for breaking down social inequalities and ensuring that vulnerable and poor populations are covered (7). The Global Fund, in its guidance note on sustainability, co-financing and transitions, proposes diversifying sources of funding as a key to long-term sustainability. It proposes the integration of HIV services into NHI programmes to ensure efficiency, programmatic and financial sustainability (6).

Together with partners, UNAIDS developed a new HIV response sustainability approach with the primary aim of securing the future of the HIV response. For this to be realized, the existing HIV response also must be transformed. These transformations require clear, well-crafted steps towards stronger health systems, better integration of services, stronger country ownership and more streamlined external support. At the same time, transformations must contribute towards universal health coverage, gender equality, human rights and better financing. The

UNAIDS [HIV response sustainability primer](#) and related guidance, outlines a transformation of the HIV response as intentional, structural shifts across policy, programmes, financing, systems and services so that the gains of the HIV response can be sustained beyond 2030. This goes beyond incremental changes to re-imagining how services, systems and financing operate for long-term sustainability. An important aspect of transforming the HIV response is moving from siloed and parallel structures to a full integration of HIV services, policies and supply chains with national health and social systems. This includes shifting from external, donor-centred, short-term models towards country-led and owned models, with sustainable local capacity, and domestic financing, with emphasis on rights-based, people-centred approaches while ensuring equity of access (8, 9,10).

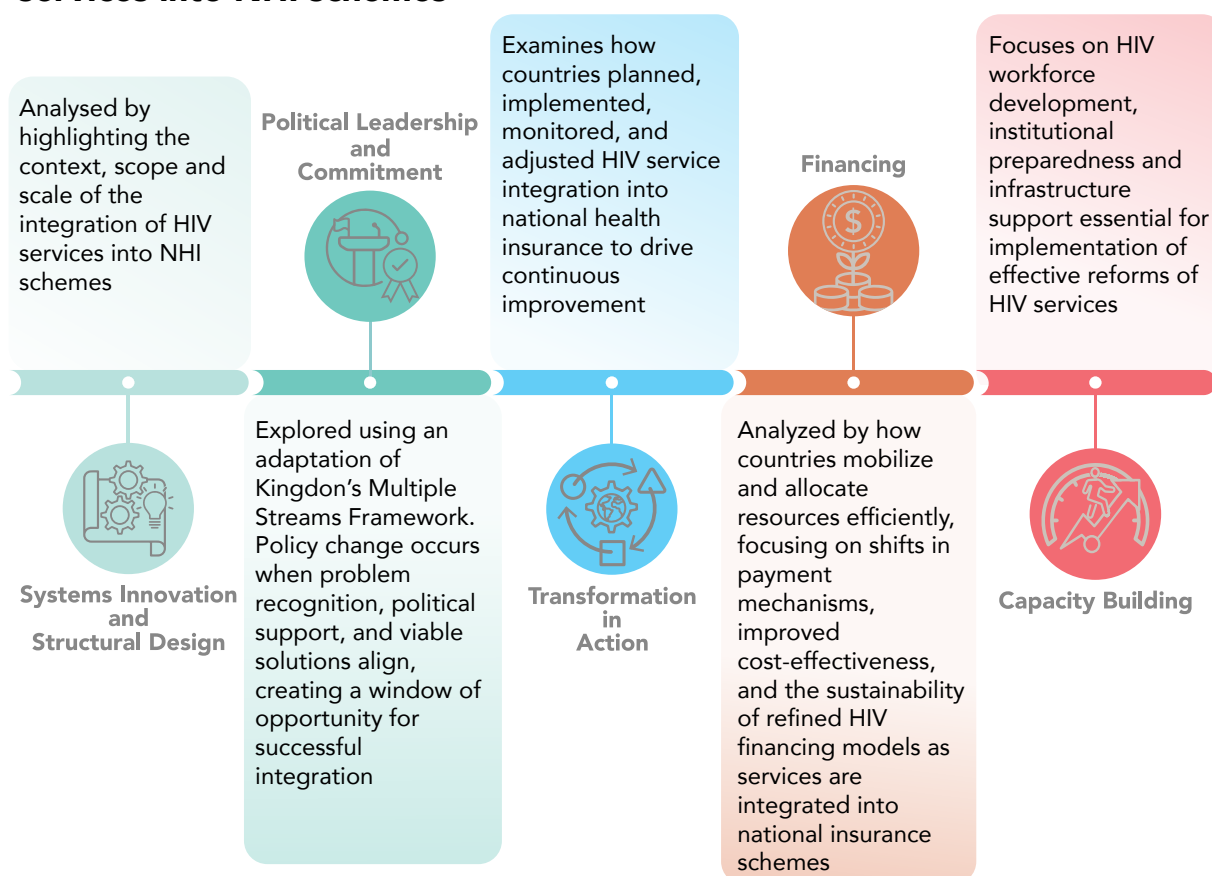
A one size fits all approach cannot be used for reforming and transforming national HIV responses, particularly in the context of diverse health systems. Strategies for achieving UHC must be tailored to local contexts and national dialogues. There are many examples of transformations in countries as it relates to integrating HIV services into NHI schemes. Cases have been selected from Kenya, Rwanda, Thailand and Viet Nam to provide examples of lessons learned across various epidemic, income, health system and insurance contexts. Promising transformations have been introduced in these countries, which include integration of some components of their HIV responses into NHI schemes. Highlights in these case studies are in no way representative of the totality of reforms needed, but provide illustrative examples and lessons learned as countries work on transforming their HIV responses. To ensure relevance, diversity and analytical depth, the following criteria were used to select these cases:

- 1** These countries have documented evidence of significant efforts to integrate comprehensive
- 2** HIV services into major NHI or social health insurance (SHI) schemes.
- 3** They have a supportive national policy environment for such transformations, as well as alignment with global guidance, frameworks and recommendations.
- 4** Data are available publicly and the national stakeholders are willing to provide documentation.

- 5** There was an attempt to provide geographical diversity, particularly the inclusion of countries outside the African context.

Analysis of these diverse experiences allowed for the identification of common challenges, successful strategies and context-specific factors influencing the integration process, offering valuable comparative insights. As countries pursue transformations in their HIV response, this series of case studies looks at some key factors, considerations and opportunities for transformational change in the HIV response. They are taken from scientific publications, reports and websites of governments and think-tanks as examples of the kinds of transformations envisaged for the HIV response sustainability approach. The five core components of the HIV response sustainability framework guided the synthesis of data from these different sources into this report, using the assessment framework outlined below (Figure 1).

● Figure 1. Five elements used to assess efforts for integrating HIV services into NHI schemes



These cases serve as examples of what can be considered in planning for HIV integration into NHIs. It is recognized that transformations require combinations of changes to the HIV programme elements that are required to achieve the country's goals and shared vision. In some cases, specific components already exist and the strategies may just need to evolve or become more fit for purpose for the HIV response. In other cases, where parallel systems have existed—and components of the HIV response are outside of country systems—strategies may be aimed at integrating into national systems and streamlining processes to eliminate duplication of effort. There may also be instances where components are missing altogether in the country or in certain regions or service delivery scenarios. This would require strategies to build, expand and efficiently manage those needed elements to achieve the desired future state.

Summary of Findings



Integrating HIV services into NHI schemes is a dynamic process that requires vision, commitment and collaboration. The collective experiences documented here offer valuable insights and inspiration for countries seeking to build resilient, equitable and sustainable HIV responses in an era of evolving health challenges and constrained resources. Not all countries are at the same stage and conditions for this transformation and therefore the summary findings are intended to help countries map out context specific pathways for change in sustaining impact beyond 2030. In addition to these summary findings countries should consider macro fiscal issues, systems for health and health-care worker capacities and other nuanced factors in determining next steps and considering risks that will affect achievement of their high-level outcomes. In a nutshell, the experience of these countries demonstrates that integrating HIV services into NHI schemes can successfully transition HIV responses from donor dependence

to sustainable domestic financing when certain conditions are met (Figure 2) (4). Four critical lessons emerge from this analysis.

■ **Political leadership and financial commitment are essential for transformation.**

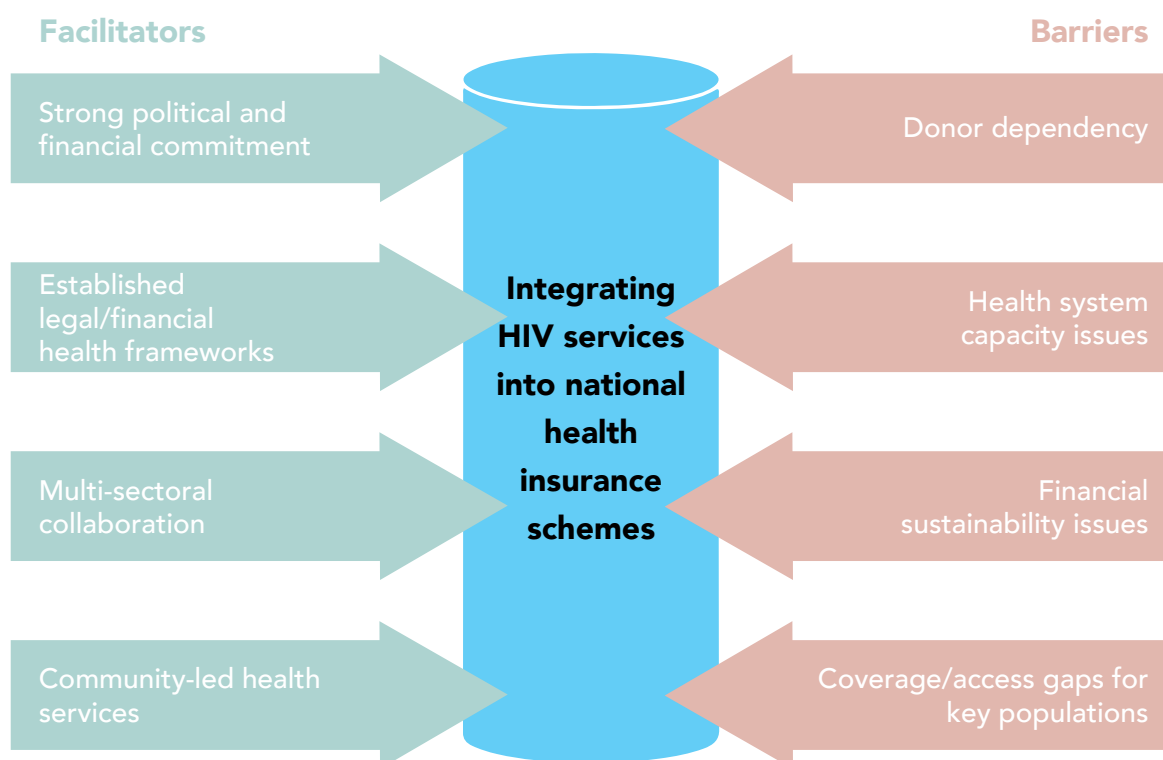
In response to declining external funding, some LMICs prioritized UHC by integrating HIV services into insurance schemes or government funded UHC systems. The aim was to ensure financial sustainability, improve access to HIV services and reduce out of pocket expenditure. Governments played a central role in initiating, driving and sustaining these reforms. They seized political momentum and policy windows to decentralize health systems, improve responsiveness and advance domestic resource mobilization. Community-led organizations and key population networks play a central role in mobilizing, advocating and monitoring the integration of HIV services into NHI and other social protection mechanisms.

