Amplifying
Community Voices
for Prevention

Strategic
Community HIV
Prevention
Empowerment

MULTI-COUNTRY REPORT

Monitoring the Implementation of HIV Combination Prevention at Country Level via the SCOPE Checklist

May 2026

EATG
European
AIDS Treatment
Group

Contents

Acknowledgements

This report was written in 2026 by Maria Plotko, with input from the SCOPE Community Expert Group Members (Hmayak Avetisyan, Amanita Calderon-Cifuentes, Vera Rodriguez, and Marco Stizioli), EATG members and staff. Specifically, EATG would like to express its gratitude to Arda Karapınar – Panosian (Red Ribbon Istanbul), Camelia Kandiliani (National Trans Coalition Human Rights NGO (NTC)), Ayushi Kishorbhai Patel (GOSHH Ireland CLG), Jorge Garrido (Apoyo Positivo), Linda Pavanello and Letonde Hermine Gbedo (Comitato per i Diritti Civili delle Prostitute APS), Zoran Dominković (ISKORAK), Miran Šolinc (ŠKUC-Magnus), Povi Foly Lawson and Abimbola Ajomale (Noaks Ark Mosaik) for their valuable comments and contributions to the report.

Disclaimer

This research was part of the SCOPE Project, which has been developed by the EATG and was made possible through a grant from ViiV Healthcare Europe Ltd. ViiV has not had any control or input into the structure or content of the events.

Abbreviations

Term	Explanation
ART	Antiretroviral therapy (HIV treatment with a combination of antiretroviral medicines)
CCM	Country Coordinating Mechanism
EATG	European AIDS Treatment Group
GP	General practitioner (the first-contact primary care doctor that many systems call a family doctor)
HAV	Hepatitis A virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, asexual, plus other diverse sexual orientations and gender identities
Mpox	Mpox virus infection (formerly called monkeypox)
MSM	Men who have Sex with Men
NGO	Non governmental organisation
NGS	National Gender Service (Ireland's national public gender affirming healthcare service for adults)
OAT	Opioid Agonist Treatment
PEP	Post exposure prophylaxis (short-term HIV medication after possible exposure to prevent infection)
PrEP	Pre exposure prophylaxis (HIV medication taken before possible exposure to reduce the risk of infection)
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
WHO	World Health Organization

Introduction

This regional report synthesises self-assessments from community-based organisations in Italy, Armenia, Sweden, Slovenia, Ireland, Croatia, Turkey and Spain, which applied the SCOPE HIV Combination Prevention checklist to review their own services and national contexts relating to key populations.[1] Conceived as a practical self-tool, the checklist was developed within the EATG's SCOPE – Amplifying Community Voice for Prevention,[2] and organisations used its second, updated version, revised by the research consultant together with the SCOPE project's Community Expert group members, based on feedback from the pilot phase.

The tool is designed to guide organisations in examining both their own practices and the broader country context, and to assess how far they align with commitments set out in the Global AIDS Strategy 2021–2026[3] and the latest WHO guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations[4] (2022).

The findings highlight a persistent gap between the formal availability of HIV and sexual and reproductive health and rights (SRHR) services and their real-world accessibility among communities most affected by HIV, shaped by law, policy, funding, geography and stigma, as well as by the limited structural integration of community-led responses into national systems.

Legislative and policy context

Across countries, legal and policy environments strongly influence who can safely access HIV and SRHR services and how NGOs are able to operate. Criminalisation of sex work, drug use or same-sex relations, lack of anti-discrimination protections, restrictive migration and registration rules, and limited, project-based NGO funding all of which translate into concrete barriers such as service avoidance, unstable services and constrained advocacy.

Country specifics

In Sweden and Spain, universal health systems and formal non-discrimination guarantees coexist with complex bureaucracy and regional differences that particularly affect migrants and administratively "invisible" populations, for example undocumented migrants or homeless people. In Spain, the Council of Ministers has recently approved a new Royal Decree[5] to

---

1 According to UNAIDS, the five main key populations particularly vulnerable to HIV and who often lack adequate access to services are gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated individuals.

2 The SCOPE project has been developed by the EATG, and was made possible through a grant from ViiV Healthcare Europe Ltd. EATG acknowledges that the funders had no control or input into the structure or the content of the initiative.

3 UNAIDS. "Global AIDS Strategy 2021–2026 — End Inequalities. End AIDS." 2021. https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy

4 World Health Organization. Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: World Health Organization, 2022. https://www.who.int/publications/i/item/9789240052390

5 Government of Spain, Ministry of Health. 2026. El Consejo de Ministros aprueba el real decreto que refuerza la universalidad en el acceso a la asistencia sanitaria pública (press release, 10 March 2026). Available at: https://www.sanidad.gob.es/en/gabinete/notasPrensa.do?id=6866

reinforce universal access to the national health system across the whole territory and reduce administrative barriers for groups who have traditionally struggled to enter or remain in care, although it is still too early to know whether this will translate into real improvements in access on the ground.

In Sweden, the Communicable Diseases Act requires people diagnosed with HIV to follow legally binding “rules of conduct”, including regular follow-up and partner notification, which some migrants experience more as surveillance than care; worries about partner notification, data sharing with migration authorities and entitlement rules for undocumented people can discourage testing, even though treatment itself is available. Swedish NGOs also report growing funding instability, with short-term projects, policy changes and recent budget reductions leading to staff losses and threatening continuity of services.