■ **Successful integration into insurance schemes requires careful sequencing.** Several countries have adopted a phased approach to integrating HIV services into NHI schemes—starting with inclusion within existing formal insurance systems and then advancing sustained advocacy to extend coverage to those not yet enrolled, particularly poorer, more vulnerable groups and key populations. Full integration of HIV services has generally been phased, with most countries initially excluding antiretrovirals (ARVs) from benefit packages, starting instead with prophylaxis and other non-ARV HIV products and gradually adding ARVs over time. This allowed the insurance systems and the government supporting UHC funding to gradually scale up while managing resource demands. Government funding architecture has evolved from grant financing by the Ministry of Health/Ministry of Finance (MoH/MoF) to align with NHI frameworks, which require separation of payer and provider duties, establishment of new public–private partnership (PPP)/contracts and service delivery and payments structures.

■ **Sustainable financing of the integration of HIV services into NHI requires deliberate shifts in responsibility and strategy.** Governments, Ministries of Health and donors such as PEPFAR and the Global Fund were central actors in reshaping funding from a heavy reliance on external donor funding toward greater domestic financial responsibility. These steps enabled countries to build more self-reliant, resilient health delivery system, as well as sustainable health financing systems.

■ **Building local capacity is fundamental for sustainable transformation.** Civil society organizations (CSOs), international partners such as UNAIDS, PEPFAR and the Global Fund, along with governments and local research institutions, played critical roles in strengthening system capacity. They provided technical assistance, implemented performance-based financing models, drove advocacy for inclusion of the poor, vulnerable and key populations in NHIs using public finances, and developed community-based health insurance (CBHI) mechanisms that emphasized local ownership.

● **Figure 2. Key facilitators and barriers for integrating HIV services into NHI schemes**





Country Case Studies



Rwanda

Kenya

Thailand

Viet Nam

Thailand

● Background

Thailand experienced one of Asia's earliest and most severe HIV epidemics, with an estimated one million people living with HIV by the mid-1990s out of a population of 60 million. The National AIDS Programme was established in 1987, followed in 1991 by the '100% condom' campaign. By the late 1990s, the government initiated free ART programmes with the support of international donors such as the Global Fund, though with limited population coverage as medicines were expensive (11). Thailand launched a free national programme in 2000 for the prevention of the vertical transmission of HIV, allowing all HIV-positive pregnant women to access ART. By 2007, new cases were decreasing, although prevalence remained high with 610 000 people living with HIV and approximately 30 000 annual deaths. The epidemic disproportionately affected key populations, including gay men and other men who have sex with men, people who inject drugs and sex workers. By the end of 2024, an estimated 565 600 people were living with HIV in Thailand, with an adult (15–49 years) prevalence of around 1.1%. New HIV infections have declined substantially, reflecting approximately a 50% reduction since 2010 (12, 13).

Thailand's HIV response has always relied heavily on domestic health financing. Prior to the achievement of UHC in 2001, the overall domestic health financing was a mix of general taxation, payroll contributions and significant out of pocket payments (14). While there were several insurance and social protection schemes already in place, they did not cover HIV services. To address the issue of multiple contributory schemes that were fragmented and inequitable, the Government of Thailand successfully rolled out the Universal Coverage Scheme (UCS) nationwide in 2002 (15). The aim was to cover the 75% of the population not already enrolled in existing schemes through a '30 Baht Scheme'. This scheme covered beneficiaries from the previous Medical Welfare Scheme (MWS) and Voluntary Health Card Scheme (VHCS), the two



public health insurance programmes in Thailand prior to the 2001 health-care reform as well as the 30% uninsured (16). The scheme was managed by the National Health Security Office (NHSO) and funded through general taxation. This was built on a historically integrated model, with all services part of the mainstream health delivery systems, such as: reproductive, maternal, newborn and child health (RMNCH) services; the expanded programme on immunization (EPI); prevention of vertical transmission; family planning; TB; disease control; and health promotion. These were fully integrated into the UCS benefit package and fully funded by general tax and managed by the NHSO (26).

● Systems innovation and structural design

Thailand sequenced integration steps deliberately, with a phased and adaptive integration roadmap. This avoided shocks to the system and ensured readiness of providers and budgets.

Integration of ART and core HIV care services.

In the beginning, the UCS excluded ART due to high costs and logistical concerns, though universal ART for UCS members was launched in 2003. This was after Thailand's Government Pharmaceutical Organization (GPO) first produced the low-cost generic triple antiretroviral fixed-dose combination known as GPO-Vir in 2002 at US\$ 25 per person per month and a study by the World Bank showed it to be cost-effective (17). The NHSO, a newly established agency by the National Health Security Act 2002, took over HIV treatment financing from the Department of Disease Control (DDC) in 2006, becoming the main fund manager under the UCS (18). In 2006, Thailand integrated its HIV services, including ART, into its UCS following price reductions and strong advocacy. The criteria for ART initiation were expanded in 2014 to include all people living with HIV regardless of CD4 count. In addition, PrEP was formally included in 2021 following successful pilot programmes and a determination through health technology assessment (HTA) that it was cost-effective (19). Other services integrated into UCS include: HIV testing (since 2022); viral load and CD4 monitoring; HepB, HepC and STI screening and treatment; prevention of vertical transmission; and treatment for opportunistic infections (20).

Integration of prevention and key population services.

By 2014–2015, the NHSO under UCS explicitly allocated national budgets for HIV prevention among key populations (e.g. gay men and other men who have sex with men, and

sex workers). For instance, approximately THB 25 million was earmarked in 2014 and THB 12 million in 2015 for these efforts. In 2016, the first regulatory step allowed 'key population-led health services' to conduct HIV testing under the supervision of health facilities—marking the start of structured support for community and key population-led services within UCS. Integration did not automatically guarantee strong prevention outcomes. While treatment outcomes were strong, prevention among key populations lagged in earlier years. Global HIV prevention guidelines recommend sustained community-led outreach and differentiated prevention as important to closing gaps (21).

Expanding social contracting to

community-based organizations (CBOs).

Full institutionalization—enabling community-led organizations (CLOs) to receive direct reimbursement for HIV prevention, treatment and care under UCS—was only achieved in 2022. Integrating community services into UCS required defining community-led services to be included in benefit packages, establishing accreditation and payment mechanisms, as well as capacity-building for reporting and data systems. Policy development was spearheaded by technical panels comprising the Ministry of Public Health, NHSO, HIV experts, and CSOs. The reach–recruit–test–treat–retain (RRTTR) model allowed NHSO to contract with CSOs and key population-led health services for preventive services. This strategic contracting with CSOs enabled grassroots innovations in service delivery—such as peer-led HIV testing, mobile clinics and culturally sensitive counselling—often better tailored to key populations than conventional services. By integrating such innovations into the

national framework, Thailand bridged policy and practice, making the health system more inclusive and responsive to vulnerable groups.

● Political leadership and commitment

Thailand's UCS reform agenda was a political commitment at the Prime Minister level, which enabled full domestic financing for HIV within a broader UHC agenda. The 2001 election in Thailand ushered in a government committed to UHC and the HIV response as a national priority, linking it to economic development and social protection. This was motivated by high out of pocket health expenditures and the high proportion of uninsured people (30% of the total population). High mortality rates, challenges with early access to ART, and later to PrEP among key populations, and an equity issue boosted further political commitment. Similarly, inadequate funding to community-led services highlighted the need for increased domestic funding support and capacity-building.

HIV high on the 2001 UHC agenda. This required sustained advocacy from key actors and advocates including the Ministry of Public Health, NHSO, Department of Disease Control, civil society and people living with HIV networks such as the Thai Network for People Living with HIV, and others (22). Policy entrepreneurs, such as

Ministry of Public Health officials, NHSO leaders, researchers and civil society advocates capitalized on opportunities to push for ART and PrEP integration (19). Later, a policy window facilitated by HTA evidence, that demonstrated the cost-effectiveness, and sustained advocacy enabled the inclusion of PrEP and community-led health services (CLHS), where local actors and CSOs played a crucial role in service delivery, particularly for marginalized groups. The National Health Security Act (2002) guaranteed HIV treatment and prevention as part of citizens' rights under UCS.

Protecting the HIV agenda. A strong governance and multisectoral approach was essential to ensure that integration did not undermine HIV-specific accountability. While HIV financing was incorporated into the UCS, Thailand retained dedicated HIV governance structures—such as the National AIDS Committee—and ensured cross-sector engagement (health, education, labour and social protection). This approach preserved focus on human rights, prevention and key population programming—areas often overlooked during integration into broader UHC systems.

Thailand integrated HIV services through phased reforms, expanding treatment and prevention, embedding community-led models, strengthening governance, and sustaining political commitment to ensure equitable access, system resilience, and long-term programme sustainability



● Transformation in action

The integration of UHC reforms and HIV services during the past two decades demonstrate the long-term commitment of Thai health systems to ending AIDS by 2030. Integration made HIV services free at the point of care under UCS. This improved equity, dramatically expanded ART coverage and testing rates, and out of pocket costs fell sharply, especially for poorer households and migrant workers. In addition, evidence-based policy formulation was also guided through multistakeholder consultations and the development of a national strategy, driven by evidence from HTAs and high-level political commitment to equity. Extensive geographical coverage of health delivery systems, together with a committed health workforce, are the foundation for implementing UHC with an equity outcome. UHC has been a powerful equalizer, as it nullified infant mortality gaps between rich and poor provinces (23). Thailand phased in ART in 2006 and PrEP services in 2021 by leveraging domestic financing and contracting with CSOs (19, 24, 26).