Ireland offers extensive SRHR and HIV entitlements on paper, including free contraception for many ages, free public STI testing and treatment, and universal free HIV care regardless of legal status. However, city-centric specialist clinics, long waiting lists, digital and documentation requirements for home testing, and the absence of a national interpretation service, all of which undermine these guarantees, especially for migrants, asylum seekers, people experiencing homelessness and rural residents, who rely on NGOs for helplines, outreach testing and navigation of the health system.

Italy formally allows sex work but criminalises brothel keeping, facilitation and exploitation under the Merlin Law, while restrictive and sometimes unlawful local asylum practices (for example in Trieste), the legal restriction of assisted reproduction to heterosexual couples, and regionally administered health services with temporary health codes (STP/ENI) which creates a fragmented system of entitlements. Asylum seekers, undocumented migrants, EU citizens in poverty and foreign students therefore face major barriers to healthcare and protection from violence and often depend on NGOs for outreach, legal support and help navigating complex bureaucracy.

Slovenia has a comparatively enabling legal environment, with a longstanding HIV strategy and a strong harm reduction history, including legally allowed supervised consumption sites and two established facilities (in Ljubljana and Nova Gorica), but sex work operates in a legal ‘grey area’: it is neither explicitly illegal nor fully legal, and various other legal provisions are routinely used to target and prosecute sex workers.[6] Access to services for people without full insurance and for those living outside major cities remains uneven, and waiting times for PrEP can be around three months, as all services are by appointment. NGO funding depends on periodically changing public calls and point-based evaluations every three years, which creates uncertainty and limits long-term planning.

Croatia reports long waiting lists for some services, the need for a family doctor referral to start PrEP, and limited access to several services outside the capital and largest cities. While antidiscrimination protections and recognition of LGBTQIA+ rights through registered partnerships create a comparatively enabling legal framework, gaps remain: some unemployed people and migrants without regular papers or a secure right to stay (for example undocumented people or those with expired visas) cannot access basic health services without large

---

[6] Sex Workers’ Rights Advocacy Network (SWAN). 2019. Sex Work Legal Frameworks in Central and Eastern Europe and Central Asia. Available at: https://www.nswp.org/sites/default/files/sexwork-legalframeworks_en_swan_-_2019.pdf

out-of-pocket payments, trans people face limitations in accessing appropriate healthcare, and people under 18 cannot access HIV/STI testing without parental consent despite being legally able to consent to sex. Funding for Croatian NGOs is also mostly project based and varies year by year, restricting the long-term sustainability of community-based services. Low, competitive, project-based funding forces NGOs to make difficult choices about which services to maintain.

Armenia and Turkey illustrate more hostile environments: sex work and drug use remain criminalised, Armenia lacks legal gender recognition or comprehensive anti-discrimination legislation, and biomedical prevention tools like PrEP and PEP are not reimbursed in Turkey, all of which drives key populations away from services.

While there is no specific anti-discrimination law protecting people living with HIV, general labour and health regulations in Turkey are used in ways that permit mandatory HIV testing during recruitment and enable unfair dismissals, as documented by national rights violation monitoring, which reports that health rights violations (including denial of surgery) account for around 40% of recorded cases. Turkey's centralised MEDULA recording system allows non-specialist providers to see antiretroviral medications, creating a strong fear of "unintentional disclosure" and leading many people to avoid public facilities or delay care even when formally entitled to it. At the same time, shrinking civic space and increasing political conservatism have made NGO registration and long-term financial planning more precarious, reinforcing instability for community-based services despite their central role in reaching key populations.

In Armenia, these legal gaps contribute directly to trans and other key population communities avoiding or delaying care, as documented in a policy brief[7] on access to PrEP and PEP for trans communities published by the National Trans Coalition, based on interviews and wider community consultations. NGO funding in Armenia is mostly project based and comes from international sources, and services are heavily concentrated in Yerevan, the capital; for rural communities, long travel distances and missing or hostile local services means that, in practice, people have almost no real way to get HIV and SRHR care.

---

[7] National Trans Coalition. 2025. Strategic pathway to remove structural barriers for trans communities to PrEP and PEP services in Armenia* (in Armenian). Available at: https://drive.google.com/file/d/1kQc5d9r4Xwc5C7vWZbQFOGEk4BLupBGz/view

1. Sexual and reproductive health services

All participating countries report that core SRHR services (contraception, pregnancy-related care, STI testing and treatment, and selected vaccinations) are formally available, often free or reimbursed within public systems. However, the findings from the checklist results and narratives consistently describe these services as “available but not accessible” for many key populations due to geographic concentration in cities, long waiting times, cost, documentation requirements, lack of anonymity, language barriers, provider stigma and limited cultural competence.

In several settings, assisted reproduction and vaccination packages formally include indications relevant for key populations, but in practice eligibility rules, age limits, exclusion of s LGBTQIA+ couples or undocumented migrants, and limited specialised units mean that many people can only access these services in theory rather than in reality.

NGOs attempt to bridge these gaps by providing low-threshold testing, outreach in community spaces, navigation support, accompaniment to services and tailored information, but their ability to fill these needs is limited by funding, staff capacity and lack of formal integration into public service pathways.