Data systems and monitoring were crucial for accountability. Thailand used national digital systems to monitor ART retention, viral load (VL) suppression, coverage among key populations and facility performance and payments (26). These real-time monitoring systems and performance reviews, which were led by the NHSO and supported by CSOs, allowed stakeholders to evaluate ART outcomes, viral suppression and service reach among key populations. Subsequently, Thailand expanded service eligibility and access by increasing investments in key population-led health services, introducing HIV self-testing approaches and scaling peer-led and community-based models that improve outreach, testing uptake and service retention among key populations (27, 28). The key population-led health services now identify one in five people living with HIV and serve four out of five PrEP users. By 2023, more than 26,000 individuals were receiving PrEP—largely through key population-led health services—while ART coverage reached approximately 82%, with viral suppression among those on treatment at 96% (30).

● Financing

Thailand leveraged domestic financing, mainly from general taxation, to ensure the integration of HIV services into UCS for the Thai population, while funding for HIV services for non-Thai people was mostly from external resources. International donors such as PEPFAR and the Global Fund supported the early integration process by: helping community-led and key population-led organizations demonstrate feasibility; establish certification and quality systems; conduct costing exercises; and later extend services to non-Thai populations (31, 32). Integration of HIV services into the UCS provides a stable domestic financing mechanism that insulates HIV services against fluctuations in external donor aid, especially if external funding declines or donors withdraw.

Achieving financial sustainability required explicit, ring-fenced budgeting. As Thailand shifted from vertical donor-funded HIV

programming to routine government financing through the NHSO, the following steps were crucial: Firstly, making ART a standard 'benefit package item' with a clear costed tariff, ensuring predictable funding; and secondly, intentionally absorbing and gradually establishing clear budget lines for HIV testing, VL monitoring, prevention of vertical transmission and PrEP. The anticipated impact of expanded ART and PrEP services was substantial, improving health outcomes across the country while reducing long-term health-care costs (34).

Standardized clinical pathways and reimbursement mechanisms helped improved efficiency. To ensure consistent service quality and cost control, the NHSO introduced Diagnosis-Related Group-based reimbursement and capitation models for HIV services. This required national treatment guidelines to be standardized,

enabling price negotiations and procurement efficiencies for ARVs and diagnostics. Providers received predictable payments, which incentivized scale-up and reduced fragmentation.

Local production and pooled procurement drove down ARV costs. The integration of ART into the UCS led to significant improvements in cost-effectiveness, with the bulk purchasing of generic drugs reducing costs while ensuring quality medicines (17). Thailand's Government Pharmaceutical Organization (GPO) produced generic ARVs, which dramatically reduced ART cost and enabled rapid ART scale-up (34). Thailand demonstrated that comprehensive reforms across multiple programme elements can drive financial sustainability. Integration into UCS, coupled with procurement reforms—such as centralized purchasing, long-term forecasting and investment in domestic manufacturing capacity—significantly reduced costs (35).

Community and key population groups needed dedicated contracting models.

Community-led health services, especially for key population-led health services, are funded through contracting models like RRTTR, which is a people-centred HIV service delivery model that ensures individuals—especially key populations—are identified, engaged, tested, treated and supported to remain in care for optimal health outcomes (36). Formal funding for CLHS under UCS began in 2022 and further increases in the NHSO reimbursement rates are planned for 2025.

Integration improved equity and reduced out of pocket costs. Financial protection has improved through UCS, which offers services with minimal or no co-payment; For example, ART, PrEP and HIV self-testing are free or subsidized, reducing out of pocket expenses. UCS has significantly decreased catastrophic health expenditures, especially for inpatient and catastrophic health events (35).

● Capacity building

Thailand's integration success was underpinned by a coordinated, system-level strategy focused on contextualizing global best practices through sustained local capacity-building. The NHSO, in collaboration with CSOs, ministries and academic institutions, facilitated intersectoral workforce planning to ensure the right skill mix at all levels of care (29).

Thailand must overcome a critical barrier—the longstanding lack of genuine recognition of the role of civil society by professional councils and the Ministry of Public Health—to achieve the goal of an intersectoral workforce. Investments in health information systems, including real-time HIV monitoring platforms, national ART registry with full confidentiality protection, data-driven planning and adaptive responses. Supportive leadership and continuous skill development reinforced a culture of innovation and accountability, ensuring progress and good practices were consistently shared and locally grounded. Through further technical assistance

from PEPFAR, local systems were equipped to manage public financing for private service delivery, strengthening long-term sustainability (33).

Thailand sustained HIV integration through coordinated strategies, data systems, workforce planning, and capacity-building to ensure sustainability ””



Viet Nam

● Background

Viet Nam's population living with HIV increased by almost 150 times, from 1700 in 1990 to 250 000 in 2023. New infections more than tripled, from 0.13 per 1000 in 1992 to 0.43 per 1000 in 1998 before declining to 0.11 by 2023. The number of people living with HIV was 250 000, while the prevalence rate stood at 0.3 by 2023 (37). The HIV epidemic has been concentrated among key populations, particularly people who inject drugs, transgender, gay men and other men who have sex with men, and female sex workers. Although prevalence and incidence rates among people who inject drugs and female sex workers have declined slightly, gay men and other men who have sex with men have experienced rising infection rates between 2012 and 2020 (38). Viet Nam attained lower-middle-income status in 2009, and by 2013 donor support started to decline, prompting the shift toward increased domestic funding. By 2020, domestic sources contributed 53% of total HIV expenditure, up from approximately 20% in 2013 (39).

In 1992, the national SHI scheme was introduced, initially covering formal sector workers but gradually expanding to include the poor, children and near-poor populations under the 2008 Health Insurance Law. The scheme covers 100% of costs for the poor and 80–95% for others, with subsidies available to mitigate remaining co-pays. However, in 2010, out of pocket expenses constituted nearly 60% of health expenditure despite expanding insurance coverage (40). Therefore, the Health Insurance Law was amended in 2014 to mandate broad SHI expansion (41). Managed by Viet Nam's Social Security (VSS), SHI provided coverage for over 94% of the population as of 2024 (42).

● Systems innovation and structural design

Viet Nam's integration of HIV into SHI improved financial protection, stabilized domestic financing, expanded access, strengthened data and planning, and provided a pathway toward sustainable, domestically funded HIV services—while highlighting the need to address equity and administrative challenges. Some of the significant strategies for systems transformations, along with lessons learnt, include the following:

Policy alignment provided the legal, financial, operational and equity foundations. While HIV treatment had been traditionally funded through donor support in Viet Nam, donor transition plans motivated a new policy revising SHI law and packages to allow for the procurement of ARVs, creating procedures for HIV services reimbursement by SHI, and initiating government support for the enrolment of people living with HIV (43, 44). The policy led to centrally procured ART drugs being distributed through SHI-covered facilities, embedding HIV care within the national health system and ensuring continuity (41). The 2021 revision of Viet Nam's Law on Prevention and Control of HIV/AIDS (Law No. 71/2020/QH14, effective 1 July 2021) further reinforced the role of SHI in financing HIV services by explicitly linking HIV care to SHI coverage. It clarified that people living with HIV who are participants in health insurance have their medical examination and treatment costs covered by the SHI fund and tasked the Minister of Health with issuing the list of ARV drugs and related HIV services to be covered by the SHI (45). Prior to this revision, financing for HIV services was largely guided by separate decrees and policies, with SHI gradually integrating treatment services, but without an explicit legal definition by law.

Core HIV services were considered in the design of the SHI. Viet Nam's SHI package included comprehensive HIV coverage since its inception. Circular 15/2015/TT-BYT, issued in June 2015, explicitly mandated SHI coverage for ARV and other chemotherapies, medical supplies and technical services related to HIV/AIDS, HIV testing and diagnostic services, treatment of opportunistic infections, in-patient HIV care and prevention of vertical transmission services (46). This reinforced SHI's role in Viet Nam's broader

UHC agenda. Despite major progress, Viet Nam's HIV response remains vulnerable in four main areas. The largest vulnerability is HIV prevention interventions, especially those tailored to key populations. Second, several essential prevention commodities are not covered. Financing for CLOs and system strengthening remain highly dependent on donors.



Viet Nam expanded HIV access by integrating services into social health insurance, increasing coverage, improving continuity, and addressing equity and administrative challenges ”

Explicitly linking HIV care to SHI coverage expanded service coverage. The integration of HIV services to SHI removed financial barriers, expanded provider networks and integrated HIV care into routine health services. A key strategy was pairing service integration with aggressive enrollment policies, including provincial subsidies for insurance premiums for people living with HIV. By 2020, over 90% of people living with HIV were covered by SHI—up from 50% in 2016 (47, 48, 49, 50,51). By 2023, coverage had surpassed 95% (49, 51). However, PrEP is still not covered under SHI and remains dependent on external financing, such as PEPFAR, that finances 71% of the cost (38). Linking HIV care to SHI also enabled almost all out-patient HIV treatment facilities to be integrated into the public health system

and became eligible to receive SHI reimbursements (52). Additionally, HIV services became available in all primary health-care facilities and provincial hospitals, improving accessibility outside major urban centres. This expanded service delivery beyond a few specialized centres reduced travel time and other indirect costs, making it easier for patients—especially in rural areas—to stay in care. Service integration also improved continuity of care, making it easier for people living with HIV to access multiple services in one system, increasing engagement, improving co-management of comorbidities and reducing fragmentation and loss to follow up (43).

Prioritizing digital information systems. Viet Nam recognized early that robust digital infrastructure was critical for reimbursing HIV services through SHI. To achieve this, the government invested in a coordinated suite of digital reforms. Enhancing interoperability, introducing e-claims systems, deploying digital enrolment tools and expanding electronic medical records created a seamless environment for continuous reimbursement, efficient financial management and real-time patient monitoring—while minimizing service disruptions. These digital investments were pivotal in enabling Viet Nam’s rapid scale-up of SHI coverage for HIV and a smooth transition from donor support to domestic financing (53).

● Political leadership and commitment

The looming financial shortfall due to declining donor support posed a major risk to sustaining the HIV response, especially life-saving ART, thus emphasizing the urgency of domestic financing. The national target to end AIDS by 2030 added further pressure for sustainable solutions. While donor withdrawal significantly influenced the political prioritization of integration, legislative reforms established the legal foundation for SHI-based HIV financing (43). Leveraging SHI to finance the provision of HIV services provided an opportunity to capitalize on Viet Nam’s expanding insurance system (48).