Country specifics

In Spain, SRHR is covered and adolescents have notable rights to confidential care, yet regional implementation and stigmatisation from providers lead to highly uneven access. Core SRHR services are formally included in the public system, but assisted reproduction, timely gynecological and urological care, vaccination according to local epidemiology (such as HPV, HAV or Mpox), and access to safe abortion in some territories are often “available on paper but not consistently reachable” because of long waiting times, documentation requirements and territorial variability. Planned free condom programmes remain patchy, and coverage gaps fall heavily on migrants and other excluded groups. In Spain, a progressive self-determination law coexists with long waiting times, a small number of specialised units and exclusion of undocumented migrants from most trans-specific healthcare, meaning that legal recognition does not automatically translate into timely, affordable access to gender-affirming care or surgery. Access to assisted reproduction and vaccination according to local epidemiology is particularly constrained for trans people and migrants without regular residence. Administrative barriers linked to municipal registration and healthcare procedures mean that undocumented migrants, EU citizens without registration, international students and other people with unstable status frequently depend on NGOs such as Apoyo Positivo for administrative navigation simply to enter or remain in the public system and to access SRHR and gender affirming care.

In Sweden, SRHR services formally exist nationwide, but among migrant and other key population clients many essential elements remain “on paper but hard to reach”: comprehensive sexual health counselling, PrEP access, mental health support related to HIV, and culturally adapted SRHR information are all affected by language gaps, lack of knowledge about entitlements, uncertainty about costs and fear that contact with institutions could affect migration status. Outreach and counselling work shows that many clients delay testing or prevention for these reasons and are unsure whether services are truly confidential or whether they will be asked for documentation before receiving care. NGOs like Noaks Ark Mosaik therefore rely on outreach, cultural mediators and multilingual education to make these services genuinely reachable for migrants, mobile populations, trans and gender diverse people and sex workers who would otherwise avoid public services.

Ireland provides a broad SRHR package, including a national condom distribution scheme from age 17, free contraception for women, girls, trans and nonbinary people aged 17–35, access to safe abortion up to 12 weeks of pregnancy, free public STI testing and treatment (with home testing kits available from age 17), free HPV cervical screening and free hormone replacement therapy for menopause when prescribed. In practice, however, many of these services are concentrated in major cities, have long waiting lists and require digital access and documentation that many migrants, asylum seekers and people in precarious housing do not have, so community organisations such as GOSHH operate a confidential helpline, outreach rapid testing in rural areas and accommodation centers, a local collection point for home STI kits with in person registration support, and one-to-one help for clients with limited English or knowledge of the health system, even though they cannot fully compensate for systemic gaps.

Italy's national network of public family counselling centers offers a strong SRHR platform with direct access (no prescription) to gynecological check ups, pre and post natal care, contraception counselling for young people including without parental consent, and broader family support services. However, closures and under resourcing in some cities have led to long waiting lists for gynecological care, very uneven access to safe abortion due to high levels of conscientious objection among doctors, and the exclusion of LGBTQIA+ couples from assisted reproduction. Contraceptive pills remain unaffordable for many without income, and community-based STI and hepatitis testing are available only in a few major cities. In practice, access to gender affirming care requires a multidisciplinary 'gender dysphoria' diagnosis, with very few centers and almost none in the south, resulting in years-long waiting lists. Access to gender-affirming surgery free of charge is extremely limited, so many trans people either postpone care, pay privately or travel abroad despite formal frameworks suggesting broader availability. As a result, NGOs like Comitato per i Diritti Civili delle Prostitute APS to step in to accompany migrant sex workers and other marginalised groups through registration in the National Health System, exemptions from health co payments[8] and referrals to specialised services and surgeries, and to respond when hospitals unlawfully refuse HIV-related care to people without a health card despite formal entitlements.

In Slovenia, women's reproductive health services are well organised and insured, but STI clinics and NGOs like ŠKUC-Magnus are concentrated in larger cities, and people without full insurance, including some migrants and students, rely on pro-bono clinics in bigger cities on a case-by-case basis. Condoms and lubricants, some STI treatments and vaccination according to local epidemiology are described as 'available but not accessible', while adolescent access to SRHR remains restricted by parental consent requirements, leaving gaps for young MSM, trans people and migrants. Despite a strong harm reduction history and generally good coverage of reproductive health for insured women, sex workers and uninsured migrants often navigate a patchwork of NGO testing, academic projects and advocacy initia-

---

[8] Once a person is registered in the National Health System (SSN), they receive a health card and choose a family doctor, on the same basis as Italian citizens. Some people, such as unemployed people or those with certain chronic illnesses, can get exemptions from health **co payments** (the part of the treatment cost normally paid by the patient).

tives rather than a coherent, rights-based SRHR pathway. Although name and gender change procedures are formally allowed and protective laws exist, trans specific healthcare is not accessible regardless of economic or migratory background, and organisational capacity to provide structured trans services is very limited, so many people rely on ad-hoc information and advocacy instead of a predictable, integrated care protocol.

In Croatia, a range of SRHR services, including STI testing and treatment, vaccination, and provision of condoms and lubricants, is available at national level, but free and anonymous STI testing often depends on project or limited public funding, which restricts coverage. Referral for STI testing within the public system can be difficult to obtain unless clients are symptomatic and usually involve multiple steps (GP, specialist, laboratory and back), creating practical barriers and delays. Only a few services function as one-stop and some of these have long waiting lists, so community-based HIV and syphilis testing by Iskorak, offered year-round for MSM and trans people, plays a key role, even though broader STI testing can only be provided during specific periods such as European Testing Week.

In Armenia, contraception and basic SRHR services are formally available, but assisted reproduction and some targeted vaccinations exist mainly in theory; high cost, distance, documentation rules and provider stigma sharply limit access for key populations, with NGOs like National Trans Coalition Human Rights NGO filling only part of the gap.