The strong government commitment to UHC and the HIV response provided a supportive environment and the impetus for the successful integration of HIV into SHI. In 2015, the Prime Minister mandated the SHI to include HIV services in the SHI package and increase the enrollment of people living with HIV to 80%, from the 30% recorded in 2013, and to 100% by 2020

(44). All provinces were mandated to allocate funds to buy health insurance for people on ART, which increased the enrolment from 90% in 2019 to more than 95% coverage by 2023 (48, 49, 50).

Policy entrepreneurs, including leaders in the Ministry of Health and Viet Nam Social Security, as well as PEPFAR-supported experts, catalysed reforms, with the 2015 government decision to mandate HIV integration into SHI serving as a pivotal move coupling the streams. Policy-makers and technical experts, including from the organizations mentioned above, as well as international partners such as PEPFAR and the Global Fund then collaborated to define SHI-covered HIV services, streamline ARV procurement and build reimbursement systems. In 2021, a revised HIV law further mandated testing for pregnant women and reduced the age of consent for testing to 15, representing an expansion of HIV services into SHI that promotes earlier detection and improves access among key populations.

● Transformation in action

A clear vision for the integration of HIV services into SHI was articulated by the Ministry of Health and a system performance assessment, in collaboration with the Viet Nam Social Security and the Viet Nam Administration of HIV/AIDS Control, was conducted to identify gaps and areas for improvement. The strategy for change involved: setting clear transformation targets, including achieving 100% SHI enrolment for people living with HIV; contracting all HIV outpatient clinics with SHI; and expanding the SHI-covered HIV service

packages. Pilot programmes and assessments conducted jointly by the Ministry of Health, Viet Nam Social Security and Viet Nam Administration of HIV/AIDS Control gathered data to evaluate the success of integration and inform necessary adjustments. Delays in ARV procurement prompted streamlining of reimbursement and stock management systems. Low rural uptake led to decentralized service delivery and provider feedback on billing gaps resulted in targeted training (51).

The impact of the transformation on the quality, efficiency, and sustainability of HIV services was tracked by performance assessments carried out by the Ministry of Health, Viet Nam Social Security and Viet Nam Administration of HIV/AIDS Control, ensuring that the shift to SHI financing did not compromise access to care and the quality of care for people living with HIV. As a result, only 13.4% of clients incurred out of pocket costs for ART post-transition, averaging \$8/year (44). By late 2021, more than 85 000 people living with HIV out of 250 000 had transitioned to SHI-funded ART. As of 2023, ART coverage stood at 78%, and viral suppression reached an impressive 98% among treated patients. PrEP scale-up was also notable, with over 44 000 users at 210 sites by early 2025 (38).

● Financing

Following the 2015 mandate requiring full enrollment of people living with HIV, and its rise as an LMIC, Viet Nam began steps to transition from international to domestic funding, as described below.

Making SHI the core funding mechanism to protect HIV services from fluctuations in external aid. To encourage predictable, long-term financing, Viet Nam gradually transitioned toward domestic financial sustainability. To do so, both the central and local government mobilized domestic resources to support the scheme. Provinces developed sustainable financing plans and increased their budget contributions to HIV services. This contributed to broadening the domestic funding base as domestic resources increased from 36% (2016) to 53% (2020) of total HIV expenditure (56).

Centralizing procurement for cost management. Viet Nam's integration of ARV drug financing into SHI strengthened domestic procurement mechanisms and reimbursement pathways, contributing to improved supply stability and locally managed drug financing

(56). Between 2018 and 2020, Viet Nam embarked on a sequenced, multiyear policy and operational transformation, to shift ARV drug procurement from donor mechanisms (PEPFAR/Global Fund) to the SHI system. In 2018, the Ministry of Health designated Vietnam Social Security as the national agency for centralized ARV procurement using SHI funds; this establishes the legal basis for shifting from fragmented provincial or donor purchasing. To prepare, these two bodies developed multiyear national quantification for SHI covered clients, provinces created transition roadmaps and an integrated plan aligned PEPFAR and Global Fund transitions. Before national tenders could proceed, robust back-end infrastructure was required. SHI developed the reimbursement framework for HIV services. In 2019, Viet Nam Social Security conducted the first national ARV tender using SHI funds, replacing fragmented provincial purchasing. By the end of 2020, virtually all ARV procurement for people enrolled in SHI was funded and managed through Viet Nam's centralized mechanism. This shift reduced procurement costs compared to previous donor driven or decentralized approaches.

● Capacity building

Capacity-building was one of the most decisive factors in Viet Nam's successful transition of HIV services to SHI. It helped ensure that facilities could meet administrative, financial, regulatory and clinical requirements—reducing risks of service disruption and improving sustainability. Some key strategies and lessons learned included, as described below

Developing local leadership and advocacy skills. All provinces received technical assistance on advocacy for their provincial people's committee to allocate provincial funds for health insurance cards, support for ARV co-payment and to conduct an information, education and communication (IEC) campaign to encourage voluntary ART enrollment. Development of local leadership and support for technical infrastructure were also essential to enable the system-wide shift to an integrated, nationally funded, HIV service delivery (44, 47).

Critical technical assistance and knowledge transfer. To prepare for SHI reimbursement for ART, international partners, including PEPFAR, the Global Fund and UNAIDS, provided technical assistance to more than 400 health facilities to provide SHI medications. In addition, PEPFAR provided targeted technical assistance to Viet Nam Social Security and the Viet Nam Administration of HIV/AIDS Control to strengthen their capacity in managing and financing integrated HIV services, as well as in enhancing health information systems. This included actuarial training for Viet Nam Social Security staff to accurately project the cost of including HIV treatment services in the SHI benefits package, and support in developing SHI related regulatory policies.

Equipping health workers to deliver under the new model was essential. As Viet Nam integrated HIV services into SHI, facilities needed substantial capacity building—including training in health insurance reporting, claims documentation and financial procedures—to meet the administrative requirements of SHI reimbursement. Training programmes were also conducted for health workers to ensure they had the skills for service delivery under the new domestic financing model. Additional efforts involved designing non-stigmatizing enrollment processes for people living with HIV and key populations and advocating government leadership to ensure the financial protection of those most affected.

Viet Nam advanced HIV financing through social health insurance, driven by donor transition pressures, strong policy leadership, centralized procurement, expanded coverage, and sustained capacity-building for system resilience and equity challenges, improving access continuity and long-term efficiency



Rwanda

● Background

Rwanda's HIV incidence was 8.3 per 1000 uninfected population in 1990 and declined significantly to 0.24 per 1000 by 2024 (57). The country made notable progress in the HIV response with its 'Treat-All Policy' established in 2016; HIV prevalence fell to 2.7% by 2024, with an estimated 230 000 people were living with HIV as of that year. While the country has made significant strides toward achieving the UNAIDS 95–95–95 targets, challenges persist—particularly among adolescent girls and young women and key populations (59).

Rwanda's HIV response has used a financing model that combines government funding, donor aid, insurance premiums and out of pocket payments. In 2023, PEPFAR and the Global Fund together financed 84% of HIV-related expenditures (58, 59). One of Rwanda's most transformative health system reforms has been the development of Community-Based Health Insurance (CBHI), or Mutuelles de Santé, which has improved both service access and financial protection. Piloted in 1999, scaled nationally by 2004 and made mandatory in 2007, CBHI achieved coverage of 83.5% of the population, representing 92% of insured population. While this national insurance is not an 'NHI' in the strict single payer sense, it covers HIV care as part of overall health services (60).

● Systems innovation and structural design

Integrating HIV services into CBHI required comprehensive health system reforms rather than a single policy adjustment. This approach aligned with the country's broader UHC reforms and HIV sustainability priorities. Key system transformations that enabled HIV integration are described below.

Formal policy integration of HIV into an essential health service package. Initially supported by donor programmes and local initiatives, CBHI was placed under the management of the Rwanda Social Security



Board (RSSB) in 2015. While CBHI does not directly finance ART, which remains donor funded and free to all patients regardless of insurance status, it plays a crucial complementary role in Rwanda's HIV response. Alongside these reforms, Rwanda is planning a phased ART scale-up strategy, integrating HIV services into the broader primary health-care system to ensure equitable and sustainable access. Initially, CBHI focused on providing general health services. Over time, as the HIV epidemic became a national priority, the CBHI benefit package was expanded to include treatment of opportunistic infections, helping to reduce out of pocket expenses and financial barriers for people living with HIV. This provided the legal basis for CBHI reimbursement of HIV care and removed ambiguity over whether HIV services could be financed through insurance rather than donor funds.

Designing and costing benefits package to ensure predictability for CBHI financing. HIV services were previously delivered through vertical, donor-financed systems with different costing structures. Integrating into CBHI facilitated access to integrated health service delivery platforms, offering financial risk protection that ensures vulnerable populations,

including the poor, are not excluded from general health services, noncommunicable disease care and mental health support. HIV services—including clinical consultations, laboratory tests, and treatment monitoring—were explicitly costing and incorporated into CBHI benefit packages. Service tariffs were aligned with CBHI payment rules (60). Financing for HIV prevention services is mixed: some are covered through CBHI; while population-level and key population interventions are funded by public health budgets and development partners delivered within the same health system. Voluntary medical male circumcision (VMMC) is also supported under CBHI (61). Integration also extended to TB/HIV services and increasingly includes screening/management for noncommunicable diseases and mental health within HIV care platforms.

Health information systems and digital integration. Implementation of CBHI required standardized documentation and digital reporting. To reduce parallel reporting and administrative bottlenecks, HIV patient records were integrated into the national health management information system, which enabled eligibility verification, service coding and streamlined claims submission.

● Political leadership and commitment

Politically, the government strongly prioritized health and development (63). The collapse of Rwanda's health system in the 1990s was a major challenge that spurred efforts toward integration and reform. Infrastructure destruction, health worker shortages and widespread disease, including HIV, were viewed as barriers to national recovery and economic development. Financial barriers also restricted access to care, focusing attention on the need to reduce inequities related to user fees (61). To enhance quality and accountability, the Ministry of Health introduced Performance-Based Financing (PBF) in 2001–2002, linking funding to measurable outcomes and incentivizing health workers and facilities to improve service delivery, including for HIV care (64). HIV integration required

coordinated reforms across financing, service delivery and insurance administration. Donor transition plans were deliberately aligned with national health insurance reforms—particularly the CBHI scheme—under strong government leadership. This process was supported by close collaboration between the Ministry of Health, the Rwanda Biomedical Centre and CBHI administrators, ensuring continuity of HIV services as external financing declined and responsibilities shifted to domestic systems (66, 67, 68, 69).

● Transformation in action

Rwanda's Vision 2020 set a strong foundation for health system reform, emphasizing integration, UHC and reduced donor dependency. In 2002, Rwanda outlined a clear vision for health system reform focused on integration, UHC and reduced donor dependency (63). Planning involved assessments and stakeholder consultations, leading to a strategy that prioritized ART scale-up, HIV service integration into CBHI, and expanding CBHI coverage. Robust monitoring systems and health information tools tracked progress through regular reporting and workshops led by the Ministry of Health and the Rwanda Biomedical Centre that informed adjustments (65). Expansion of CBHI and UHC reforms were designed to improve access to and utilization of HIV services within the broader health system, with evidence showing that higher CBHI use was associated with increased uptake of key HIV services such as prevention of vertical transmission and voluntary counselling/testing. These reforms strengthened national health infrastructure, improved outcomes and built a resilient, adaptive system when accompanied by strong data systems and responsive governance. As a result of the reforms, Rwanda achieved the 95–95–95 targets in 2022 (58). PrEP uptake is increasing among key populations, and over 4.2 million people were screened for STIs in 2022–2023 (62). The poorest pay no premiums, with support from government and donors.

● Financing

Transitioning to domestic financing through CBHI was the key to affordable HIV care. Rwanda's HIV programme has been primarily financed through international donors, with the Global Fund and PEPFAR financing 88.5% of the national HIV response by 2025 (70). While these funding streams have supported major progress in care and prevention, they raise concerns about long-term sustainability. Nationally, the Rwandan Government subsidizes the CBHI scheme and has implemented PBF systems which are also donor supported. Under CBHI, outpatient co-payments are capped at Rwandan franc (RWF) 200 (approximately US\$ 0.15) to ensure affordability, while the poorest citizens are fully covered through additional subsidies provided by the Global Fund (63). Research and policy analyses show that the implementation and expansion of CBHI in Rwanda have substantially reduced out of pocket health-care payments for insured enrollees, with reports that the out-of-pocket health expenditures as a share of total health spending fell from about 26.6% in 2000 to approximately 10.4% by 2020. (61, 64, 67).

● Capacity building

Task-shifting, standardized protocols and differentiated service delivery supported the transformation. The Ministry of Health and Rwanda Biomedical Centre, supported by PEPFAR, the Global Fund and the World Bank, introduced: task-shifting by: training nurses to manage ART; PBF to incentivize quality care and community health workers (CHWs); and peer educator programmes for outreach and adherence (60). Standardized HIV protocols (2002) and regular updates (e.g. Treat-All in 2015) ensured uniform service delivery, while differentiated service delivery (DSD) models like training on multimonth ART dispensing reduced clinic burdens (61). Training in integrated services (TB/HIV, prevention of vertical transmission) further streamlined care. These efforts, supported by nongovernmental organizations (NGOs) and WHO, continue to drive Rwanda to sustain its achievement of the 95–95–95 targets, though challenges like donor dependency and workforce gaps remain.



Kenya

● Background

Kenya has a generalized HIV epidemic, with an adult prevalence of 3.0% and an estimated 1.3 million people living with HIV as of 2022⁴. While the country has reduced new infections and AIDS-related deaths, key populations—such as female sex workers (27.5%), gay men and other men who have sex with men (19.1%) and people who inject drugs (18.3%)—continue to face a disproportionate burden (71, 72, 73). Females account for approximately 65% of the people living with HIV, adolescents and young people aged 10–24 years accounted for 38% of all new HIV infections, with adolescent girls and young women comprising eight out of every ten new cases in this age group. However, there are significant geographical disparities, with seven counties, including Nairobi and Kisumu, accounting for 50% of all people living with HIV (73).

Health financing is supported by government funds, donors, private insurance and high out of pocket spending, which accounted for 24–26% of total health expenditure in recent years (74). Historically, the National Hospital Insurance Fund (NHIF), established in 1966, was the main public insurance scheme. It served primarily formal sector employees and was expanded later to include informal workers. Kenya's health system was significantly restructured in 2013 through devolution, i.e. transferring most service delivery functions to 47 county governments, while the Ministry of Health retained policy and regulatory roles (75). This caused local governments to take charge of most health service delivery, improving local responsiveness and management, while policy-making and regulation remained centralized. Yet, by 2022, only 24% of the population was covered (76). To address this, Kenya launched a major reform under the Social Health Insurance Act (SHIA) of 2023, replacing NHIF with the Social Health Authority (SHA), which manages three funds: the Primary Healthcare Fund; the Social Health Insurance Fund (SHIF); and the Emergency, Chronic and Critical Illness Fund (77).

● Systems innovation and structural design

The new mandatory contribution model under the Social Health Insurance Act was introduced to transform health financing for UHC, ensuring universal, affordable and high-quality health insurance for all citizens. This reform explicitly sought to expand access to HIV services without imposing financial hardship. However, the rollout faced early legal and administrative challenges, including a High Court suspension that delayed implementation until early 2024. The scheme was ultimately launched in late 2024, at which point all Kenyans were required to register under the new Social Health Authority. This transition coincided with significant budget reductions and health-sector financing gaps—most notably the 2025 cuts in funding from the United States Government that directly affected HIV programmes (78, 79, 80).

Stacked health service coverage approach.

Kenya's health financing reforms adopt a stacked (layered) service coverage model, in which different health needs are covered by distinct but complementary financing layers, rather than a single flat benefits package. Each layer addresses a specific level of care intensity, cost and population need. Under the Social Health Authority, health benefits are financed through three distinct funds, each addressing different levels of care, including HIV services. Layer 1 is the Primary Healthcare Fund providing universal access to preventive, promotive and basic services at the community and primary care levels. Layer 2 is the Social Health Insurance Fund—contribution-based with government subsidies for the poor—covering the majority of outpatient and inpatient services across accredited facilities. This is the core insurance layer of the system. Layer 3 is the Emergency, Chronic and Critical Illness Fund, a publicly financed risk pool that provides financial protection against high-cost, severe and long-term conditions for the most catastrophic illnesses (81). There are structural limitations to a stacked approach, where coverage is primarily facility-based and community-based programmes are generally covered only when linked to service channels recognized by the Social Health Authority. As a result, most community-based HIV programmes

are only covered when they are delivered through service channels formally linked to the SHA system. Ongoing advocacy efforts aim to secure continued support for the inclusion of the full range of HIV services within the Social Health Authority—including prevention services outlined as priority interventions in Kenya's HIV Prevention Operational Plan. This includes ensuring that PrEP and other essential prevention services are fully covered. This requires shifts towards integrating community interventions into primary care networks to maintain continuity of prevention and treatment services.

Kenya integrated HIV into social health insurance through layered financing reforms, expanding access, embedding services in primary care, strengthening systems, despite funding gaps and implementation challenges ”

HIV within the Social Health Authority. The benefits package incorporates comprehensive HIV services, including ART, advanced HIV care and treatment of related conditions throughout the layers of the system. Importantly, the Social Health Authority model embeds HIV care within the general health system rather than maintaining stand-alone, vertical HIV clinics. By anchoring UHC at the primary care level, the system is designed to ensure that HIV services are

accessible through primary health facilities. This integrated approach aims to reduce stigma and discrimination, improve continuity of care and strengthen long-term management of co-morbid and chronic conditions. This includes provision of TB and HIV services, including ART, STI management and associated testing, especially in private facilities. The approved primary health-care and Social Health Insurance Fund benefits include ARVs and HIV testing and follow-up tests, TB, management of HIV, STIs, noncommunicable diseases, mental health screening, management, referral and rehabilitation (82, 83).

Digital backbone in the Integrated Healthcare Information Technology System (IHTS).

An investment into IHTS dating back ten years was the foundation for integrating and transitioning preexisting health information management systems, in partnership with the private sector, to ensure seamless service delivery and financial tracking (84, 85). It is designed to operate with the Kenya Health Information System (KHIS/DHIS2), the Facility Electronic Medical Records (EMRs) and laboratory information systems. This facilitates the integration of previously vertical programmes, such as HIV, into the unified purchaser system and improves visibility of the full HIV service cascade (86, 87). However, as the Social Health Insurance Fund is still in its early stages, comprehensive information systems and monitoring and evaluation systems are still encountering their own challenges (88). Interoperability remains uneven, especially in lower-level facilities and community settings (89). Early monitoring has already highlighted challenges, such as service disruptions linked to PEPFAR funding cuts and persistently high out of pocket spending, currently at 24%, risking setbacks if the Social Health Insurance Fund rollout slows.

● Political leadership and commitment

Kenya's transition to the Social Health Insurance Fund was shaped by multiple policy factors. Key issues included: unsustainable donor reliance; limited coverage from the National Hospital Insurance Fund (especially among informal workers); high out of pocket costs; and inefficiencies in vertical HIV programmes (90). The urgency was heightened by PEPFAR funding cuts, which disrupted services and exposed fragilities in the system (91). Political support for UHC is strong, but implementation is challenged by devolution-related capacity gaps and coordination needs (75).

A critical policy window opened with the SHA Act of 2023, aligning with Kenya's UHC agenda and the need for sustainable domestic financing. Multiple actors are involved, including the: Ministry of Health; National AIDs and STI Control Programme; Social Health Authority; county governments; CSOs (e.g. HENNET, Y+ Kenya); and international donors. Policy entrepreneurs—Ministry of Health leaders, National Syndemic Diseases Control Council, National AIDs and STI Control Programme, CSOs, communities of people living with HIV and development partners—have seized this window to push for HIV integration into the Social Health Insurance Fund (92).

● Transformation in action

Kenya's vision for UHC by 2030 is aligned with the 95–95–95 HIV targets despite cuts in PEPFAR funding. Stakeholder consultations involving the Ministry of Health, CSOs, counties and donors informed the design of the Social Health Insurance Fund, with ambitious targets set, including 100% enrollment in the Fund by 2027 and reduction of out of pocket spending to under 15%.

Despite these challenges, Kenya has made significant gains: the 95–95–95 targets had been attained by 2023, prevention of vertical transmission stood at 89% and multimonth dispensing (MMD) has been scaled up to 72% of eligible clients, reducing the burden on facilities and patients (93). While the National Hospital Insurance Fund provided limited financial relief, its coverage and benefits were insufficient. The Social Health Insurance Fund aims to address these gaps by improving equity through income-based contributions and expanding benefits to include chronic and critical illnesses.