In Turkey, SRHR services are nationally available, but anonymity is poor, public free condom distribution has almost ceased, and regional economic differences deepen inequalities; NGOs like Red Ribbon Istanbul offer peer information and support but lack a national framework for community-led SRHR delivery. Free condom provision, formally the responsibility of primary health centres, has in practice almost disappeared due to supply chain problems and shifting political priorities, leaving many key populations without low threshold access to basic prevention tools. HPV vaccination is not part of the national immunisation scheme and therefore depends on high out-of-pocket payments, which makes it inaccessible for many young people and key populations. Although abortion is legal, administrative hurdles and conscientious objection in public hospitals can effectively restrict access in some settings, reinforcing the gap between formal rights and real world availability for those in precarious situations.

2. HIV-specific services

HIV testing, treatment and care are formally available in all countries, often free at point of use, and in several settings (Ireland, Sweden, Spain, Slovenia, Italy) treatment is provided regardless of legal status. Yet results from checklists and further narratives underline systemic obstacles: hospital-centered models for PrEP and PEP, long waiting lists, rigid eligibility criteria, urban concentration of HIV clinics, provider stigma, and weak or informal referral pathways between community services and public clinics. For migrants, undocumented people, trans and gender diverse people and sex workers, these barriers are compounded by documentation checks, data sharing fears, criminalisation, and the absence of culturally competent mediation, making 'available' HIV services effectively out of reach in many situations.

In some contexts, such as parts of Italy and Spain, undocumented migrants encounter de facto refusals of HIV related care or billing practices that contradict formal entitlements, while in Slovenia and Sweden access for uninsured or newly arrived migrants depends heavily on pro bono clinics and NGO navigation. This reinforces the central but under-recognised role of community organisations in preventing drop-offs along the HIV care cascade for these groups.

Community organisations deliver rapid and community-based testing, pre- and post-test counselling, adherence support and case management, but they are rarely structurally recognised or financed as partners in the HIV care continuum.

Country specifics

In Spain, HIV testing is widely available and a core strength, yet counselling quality varies. The national cascade[9] shows high performance in treatment and viral suppression (with more than 96% of diagnosed people on treatment and around 90% of those on treatment virally suppressed), but an undiagnosed fraction of about 7.5% and persistent late diagnosis, especially among migrants and other socially vulnerable groups. PrEP and PEP remain hospital-centered with long waits, regional disparities and serious access problems for people without health coverage, leading NGOs to take on informal case management roles. Community organisations such as Apoyo Positivo provide active peer navigation after reactive community tests and intensive mediation with hospital units to prevent loss to follow up , yet these pathways rely on local relationships rather than standardised national referral systems and receive no dedicated structural funding.

After negative tests, prevention counselling and information on PrEP are offered whenever possible, but inconsistent linkage to biomedical prevention and administrative barriers for undocumented migrants still limit the preventive potential of community-based approaches. For migrants without full health coverage, trans people and sex workers, hospital centered PrEP and PEP models, administrative exclusions and stigma within emergency departments or infectious disease units create additional barriers beyond geography and waiting times. Community-based organisations attempt to fill these gaps through peer navigation and ac-

---

[9] The HIV care cascade is a simple way of showing the different steps people go through in HIV care: knowing their HIV status, starting treatment and keeping the virus at an undetectable level over time. At each step, some people are "lost" because of barriers such as lack of testing, difficult access to clinics, stigma, or problems staying on treatment, so the cascade helps to see where the biggest gaps are and where support is most needed.

companiment, but without structural funding or formalised referral agreements, access remains fragile and highly dependent on local relationships.

In Sweden, universal access and strong treatment outcomes are the norm once people are in care, but migrants encounter long waiting times, complex specialist referrals and language barriers, and the HIV care cascade tends to break down earlier, at the stages of testing and timely linkage. Outreach and counselling work suggests that limited awareness of free HIV services, language challenges, stigma within communities, uncertainty about confidentiality and fear that health system data could affect migration status all discourage early testing; some clients wait until symptoms appear or until a routine health visit prompts testing, and newly arrived migrants often lack clear information on where to test anonymously or how the system works. NGOs run onsite testing and peer support help reduce dropouts and improve linkage and adherence, but their reach is constrained by project-based funding and the lack of formal integration into national pathways.

In Italy, community-based HIV testing is available mainly in major cities, where NGOs offer anonymous rapid testing, information and counselling in informal, low threshold settings with generally effective referral of reactive cases to hospital-based HIV services; PEP is universally and freely available via emergency departments for all, including undocumented people, while PrEP is in principle free but still unevenly implemented across regions, with some initiation services remaining chargeable and growing waiting lists in STI centres as demand increases, so that practical access to biomedical prevention remains geographically and administratively unequal. Civil society reports highlight that some hospitals have recently denied HIV treatment to people without *a tessera sanitaria* (the Italian public health insurance card), despite national provisions for universal access, forcing NGOs to intervene case by case to restore care. For migrant sex workers and other undocumented people, this kind of informal restriction reinforces fear of institutions and increases reliance on community-based testing and navigation.

In Ireland, HIV information resources, a national HIV and sexual health helpline, free public HIV testing (clinic based, home testing kits and community rapid testing) and universal free HIV treatment irrespective of legal status form strong pillars of the response, yet long waiting lists for PrEP, city based HIV clinics, limited out of hours PEP access and language gaps in patient information restrict real world access, and NGOs such as GOSHH respond by offering rapid testing in-house and through outreach in colleges, accommodation centres and soup kitchens, running a helpline that explains testing, PrEP and PEP options, directly arranging referrals for reactive results, and informally translating for clients with limited English, even though staffing and funding constraints limit how far they can compensate for national bottlenecks.

In Slovenia, there are now two HIV clinics with very rare stockouts and improving protocols, but access for uninsured or partially covered groups is limited, and people in rural areas still travel substantial distances for HIV care; waiting times for PrEP can reach around three months because all services are by appointment. The HIV treatment cascade for 2025 shows that 89% of people living with HIV are diagnosed, 97.2% of those diagnosed are on treatment, 97.5% of those on treatment are undetectable, and around 90% report good quality of health, with the biggest gaps at the first step (diagnosis) and at the level of overall wellbeing.

In Croatia, anonymous, free and voluntary HIV testing centres operate in seven cities, while HIV care is centralised in a single clinic in Zagreb, and PrEP is available only in hospitals in three cities. People living in smaller towns and rural areas therefore face longer travel and organisational barriers to accessing HIV specific services, particularly PrEP. Waiting times for PrEP in Zagreb can reach several months because of limited capacity, which aligns with cascade data showing that the sharpest drop occurs at the diagnosis stage, while ART coverage and viral suppression are high once people are in care. Iskorak's community-based HIV testing in Zagreb and Osijek, supplemented by temporary services in two additional cities during the European Testing Week, helps to partially close these gaps but remains constrained by project-based funding.

In Armenia, voluntary testing and ART are integrated nationally and PrEP and PEP exist nominally, yet uptake is very low, services are centralised in the capital and referral pathways from testing to prevention and care remain weak; NGOs provide community testing and navigation but face serious limits in scale and resources. The most recent HIV cascade for trans people in Armenia shows steep drop-offs between estimated need, testing and treatment (100%:36%:25%), with the largest gaps at testing and linkage to care stages, driven by centralised services, stigma, criminalisation and lack of trans competent provision.

In Turkey, ART is covered by insurance, but PrEP and PEP are outside reimbursement, anonymous testing sites are scarce, and provider stigma plus rigid protocols discourage key populations from entering or remaining in care; NGOs like Red Ribbon Istanbul rely on individual "friendly" clinicians rather than system-level pathways. The HIV care cascade appears to break down most sharply at the prevention and linkage to care stages, as high out of pocket costs for PrEP and PEP, combined with fears of disclosure through centralised data systems and workplace discrimination, lead to delays in testing and interruptions in treatment. Community-based organisations report that scaling up testing and prevention is constrained by the exclusion of PrEP and PEP from public reimbursement, the scarcity of anonymous municipal testing centres outside a few large cities, and regulatory frameworks that do not formally recognise or fund community led services.

3. Support and social services

Psychosocial, legal, housing and employment support are essential for HIV prevention and care, yet they are often poorly developed, fragmented or not tailored to key populations within public systems. As a result, community organisations frequently operate as de facto social workers, legal advocates and mental health coordinators, stretching their mandates without adequate resourcing and leaving many complex needs unmet.

Barriers include strict eligibility criteria, documentation requirements, criminalisation of sex work and drug use, limited capacity of public social services, geographic concentration in cities, and lack of confidential, trauma-informed support for those facing violence, self-stigma and discrimination.

Country specifics

In Spain, there is no national framework for HIV-related psychosocial, legal and social support, so NGOs fill gaps around mental health, stigma, legal problems and housing crises, but support remains inconsistent and highly dependent on NGO capacity and territory. Casework from organisations such as Apoyo Positivo shows that unstable migration status, housing precarity, untreated mental health needs, labour instability and persistent institutional stigma are among the most frequent reasons why clients delay linkage or fall out of HIV care, even where treatment is formally available. Each year, Apoyo Positivo alone supports around 250 people who face major administrative barriers to entering or navigating the health system, illustrating how social protection gaps and bureaucratic exclusion directly undermine an otherwise strong clinical response.

In Sweden, formal support exists, but migrants face barriers linked to registration, language and trust, and NGOs rely on partnerships, for example with legal aid and syringe exchange services, to assemble a functional support network for each client. For many migrant clients, key social barriers such as unstable housing, insecure residence status, language challenges, limited knowledge of how the Swedish healthcare system works and stigma related to HIV, sexuality and migration often prevent regular engagement in HIV care, delaying testing, continuity and access to support services; for example, one migrant woman who did not receive language support misunderstood appointment instructions, missed follow-up visits and dropped out of care for several months before reconnecting with services through Noaks Ark Mosaik. Sweden also applies a “criminalisation of clients” model to sex work, also known as the “Swedish Model” or Nordic Model; which, although it targets buyers rather than sex workers themselves, still creates barriers by pushing sex work further underground and making it harder and less safe for sex workers to seek support and report violence.

In Italy, housing needs often remain unmet and NGOs like Comitato per i Diritti Civili delle Prostitute APS are forced to stretch their mandate to provide pocket money, food, job search support and bureaucratic assistance far beyond their core mandate in order to prevent extreme marginalisation among sex workers, trafficked persons and migrants.

In Ireland, multiple public social, housing, mental health and legal services exist on paper, but eligibility rules, documentation requirements, waiting lists and geographical concentration mean that many clients, especially migrants, asylum seekers, and people living with HIV, experience delays or exclusion, so NGOs like GOSHH have created community social spaces, HIV support groups, accompaniment to clinic appointments and practical help with transport costs to prevent unmet social needs from derailing engagement in HIV care.

In Slovenia, historically strong peer-support groups for people living with HIV have declined as needs and preferences changed, and current social support for PLHIV is described as poorly covered, with information largely moving online.

In Croatia, Iskorak offers some psychosocial and social support but must frequently refer clients to other NGOs or public services, which themselves are limited, for example, free legal aid and housing or social support for homeless and unemployed people are scarce. This uneven landscape means that broader social determinants, including housing and unstable employment, remain insufficiently addressed, even though they directly affect the ability of key populations to engage with HIV prevention and care.