● **Financing**

Kenya's HIV response has relied heavily on donor funding, with PEPFAR and the Global Fund financing close to 80% (94). In 2022, domestic public resources accounted for nearly half of Kenya's current health expenditure (about 47%), while domestic private sources contributed a substantial additional share (around 35–36%) of total health spending, underscoring the significant role of domestic financing in Kenya's health sector (95, 96). The introduction of the Social Health Insurance Fund adds a new domestic funding pool which reduces out of pocket expenditures, while working with international support, to improve both funding effectiveness and service delivery. The Social Health Insurance Act establishes a comprehensive, mandatory insurance framework, with contributions set at 2.75% of gross income and government subsidies for households in need of financial assistance (96, 97). The Social Health Insurance Fund benefit package has been defined as HIV, noncommunicable diseases, mental health and other chronic conditions.

Kenya's health financing strategy (2020–2030) expanded revenue sources beyond traditional government budget allocations to include sin taxes and levies, leveraging public–private partnerships, grants, donations and other non-tax revenue streams (82, 100). However, enrollment from the informal sector remains untested. The shift from the National health Insurance Fund's fee-for-service model to the Social Health Insurance Fund's capitation system for outpatient care is streamlining the provision of services. However, up to 2024, ARV financing relied on a hybrid of donor and other domestic sources. In early 2026, the Government allocated Kenyan shilling (KES) 6.1 billion to the Social Health Authority—well below the estimated KES 168 billion required for full implementation. Early implementation data indicate that the Social Health Authority collected substantial contributions and disbursed significant payments to facilities, but budget allocations remain far below estimated financing needs and active contributor participation remains limited, raising sustainability concerns (101, 102). Overall, these reforms are advancing sustainable HIV financing and strengthening care delivery, despite ongoing disparities in local resource distribution. The latest Kenyan HIV response data show the country funding 63% of the response using domestic resources (94). However, the 2025 funding crisis prompted calls for supplementary domestic financing and rapid finalization of benefit packages (91).

● **Capacity building**

To ensure effective capacity-building for integrating HIV services into the Social Health Insurance Fund, the Ministry of Health and development partners implemented targeted training programmes for health-care workers on Social Health Insurance Fund enrollment processes and insurance management (88). County teams were trained in claims processing to ensure efficient reimbursement for HIV services. Multiprofessional workforce planning was employed to address human resource gaps, while leadership support was provided at the county level to guide implementation.



Lessons and Recommendations

Achieving the high-level outcome of integrating HIV services into broader health systems is a key strategy for achieving UHC and sustaining HIV responses. In the context of declining external funding, increasing domestic resources for the HIV responses is an imperative for low- and middle-income countries. The integration of HIV services into national health insurance schemes represents an opportunity for sustainable and equitable financing. The four case studies highlight the following.

Key lessons	Priority Recommendations
Political leadership and commitment. Strong political will was critical in ensuring the credibility of national health insurance, enabling needed legislation and aligning HIV service delivery with UHC goals in the countries. Thailand's early adoption of UHC and Viet Nam's legislative reforms to include HIV in SHI show the importance of leveraging political momentum to drive systemic change. In Kenya, recent reforms reflect a growing government commitment to equity and sustainability, albeit resistance from part of the private sector or citizens.	1 Prioritize high-level advocacy to secure political commitment and leadership for HIV integration into national health insurance, including: engaging policy-makers and influencers to champion the legislative and regulatory reforms required; aligning HIV sustainability goals with national health and development agendas; and building political momentum to ensure country ownership and accountability.
	2 National health insurance schemes should adopt inclusive governance and promote stakeholder engagement, particularly CSOs, key populations, and people living with HIV, to ensure that integration efforts are rights-based, stigma-free and responsive to community needs.
Systems innovation and structural design. The diversity in the pathways and scope of HIV integration depended on the country context. However, the underlying principles of sustainability, equity and resilience remain consistent across the countries.	3 Countries should strengthen the institutionalization of multisectoral collaboration and linkage to ensure that non-biomedical HIV interventions, such as economic support, mental health services and social protection, are adequately financed through complementary mechanisms.
	4 Strengthening of monitoring and evaluation systems to track integration outcomes, identify service gaps, and inform adaptive policy responses are needed.
	5 Real-time data platforms and community-led feedback mechanisms are needed to enhance accountability and responsiveness.

Key lessons	Priority Recommendations
Transformation in action. Countries adopted a phased approach, beginning with select services or populations and gradually expanding coverage. This enabled the countries to manage resource constraints while building institutional capacity. Thailand's stepwise inclusion of ART and Viet Nam's gradual transition from donor-funded ART to SHI reimbursement demonstrated the value of sequencing reforms to minimize disruption and optimize learning. Rwanda's use of CBHI to complement donor-funded HIV services highlights the importance of tailoring integration strategies to local realities.	6 Countries that do not have the luxury of a stepwise approach need to develop alternative innovative financing models in the short term while working on integrating HIV into available or new forms of national health insurance. 7 : In the medium term, countries at stages 1–3 need to launch or strengthen their national health insurance systems, supported by innovative financing models and multisectoral support. 8 In the long term, all countries need to work on economic growth to expand their public revenue base in which population contributions and the innovative public financing models provide adequate revenues for national health insurance.
Financing and domestic resource mobilization. Transitioning from donor dependency to domestic financing requires deliberate policy shifts, innovative funding mechanisms and strategic partnerships. Countries leveraged general taxation, social health contributions and targeted subsidies to finance HIV services. Thailand's use of domestic manufacturing to reduce ART costs, Viet Nam's provincial budget allocations for SHI enrollment and Kenya's introduction of sin taxes and public–private partnerships under the Social Health Insurance Fund illustrate diverse approaches to expanding fiscal space. However, challenges remain, particularly in ensuring equitable access for key populations and informal sector workers.	9 The safeguarding of HIV-specific funding within the national health insurance schemes is key to providing reassurance that resources will not be diluted and there is continued prioritization of HIV prevention, care and treatment services.
Capacity Building and system strengthening. Capacity Building was key to HIV supply chain integration. Brazil advanced workforce development through integrated approaches. Ethiopia institutionalized training with standardized curricula and a domestic facility. Nigeria stressed investment in training and standardized CBD templates for sustainability. Zambia combined integration with supplier development, training on procurement, and promoting transparency to build trust and local participation.	10 Integrate task-shifting into national human resources and financing systems and use data to monitor quality and address gaps in recognition, pay and career progression for community health workers. 11 Embed task-shifting in the health system with clear role definitions, strong training and supportive supervision, and align it with human resources for health planning and career structures to ensure sustainability and patient safety. 12 Regional and global knowledge exchange to share lessons learned, best practices and technical innovations to ensure they accelerate progress toward ending AIDS as a public health threat by 2030.

References

- 1 Strengthening health financing globally. Seventy-eighth World Health Assembly. Geneva: World Health Organization; 2025.
- 2 Narayan A, Cojocaru A, Agrawal S, Bundervoet T, Davalos M, Garcia, N. COVID-19 and economic inequality: short-term impacts with long-term consequences. Washington, DC: World Bank; 2022(<https://documents1.worldbank.org/curated/en/219141642091810115/pdf/COVID-19-and-Economic-Inequality-Short-Term-Impacts-with-Long-Term-Consequences.pdf?>).
- 3 AIDS, crisis and the power to transform: Global AIDS update 2025. Geneva: Joint United Nations Programme on HIV/AIDS; 2025).
- 4 Chang J, Hijazi M, Baker S, et al. Integrating HIV/AIDS services into financial protection systems to increase sustainability of the HIV/AIDS response. BMC Health Serv Res 24 (Suppl 1), 1671 (2024). doi.org/10.1186/s12913-025-12528-9.
- 5 UNAIDS terminology guidelines. Geneva: Joint United Nations Programme on HIV/AIDS; 2024. Guidance Note https://www.unaids.org/sites/default/files/media_asset/2024-terminology-guidelines_en.pdf
- 6 Sustainability, transition and co-financing: allocation period 2023–2025. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2022 (<https://www.theglobalfund.org/en/sustainability-transition-and-co-financing>).
- 7 The world health report: health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.
- 8 HIV response sustainability primer. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/en/resources/documents/2024/20240117_HIV_response_sustainability).
- 9 HIV response sustainability roadmap—Part A: companion guide. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (<https://www.unaids.org/en/resources/documents/2024/hiv-response-sustainability-roadmap-part-a-companion-guide>).
- 10 Response sustainability roadmap. Part B: companion guide final draft—for country use and feedback. July 2025. Geneva: Joint United Nations Programme on HIV/AIDS; to be published (<https://sustainability.unaids.org/technical-guidance/>).
- 11 Lessons from Thailand: integrating HIV services into national health schemes. Geneva: Joint United Nations Programme on HIV/AIDS; 2016 (<https://www.unaids.org>).
- 12 HIV factsheet 2024: state of the HIV epidemic in Thailand (English edition). Bangkok: Division of Epidemiology, Ministry of Public Health; 2025 (https://hivhub.ddc.moph.go.th/officer/Download/RRTR/HIV_Factsheet2024_EN_edit_060868.pdf).
- 13 UNAIDS data 2024. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/en/resources/documents/2024/2024_unaids_data).
- 14 Tangcharoensathien V, Patcharanarumol W, Ir P, Aljunid SM, Mukti AG, Akkhavong K, et al. Health-financing reforms in southeast Asia: challenges in achieving universal coverage. Lancet. 2011;5:377(9768);863–873. doi: 10.1016/S0140-6736(10)61890-9.
- 15 Tangcharoensathien V, Patcharanarumol W, Kulthanmanusorn A, Saengruang N, Kosiyaporn H. The political economy of UHC reform in Thailand: lessons for low- and middle-income countries. Health Sys Reform. 2019;5(3).
- 16 Damrongplisit K, Melnick G. Utilisation, out-of-pocket payments and access before and after COVID-19: Thailand's universal health coverage scheme. BMJ Glob Health. 2024;13:9(5):e015179.
- 17 Expanding access to antiretroviral treatment in Thailand. Washington, DC: World Bank; 2005.
- 18 The journey of universal access to antiretroviral treatment in Thailand. New York: United Nations Development Programme; 2017.
- 19 Viriyathorn S, Sachdev S, Suwanwela W, Wangbanjongkun W, Patcharanarumol W, Tangcharoensathien V. Procedural fairness in benefit package design: inclusion of pre-exposure prophylaxis of HIV in Universal Coverage Scheme in Thailand. Health Pol Plan. 2023;38(Suppl 1):i36.
- 20 Lertpiriyasuwat C, Mookleemas P, Pattarapayoon N, Rosa D, Tangcharoensathien, V. Towards ending AIDS: the additional role of HIV self-testing in Thailand. Glob Health Sci Prac. 2024;12(6). doi:10.9745/GHSP-D-24-00156.
- 21 Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/item/9789240031593>).
- 22 Dutta R. Universal healthcare program providing free access to comprehensive health benefits package. New York: New York University Center on International Cooperation; 2023 (<https://www.sdg16.plus/policies/universal-healthcare-program-providing-free-access-to-comprehensive-health-benefits-package/#:~:text=The%20UCS%20has%20led%20to,and%20their%20children%20particularly%20benefited>).
- 23 Gruber J, Hendren N, Townsend R. The great equalizer: health care access and infant mortality in Thailand. Am Econ J: Appl Econ. 2014;6(1):91–107. doi:10.1257/app.6.1.91.
- 24 Pinthong P, Buracom P. J Politics Governance. 2022;12(1):262–285.
- 25 National health accounts of Thailand: health expenditure tables 1994 onwards. Nonthaburi: Ministry of Public Health; 2025. <https://ihppthaigov.net/research/health-financing/nationalhealthaccounts>
- 26 Thailand's universal coverage scheme: achievements and challenges. Bangkok: National Health Security Office; 2020.
- 27 Seekaew P, Pengnonyang S, Jantarapakde J, et al. Give the community the tools and they will help finish the job: key population-led health services for ending AIDS in Thailand. J Int AIDS Soc. 2020;23(Suppl 3):e25535 (<https://doi.org/10.1002/jia2.25535>).
- 28 Sustaining the HIV response in Thailand: the role of community-led services. Geneva: Joint United Nations Programme on HIV/AIDS; 2022.
- 29 Leerapan B, Teekasap P, Urwannachotima N, Jaichuen W, Chiangchaisakulthai K, Udomaksorn K, et al. System dynamics modelling of health workforce planning to address future challenges of Thailand's universal health coverage. Hum Resour Health. 2021;19:31. doi:10.1186/s12960-021-00572-5“Thailand country factsheet 2023. Geneva: Joint United Nations Programme on HIV/AIDS UNAIDS; 2024 (<https://www.unaids.org>).