In Armenia, basic social services are not adapted to key population needs or confidentiality, require documentation many clients lack, and do not provide specialised violence, housing or employment support; NGOs provide meals, case management and legal support, but demand far exceeds resources.

In Turkey, there are no specialised state-funded social services for people living with HIV, so legal and psychological support for workplace discrimination and stigma are largely shouldered by NGOs, whose resources are quickly exhausted. Employment insecurity and the fear that HIV related information will be disclosed at work are among the main social factors blocking engagement in care, with some clients skipping clinical controls and drug refills to avoid taking time off or disclosing their status, which can ultimately lead to loss to follow-up.

4. Key-population-specific services

The SCOPE checklist includes dedicated sections on services for trans and gender-diverse people, people who use drugs, sex workers and migrants, revealing significant gaps between international standards and national arrangements. While some countries have specialised services or progressive legal frameworks, access is frequently constrained by criminalisation, stigma, long waiting times, administrative barriers and lack of trained providers, making community-led organisations essential yet insufficiently recognised.

Trans and gender-diverse people

For trans and gender-diverse people, Italy and Spain both describe trans-specific healthcare as fragmented and difficult to access, with lengthy, medicalised assessments that treat trans identities as a disorder before granting access to gender-affirming care, limited specialised units concentrated in a few cities, and very long waiting lists that can stretch over years. For migrant trans sex workers in Italy, this is compounded by insecure legal status and precarious housing, pushing many towards informal or unsafe hormone use and surgery abroad, with NGOs trying to accompany them through administrative and health systems that were not designed for their needs.

In Ireland, the National Gender Service (NGS) is characterised by waiting times estimated at around a decade. There were reports of the waiting list being closed. As of December 13th, 2025; it was reported that the NGS does not have the power to close their own waiting lists. There have been no further official updates and so for the moment the same issues persist in Ireland in regards to waiting lists and access to services, which means that new clients effectively cannot enter the public system and instead must self-fund care overseas, rely on private providers, or depend on NGOs for emotional support, information and advocacy, but not for clinical care.

In Armenia, there is no legal gender recognition and no structured trans-specific healthcare; trans people routinely face denial of services, misgendering and abuse in health facilities and are forced to self-medicate with hormones without medical supervision or to seek care abroad, while the National Center for Infectious Diseases conducts field work with trans communities without meaningful involvement of trans-led organisations, further undermining trust.

People who use drugs

Slovenia illustrates how a long-standing harm-reduction policy, including needle-exchange programmes and opioid agonist treatment (OAT) introduced in the 1990s, has contributed to maintaining very low HIV prevalence in this population, yet services remain concentrated in larger cities, leaving people in more remote areas with fewer options and requiring travel. A well-organised harm reduction network, with widespread provision of harm reduction equipment, opioid agonist treatment, drug checking , naloxone and two supervised consumption sites (in Ljubljana and Nova Gorica), stands out as a positive regional model.

In Spain, opioid agonist treatment and rehabilitation are generally available, but harm reduction measures such as drug checking, non-injecting consumption materials, naloxone distribution and supervised consumption sites are limited or absent and concentrated in a few urban areas.

In Croatia, Iskorak works with people who use drugs, particularly those engaged in chemsex, but national criminalisation of drugs continues to deter open disclosure and limits access to services for this group.

Ireland combines static and outreach needle exchange, naloxone distribution, opioid agonist treatment, drug checking and community or residential based treatment services, but many of these harm reduction services are still focused on Dublin and a small number of other counties. GOSHH plays a key role by offering rapid testing and outreach in settings like soup kitchens and accommodation centres used by people who use drugs, yet coverage in rural areas and small towns remains intermittent and pharmacy participation in needle exchange is limited, leaving significant gaps in access to harm reduction equipment and treatment.

In Armenia and Turkey, punitive drug laws and the absence or very limited scale of harm-reduction services mean that fear of arrest, police checks and registering as a “drug user” keeps people away from health facilities and discourages honest disclosure about substance use, severely undermining HIV prevention, overdose response and linkage to care; NGOs emphasise that even where they can provide information and some peer support, without structural harm-reduction programmes and decriminalisation, their reach is constrained.

Sex workers

In Spain, while selling sex is not a criminal offence, the criminalisation of third-party involvement, trafficking laws and local council rules result in frequent police controls, fines and displacement of sex workers, which heighten insecurity and erode trust in public institutions. Specialised community organisations therefore become the primary, and sometimes only, safe point of contact for violence reporting, HIV and STI testing, psychosocial support and navigation of social services, but they operate largely on short-term project funds and are not integrated into formal protection systems.

In Sweden, where buying but not selling sex is criminalised, Noaks Ark Mosaik works in close partnership with Noomi, an NGO supporting sex workers through advocacy, counselling, legal guidance and safety planning. This collaboration provides a concrete mitigation mechanism by creating low threshold, confidential entry points to HIV, SRHR and social support for sex workers who may avoid public services.

Italy’s legal but highly stigmatised environment is marked by police harassment, violence and ‘public decency’ rules that push sex workers out of city centres, combined with strong social and institutional stigma that makes reporting violence risky, especially for undocumented migrants. NGOs working with sex workers describe having to provide not just health information and condoms but also legal support, accompaniment to police or courts, food and emergency housing, often with very limited and delayed funding.