- 30 Thailand country factsheet 2023. Geneva: Joint United Nations Programme on HIV/AIDS UNAIDS; 2024 (<https://www.unaids.org>)
- 31 Vannakit R, Andreeva V, Mills S, Cassell MM, Jones MA, Murphy E. Fast-tracking the end of HIV in the Asia Pacific region: domestic funding of key population-led and civil society organisations. *The Lancet HIV*. 2020;7(5). doi:0.1016/S2352-3018(20)30077-1.
- 32 Reducing dependence on external donor financing: building capacity for social health insurance in Vietnam and Thailand for people living with HIV. Washington, DC: PEPFAR, United States Department of State; 2023 (https://www.state.gov/wp-content/uploads/2023/11/Full-PDF-Reducing-Dependence-on-External-Donor-Financing_Vietnam-and-Thailand.pdf).
- 33 Viriyathorn S, Sachdev S, Wanwong Y, Patcharanarumol W, Tangcharoensathien V. The impact of HIV spending on health outcomes in Thailand. *World J AIDS*. 2021;11(3):85–100.
- 34 Reducing dependence on external donor financing: building capacity for social health insurance in Vietnam and Thailand for people living with HIV. United States Agency for International Development. Washington (DC): USAID; 2024. https://2021-2025.state.gov/wp-content/uploads/2024/01/Full-PDF-Reducing-Dependence-on-External-Donor-Financing_Vietnam-and-Thailand.pdf
- 35 Tangcharoensathien V, Patcharanarumol W, Ir P, Aljunied SM, Mukti AG, Akkhavong K, et al. Price setting and price regulation in health care: Thailand universal coverage scheme. Geneva: World Health Organization; 2011 (<https://wkc.who.int/docs/librariesprovider24/wkc-projects-documents/2-8-case-study-thailand.pdf>).
- 36 Effective social contracting for HIV service delivery. Policy brief. Washington, DC: World Bank; 2019 (<https://documents1.worldbank.org/curated/en/259781591758731266/pdf/Policy-Brief-Effective-Social-Contracting-for-HIV-Service-Delivery-in-Thailand.pdf>).
- 37 Viet Nam HIV estimates. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (<https://www.unaids.org/en/regionscountries/countries/vietnam>).
- 38 Impact of US funding cuts on HIV programmes in Vietnam. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250319_VietNam_fs).
- 39 Vietnam 2013: general health accounts and disease expenditures, with sub-analysis of 2013 HIV/AIDS expenditure. Hanoi: General Statistics Office of Viet Nam, Ministry of Health, and Health Partnership Group; 2017.
- 40 Van Minh H, Phuong NTK, Saksena P, James CD, Xu K, Financial burden of household out-of-pocket health expenditure in Viet Nam: findings from the National Living Standard Survey 2002–2010. *Soc Sci Med*. 2013;96:258–263.
- 41 Le QN, Blizzard L, Si L, Giang LT, Neil AL.. The evolution of social health insurance in Vietnam and its role towards achieving universal health coverage. *Health Pol OPEN*. 2020;1:100011.
- 42 Social protection situation. Geneva: International Labour Organization; 2024 (<https://www.social-protection.org/gimi/ShowCountryProfile.action?iso=VN#:~:text=Viet%20Nam%20has%20a%20relatively,40%25%20of%20current%20health%20spending>).
- 43 Encompassing universal health coverage: the role of national health insurance in Viet Nam's HIV response. Geneva: World Health Organization; 2017 (<https://www.who.int/vietnam/news/feature-stories/detail/encompassing-universal-health-coverage-the-role-of-national-health-insurance-in-viet-nam-s-hiv-response>).
- 44 Vu LT, Johns B, Bui QT, Thuy AD, Thi DN, Thi HN. Moving to social health insurance financing and payment for HIV/AIDS treatment in Vietnam. *Health Serv. Insights*. 2021;14.
- 45 Law No. 71/2020/QH14 amending and supplementing a number of articles of the Law on Prevention and Control of HIV/AIDS (promulgated 16 November 2020; effective 1 July 2021). Hanoi: National Assembly of the Socialist Republic of Vietnam; 2020 (<https://english.luatvietnam.vn/law-no-71-2020-qh14-amending-and-supplementing-a-number-of-articles-of-the-law-on-prevention-and-control-195562-doc1.html>).
- 46 Guidelines on HIV/AIDS treatment and care under Social Health Insurance. Circular No. 15/2015/TT-BYT. Hanoi: Ministry of Health; 2015.
- 47 Progress on Viet Nam universal health coverage for people living with HIV. Geneva: Joint United Nations Programme on HIV/AIDS; 2026 (<https://vietnam.unaids.org/progress-on-viet-nam-universal-health-coverage-for-people-living-with-hiv/>),
- 48 Tran BX, Vu G, Latkin C. Financing for HIV/AIDS in the dual transition of epidemics and economy: the 10-year experience of Vietnam. *The Lancet Reg Health West Pac*. 2023;38:100886.
- 49 Forse R, Yoshino CA, Nguyen TT, Phan TH, Vo LN, Codlin AJ. Towards universal health coverage in Vietnam: a mixed-method case study of enrolling people with tuberculosis into social health insurance. *Health Res Pol Syst*. 2024;22(1).
- 50 Vietnam celebrates journey to domestic financing of HIV services. USAID Local Health System Sustainability (LHSS) Project. Washington, DC: United States Agency for International Development; 2023.
- 51 Vietnam country operational plan. COP 2022. Washington, DC: PEPFAR, United States Department of State; 2022.
- 52 Global Health Services Research Collaborative. Integrating HIV/AIDS services into financial protection systems to increase sustainability of the HIV/AIDS response: Vietnam case. *BMC Health Serv Res*. 2025 (<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-025-12528-9>).
- 53 Report on national digital transformation (June 2024). Hanoi: Ministry of Information and Communications; 2024 <https://beta-en.mic.gov.vn/report-on-national-digital-transformation-june-2024-19724100315352008.htm>.
- 54 Decree No. 63/2021/ND-CP dated June 30, 2021 elaborating the Law on amendments to the Law on prevention and control of HIV/AIDS. Government of Viet Nam. Hanoi: Government of Viet Nam; 2021. <https://thuvienphapluat.vn/van-ban/EN/The-thao-Y-te/Decree-63-2021-ND-CP-elaborating-Law-Amendments-on-Prevention-and-Control-HIV-AIDS/482752/tieng-anh.aspx>
- 55 HIV sustainability planning: analytical resource—Viet Nam (Executive Summary). Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://sustainability.unaids.org/wp-content/uploads/2024/08/Viet-Nam_-_Executive-Summary-May-2024.pdf).
- 56 National strategy to end AIDS by 2030. Hanoi: Vietnam Authority for AIDS Control; 2021.
- 57 Country factsheets: Rwanda 2024 HIV and AIDS estimates. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (<https://www.unaids.org/en/regionscountries/countries/rwanda>).

- 58 Fourth health sector strategic plan: July 2018–June 2024. Kigali: Ministry of Health; 2018.
- 59 Rwanda country operational plan. COP 2022. Washington, DC: U.S. President's Emergency Plan for AIDS Relief; United States Department of State; 2023.
- 60 Lu C, Chin B, Lewandowski JL, Basinga P, Hirschhorn LR, Hill K. Towards universal health coverage: an evaluation of Rwanda Mutuelles in its first eight years. *PLoS One*. 2012;7:(6).
- 61 Assessing and enhancing sustainable voluntary medical male circumcision services for HIV prevention in East and Southern Africa: a landscape report of voluntary medical male circumcision priority countries. Geneva: World Health Organization; 2023.
- 62 Rwanda vision 2020. Kigali: Office of the President; 2012 (https://www.minecofin.gov.rw/fileadmin/user_upload/Minecofin/Publications/STRATEGIES/Vision_2020/Vision_2020_.pdf).
- 63 Binagwaho A, Farmer PE, Nsanzimana S, Karema C, Gasana M, de Dieu Ndirabeya J, et al.. Rwanda 20 years on: investing in life. *The Lancet*. 2014;384(9940):371–375.
- 64 Performance based financing procedures manual for health facilities. Kigali: Government of Rwanda; 2021 (https://www.moh.gov.rw/fileadmin/user_upload/Moh/Publications/Guidelines_Protocols/PBF_Procedures_Manual_for_HFs_February_2021.pdf).
- 65 National strategic plan-HIV: 2018–2024. Kigali; Government of Rwanda; 2024 (RWA_Rwanda_National-Strategic-Plan-HIV_2018-2024.pdf).
- 66 Mutesi M, Habimana J, Matsiko E, Collins K, Umubyeyi A, Janauscek L, Community-based health insurance as a key pillar for achieving universal health coverage in Rwanda. Brazzaville: WHO Regional Office for Africa, World Health Organization; 2025 (<https://ahop.who.afro.who.int/wp-content/uploads/2025/10/Rwanda-PB4-EN-Summary-v0.4.pdf>).
- 67 Rwanda country cooperation strategy 2021–2024. Brazzaville: WHO Regional Office for Africa, World Health Organization; 2025 (<https://www.afro.who.int/sites/default/files/2025-04/WHO%20Rwanda%20Country%20Cooperation%20Strategy%202021%E2%80%932024.pdf>).
- 68 Binagwaho A. Transitioning to country ownership of HIV programs in Rwanda. Atlanta: U.S. Centers for Disease Control and Prevention; 2016 (<https://stacks.cdc.gov/view/cdc/41152>).
- 69 Zeng W, Rwiyereka AK, Amico PR, Ávila-Figueroa C, Shepard DS. Efficiency of HIV/AIDS health centers and effect of community-based health insurance and performance-based financing on HIV/AIDS service delivery in Rwanda. *Am J Trop Med Hygiene*. 2014;90(4):740–746 (<https://pmc.ncbi.nlm.nih.gov/articles/PMC3973523/>).
- 70 Impact of US funding cuts on HIV programmes in Rwanda. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 (https://www.unaids.org/en/resources/presscentre/featurestories/2025/march/20250318_Rwanda_fs).
- 71 Biobehavioural survey among key populations in 9 counties in Kenya, Ministry of Health. HIV Prevention Programme Science Workshop Report. Nairobi: National Syndemic Diseases Control Council; 2025 (https://nsdcc.go.ke/wp-content/uploads/2025/11/Science-Workshop-Report_FINAL.pdf).
- 72 Kenya AIDS response progress report 2025. A year of resilience. Nairobi: National Syndemic Diseases Control Council; 2025 (<https://nsdcc.go.ke/wp-content/uploads/2025/11/Kenya-AIDS-Progress-Report-2025.pdf>).
- 73 WHO African region health expenditure atlas 2023. Geneva: World Health Organization; 2025 (afro.who.int).
- 74 McCollum R, Theobald S, Otiso L, Martineau T, Karuga R, Barasa E, et al. Priority setting for health in the context of devolution in Kenya: implications for health equity and community-based primary care. *Health Policy Plan*. 2018;July 1;33(6):729–742.
- 75 Extension of health protection to enhance NHIF coverage for populations left behind. Geneva: International Labour Organization; 2023.
- 76 The social health insurance (general) regulations. Nairobi: Ministry of Health; 2023.
- 77 Nzuya C. Social health insurance reforms in Kenya and its progress toward universal health coverage. Nairobi: Institute of Public Finance; 2026 (<https://ipfglobal.or.ke/wp-content/uploads/2026/01/Social-Health-Insurance-Reforms-in-Kenya-and-Its-Progress-Toward-Universal-Health-Coverage-.pdf>).
- 78 Maritim B, Kazungu J, Nyawira L, Mbuthia B, Olpengs D, Mamwa J, et al. Social health insurance reforms in Kenya: opportunities and challenges for advancing strategic health purchasing. Nairobi: SPARC Africa; 2025 (https://sparc.africa/wp-content/uploads/2025/08/Kenya-Policy-Brief_SHP_Final.pdf).
- 79 Nungo S, Filippon J, Russo G. Social health insurance for universal health coverage in low- and middle-income countries (LMICs): A retrospective policy analysis of attainments, setbacks and equity implications of Kenya's social health insurance model. *BMJ Open*. 2024;14(12):e085903 (<https://bmjopen.bmj.com/content/14/12/e085903>).
- 80 Social Health Insurance Act, No. 16 of 2023. Kenya Gazette Supplement No. 193. Nairobi: Government Printer; 2023 (<https://sparc.africa/resource/social-health-insurance-reforms-in-kenya-opportunities-and-challenges-for-advancing-strategic-health-purchasing>).
- 81 Kenya health financing strategy 2020–2030 (abridged version). Nairobi: Ministry of Health; 2020.https://p4h.world/app/uploads/2019/04/Kenya_Health_Financing_Strategy_Abridged_Version_2020-2030.x80726.pdf
- 82 Tariffs to the benefit package under the social health insurance act. Nairobi: Ministry of Health; 2023 (<https://health.go.ke/sites/default/files/2024-06/Tariffs%20to%20the%20Benefit%20Package%20under%20the%20Social%20Health%20Insurance%20Act.pdf>).
- 83 Safaricom invests Sh104.8bn in health digitization. Digital Health Africa; 2024 (https://www.linkedin.com/posts/digitalhealth-africa_safaricom-invests-sh1048bn-in-health-digitization-activity-7244626248713330689-vRbO/).
- 84 Kinyanjui M. Private hospitals protest delayed SHA claims, say most facilities in distress. *The Eastleigh Voice*; 1 August 2025 ([https://eastleighvoice.co.ke/shif-social+health+insurance+fund+\(shif\)+scheme/189594/private-hospitals-protest-delayed-sha-claims-say-most-facilities-in-distress](https://eastleighvoice.co.ke/shif-social+health+insurance+fund+(shif)+scheme/189594/private-hospitals-protest-delayed-sha-claims-say-most-facilities-in-distress)).
- 85 Kenya officially launches the Social Health Authority (SHA). Nairobi: Ministry of Health; 2024 (<https://www.health.go.ke/kenya-officially-launch-social-health-authority-october-1-2024>).
- 86 Kenya HIV estimates report. Nairobi: National AIDS Control Council; 2023 (<https://nacc.or.ke/kenya-hiv-estimates-report-2023/>).

- 87 Dr Deborah Mlongo Barasa launches master trainer program health provider portal. CS Health. Nairobi: Ministry of Health; 2024 (<https://www.health.go.ke/cs-health-dr-deborah-mlongo-barasa-launches-master-trainer-program-health-provider-portal>).
- 88 Kenya Health Information System (KHIS/DHIS2) guidelines. Nairobi: Ministry of Health 2020 (<https://hiskenya.org>).
- 89 Kenya's advancement toward universal health coverage. Case study. Washington, DC: PROPEL Health (Population Reference Bureau); 2024 (https://propelhealth.thepalladiumgroup.com/wp-content/uploads/2024/10/PROPEL-Health_Integration-and-Sustainability_2024_508.pdf).
- 90 Impact of US funding cuts on HIV programmes in Kenya. Geneva: Joint United Nations Programme on HIV/AIDS; 2025.
- 91 Country and regional operational plan (COP/ROP) guidance of all PEPFAR-supported countries. Washington, DC: PEPFAR, United States Department of State; 2023.
- 92 Country factsheets: Kenya. 2024 HIV and AIDS estimates. Geneva: Joint United Nations Programme on HIV/AIDS; 2025 <https://www.unaids.org/en/regionscountries/countries/kenya>.
- 93 Kenya. UNAIDS HIV financial dashboards. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (<https://hivfinancial.unaids.org/hivfinancialdashboards.html>).
- 94 Domestic general government health expenditure (% of current health expenditure)—Kenya. World Development Indicators. Washington, DC: World Bank; 2024 (<https://data.worldbank.org/indicator/SH.XPD.GHED.CH.ZS?locations=KE>).
- 95 Domestic private health expenditure (% of current health expenditure)—Kenya. World Development Indicators. Washington, DC: World Bank; 2024 (<https://data.worldbank.org/indicator/SH.XPD.PVTD.CH.ZS?locations=KE>).
- 96 Social health insurance (general) regulations, 2024 (regulations prescribing a 2.75 % contribution rate). Nairobi: Government of Kenya; 2023 (<https://new.kenyalaw.org/akn/ke/act/in/2024/49/eng@2024-09-20>).
- 97 Regulatory impact statement for the social health insurance (general) regulations, 2024. Nairobi: Ministry of Health; 2024 (<https://health.go.ke/sites/default/files/2024-01/RIA%20-%20SHIA%20Regulations.pdf>).
- 98 Need for innovative ways to invest more and better in primary healthcare (PHC). Nairobi: Financing Alliance for Health; 2024 (<https://financingalliance.org/need-for-innovative-ways-to-invest-more-and-better-in-primary-healthcare-phc/>).
- 99 Financial and non-financial information flows in the Kenya health sector: a pathway to health system accountability. Nairobi: IDinsight; 2024 (<https://www.idinsight.org/wp-content/uploads/2024/10/Financial-Non-Financial-Information-Flow-Kenya-Health-Sector.pdf>).
- 100 Operational and financial performance update: October 2024–January 2025. Nairobi: Social Health Authority; 2025.
- 101 Status update on implementation of the Social Health Authority and universal health coverage reforms. Nairobi: Ministry of Health; 2025.
- 102 Budget policy statement and health sector financing allocations. FY2025/2026. Nairobi: National Treasury; 2026.

© Joint United Nations Programme on HIV/AIDS (UNAIDS), 2026

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo/>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that UNAIDS endorses any specific organization, products or services. The use of the UNAIDS logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by UNAIDS. UNAIDS is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization (<http://www.wipo.int/amc/en/mediation/rules>).

Suggested citation. Transformations driving sustainability and impact: the case of integrated supply chains for HIV-related health technologies. Geneva: Joint United Nations Programme on HIV/AIDS; 2026. Licence: [CC BY-NC-SA 3.0 IGO](https://creativecommons.org/licenses/by-nc-sa/3.0/igo/).

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNAIDS concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by UNAIDS in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by UNAIDS to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall UNAIDS be liable for damages arising from its use.

UNAIDS/XXXXXXX



UNAIDS
Joint United Nations
Programme on HIV/AIDS

20 Avenue Appia
1211 Geneva 27
Switzerland

+41 22 595 59 92

unaids.org