Ireland reports that support for sex workers is limited and uneven, with small, region-specific services and a strong need for safe, non-judgmental spaces where sex workers can access confidential distribution of condoms, lubricants and information, as well as connecting people to legal and social supports. In recent years, Ireland has also introduced a “criminalisation of clients” model; which has increased violence and discrimination against sex workers and pushed sex work further underground, making it harder and more dangerous for people to seek support.

For sex workers in Croatia, the criminalisation of sex work similarly contributes to fear of punishment and avoidance of services, further constraining access to HIV prevention and SRHR and complicating outreach by community organisations.

In Armenia, sex work is criminalised through administrative fines, and police harassment and social stigma are so pervasive that many sex workers avoid any contact with health and social services, do not report violence and remain effectively excluded from HIV prevention and care, leaving NGOs with very limited entry points for outreach and support.

Migrants, mobile and displaced people

Sweden, Spain, Italy and Ireland all show that, despite formal entitlements to some health services, documentation rules, complex registration procedures, language barriers and the absence of trained cultural mediators severely limit practical access to SRHR and HIV services. Migrants, asylum seekers and undocumented people often do not know their rights, fear that seeking care could expose them to immigration enforcement, and struggle to navigate systems designed around citizens with stable addresses and identification numbers.

In Spain, regional differences in how health coverage rules are applied mean that undocumented migrants, EU citizens without registration and international students can be de facto excluded from SRHR and HIV services, leading NGOs to spend substantial time on administrative problem-solving and advocacy.

In Sweden, migrants formally have access to SRHR and HIV services, but for the communities reached by NGOs two key types of support are often out of reach in practice: first, sexual health counselling and prevention that is adapted to their language and culture and clearly explains HIV, PrEP and SRHR rights; and second, mental health support that addresses HIV, sexuality and migration related experiences. These services are limited by language barriers, low health literacy, lack of targeted outreach, long waiting times, stigma and a shortage of culturally competent providers. The requirement for personal identity numbers and the fragmentation between different administrative systems create additional practical obstacles, while NGOs like Noaks Ark Mosaik invest in multilingual outreach, peer mediation and partnerships with organisations such as Doctors of the World and syringe exchange programmes to piece together an accessible pathway for each client.

In Italy, the system of temporary health codes and regionally administered services creates a patchwork in which some migrants can access comprehensive care while others face repeated refusals or high costs, and foreign students must purchase private health insurance whose annual cost rose from 250€ to 700€ in 2024, making access to guaranteed health services unaffordable for many and further limiting access for those who are unaware of their basic rights.

Migrants in Croatia face language and cultural barriers as well as funding limitations that restrict NGOs' ability to adapt services and provide tailored support despite clear needs.

Armenia highlights a near total absence of dedicated programmes for refugees, asylum seekers and people displaced from Nagorno Karabakh, with administrative requirements making it difficult for them to access HIV treatment and care.

Turkey notes that the lack of cultural mediation, interpretation and language appropriate information creates what organisations describe as a “total blockage” of the right to health for many migrants, particularly those living with or at risk of HIV, who consequently depend on community-based and digital services for any meaningful support.

5. Quality of services and community role

Using the checklist's quality section, organisations assessed whether services are inclusive, confidential, participatory and responsive to the lived realities of key populations. Despite positive examples of person-centred, community-based care, most countries report gaps in cultural competence, systematic stigma-reduction training, meaningful community participation in planning and evaluation, feedback mechanisms and options for anonymous access where needed.

Community-led organisations consistently improve service quality by providing safe spaces, peer support, tailored information, flexible schedules, practical support and service navigation, and advocacy, yet their expertise is not routinely embedded in public protocols, training curricula or governance structures.

Country specifics

In Spain, quality gaps are closely tied to hospital-centred models for HIV prevention and care, insufficient systematic training on sexual and gender diversity, and weak formal engagement of communities in service design. Community organisations help mitigate stigma and rigidity through peer-led, low-threshold services, but remain structurally marginalised, dependent on short-term projects and rarely integrated into official protocols or referral systems. Community representatives participate in national and some regional strategic spaces, such as the National Strategic Plan on HIV and STI working groups, but this involvement is largely consultative and does not yet translate into systematic governance, shared implementation responsibilities or stable financing for community led models.

In Sweden, overall service quality is high and HIV services are well established within the public system, but migrants face significant language and cultural barriers, complex registration procedures and fragmented referral pathways that can delay or interrupt care; Noaks Ark Mosaik responds with person-centred, rights-based approaches, including multilingual information, peer support and close collaboration with legal and harm-reduction partners, which improves trust, linkage and continuity. Community representatives in Sweden are mainly involved through consultations, advisory groups and civil society partnerships with institutions such as the Public Health Agency of Sweden, and community-based organisations contribute practical insights during programme implementation and evaluation for migrant and other key populations, but their role in formal decision-making and strategic planning remains limited and is often project based rather than structurally embedded.

In Italy, the scarcity and delayed disbursement of both public and private funds constrain NGOs' ability to maintain stable, high-quality services, with small organisations often lacking cash flow to cover ongoing activities and staff. Associations working with sex workers also face discrimination from potential funders and mistrust from institutions, increasing administrative burden and forcing them to spend significant time "proving" their legitimacy rather than focusing on service quality. Despite these constraints, NGOs rely on volunteering and strong community commitment to provide good-quality, rights-based support, but emphasise that simpler funding procedures, timely payments and public campaigns recognising the value of anti-trafficking, housing and drop-in services are essential to sustaining and improving service quality. NGO representatives participate in national and regional AIDS committees, which gives them a formal role in shaping strategies and policies and in monitoring and evaluation processes, although this does not always translate into adequate resourcing of community led services.

In Ireland, services are formally inclusive and supported by comprehensive national information resources, yet they are not equally accessible in practice, as city-based clinics, long waiting lists and limited interpretation undermine equity; the absence of recurrent cultural-competence training and limited opportunities for community participation in planning reduce responsiveness to diverse clients, with NGOs filling knowledge and trust gaps through tailored information, helplines, outreach testing and support groups.

In Slovenia, targeted training for new HIV clinic staff has reduced visible stigma and improved provider attitudes, but NGOs like ŠKUC-Magnus still navigate between rigid ministry expectations and rapidly evolving community needs, working with limited staff, underpaid positions and constrained funding, which restricts their capacity to develop new forms of peer support and psychosocial services that people living with HIV would value today. In Slovenia, NGO representatives are members of the National AIDS Committee and are therefore formally involved in HIV strategy and policy design, monitoring and evaluation.

In Croatia, NGO representatives are members of the National HIV Commission, giving them an institutional role in the HIV response, but there is no comparable national body for SRHR, which limits structured community participation in that area. Civil society reports that, despite strong commitment to service quality, reliance on project-based funding, staff turnover and language barriers, particularly in work with migrants, constrain the development of more diverse peer support and psychosocial services.

In Armenia, pervasive stigma, repeated breaches of confidentiality and lack of professional competence in LGBTQIA+ and harm-reduction care discourage service use among key populations; NGOs like National Trans Coalition Human Rights NGO invest heavily in sensitising providers, accompanying clients to services, offering community-based testing and mobile outreach, yet these efforts are not matched by systematic public-sector reforms on ethics, training and accountability, leaving overall service quality highly dependent on individual “champions” and NGO capacity. In Armenia, community organisations have seats on the Country Coordinating Mechanism (CCM), the highest decision-making body for HIV and related programmes, providing a formal channel for community input on priorities and funding, but daily service quality still depends heavily on NGO capacity and individual allies in the system.

In Turkey, provider-centric, hospital-driven models and the absence of meaningful community involvement in the design of protocols and pathways contribute to loss to follow-up and low uptake of prevention among key populations; NGOs emphasise that non-judgemental, flexible, community-led services, including digital outreach, peer counselling and rights-based case management, are essential for long-term adherence, but current policies do not formally recognise or adequately fund these quality-enhancing approaches. Community representatives are often invited to ad-hoc consultation meetings on strategy documents, yet there is no structural mechanism that embeds community leadership in governance, monitoring or evaluation, which limits the potential of community expertise to drive quality improvements.

Conclusions and recommendations

Across all countries, there is a clear disconnection between formal commitments on HIV and SRHR and the lived realities of key populations. Criminalisation, stigma, bureaucratic barriers and unstable NGO funding repeatedly turn "available" services into ones that are practically out of reach, especially for migrants, trans and gender-diverse people, sex workers and people who use drugs. Community-led organisations consistently keep people connected to information, testing, care and social support, but they are neither adequately funded nor structurally integrated into national systems, which limits both coverage and impact.

1. **Reform laws and policies**

   Decriminalise sex work and drug use, adopt human rights-based harm reduction and remove punitive practices that deter health-seeking. Introduce or strengthen anti-discrimination laws, including Sexual Orientation, Gender Identity and Expression, and Sex Characteristics (SOGIESC) protections and legal gender recognition based on self-determination, and simplify registration and documentation rules so migrants, asylum seekers, foreign students, undocumented people and others with unstable residence status can safely access SRHR and HIV services.

2. **Turn formal availability into real access**

   Decentralise SRHR and HIV services beyond major cities, reduce waiting times, offer options for anonymous or low-threshold access and remove administrative exclusions from PrEP, PEP and core SRHR care. Integrate PrEP and PEP into publicly financed benefit packages with clear protocols, provider training and community-based access points.

3. **Make community-led services part of the system**

   Create stable, multi-year public funding and formal partnership agreements for community-based testing, navigation, peer support and harm reduction, and embed NGOs in national strategies, referral networks and data systems with shared governance roles. Protect civic space and recognise community-led advocacy as a central element of the HIV response.

4. **Build social protection into HIV care**

   Include mental health, psychosocial, legal and anti-violence support as standard components of HIV prevention and treatment, with coordinated referral pathways between health, social and legal services and simplified eligibility for key populations. Resource NGOs to provide case management and accompaniment, recognising how unmet social needs disrupt HIV care.

5. **Improve quality through rights-based, community-driven care**

   Make regular, mandatory training on human rights, stigma, gender diversity, harm reduction and cultural competence standards for all relevant providers, co-designed with community organisations. Ensure strong confidentiality protections, options for anonymous access, and formal mechanisms for community feedback and leadership in service design, monitoring and evaluation. In line with EATG's definition of HIV combination prevention, these changes should be implemented as part of coordinated packages that bring together biomedical, behavioural and structural interventions, codesigned and delivered with affected communities, rather than as isolated measures.

EA
TG

European
AIDS Treatment
Group

About the European AIDS Treatment Group:

The European AIDS Treatment Group (EATG) is a patient-led NGO that advocates for the rights and interests of people living with or affected by HIV/AIDS and related co-infections within the WHO Europe region. Founded in 1992, the EATG is a network of more than 150 members from 45 countries in Europe. Our members are people living with HIV and representatives of different communities affected by HIV/AIDS and co-infections. EATG represents the diversity of more than 2.3 million people living with HIV (PLHIV) in Europe as well as those affected by HIV/AIDS and co-infections.

For more information, please visit www.eatg.org