Technical brief on HIV and key populations

Programming at scale with sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prison and other closed settings

The Global Fund

Table of Contents

1. Introduction

The purpose of this technical brief is to provide information for countries preparing funding requests for comprehensive programs that address the cascade of HIV prevention, diagnosis, treatment, and care for the following key populations:

- male, female, and transgender sex workers[i]
- gay men and other men who have sex with men[ii]

- transgender people (especially transgender women)
- people who inject drugs
- people in prison and other closed settings.

Compared with several years ago, more countries have clearly identified key populations within their National Strategic Plans; more interventions are aligned with those recommended by WHO, UNAIDS, and the Global Fund; and the reach and coverage of key populations with appropriate services is being better measured, including through disaggregation of data by sex and age. As a result, we are now better able to assess what works, which areas of programming are more challenging to implement, and which gaps in services countries should pay particular attention to when planning their programs.

Countries have set ambitious targets for HIV prevention, aligned with the United Nation's Political Declaration of 2016 calling for 90% of people at risk of HIV infection to be reached with comprehensive prevention services, and treatment targets aligned to the UNAIDS 90-90-90 goals.[1,2] Key population interventions are a priority pillar in the Global HIV Prevention Coalition's road map to reducing the number of new infections by 75% by 2020,[3] but key populations still experience high HIV incidence rates and low coverage with prevention and treatment services. Therefore, **programs for key populations must be designed for scale**. This means reliably and safely estimating the size of key populations (in close consultation with community experts); understanding their particular vulnerabilities and service needs; and designing and delivering comprehensive, evidence-informed, rights-based, and high-quality services to reach sufficient enough numbers of individuals to make an impact at the population level. These services must cover not just HIV prevention, but **the entire cascade of prevention, diagnosis, treatment, and care** for HIV (and for other priority health needs such as sexually transmitted infections, hepatitis, tuberculosis, mental health, and sexual and reproductive health).

Scale, quality and comprehensiveness of services are essential but not sufficient: **access is a key issue**. In many countries, uptake of services across the prevention and treatment

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[i] Throughout this technical brief, "key populations" refers to these five groups, rather than to other populations specifically affected by HIV, tuberculosis or malaria. For detailed definitions, see the Glossary in Annex 4. Note that while these key populations may include young people (aged 10-24), the United Nations considers children under 18 who sell sex to be sexually exploited children, and not sex workers.

[ii] The use of these terms is not intended to exclude other affirming ways in which people may describe this sexual orientation or behavior.

cascade remains poor for key populations, primarily because of **barriers related to human rights and gender**, including criminalization, religious laws, cultural norms, stigma, discrimination, and violence. For this reason, the Global Fund strategy 2017–2022[4] stresses the importance of ensuring that services are accessible, acceptable, affordable, and of high quality (as reflected in the strategy's Key Performance Indicator 5). A key component of improving access for key populations is to **identify, strengthen, and support civil-society, community-based, and key-population led organizations and networks to provide large-scale programming**. Such organizations can be well placed to create trusted, safe platforms for service delivery, whether these are direct services via drop-in centers, community outreach workers, or internet-based communications; or tracked referrals to vetted service-providers that are respectful of, and safe for, key populations.

This technical brief outlines the principles and approaches summarized above. It should be read in conjunction with the Global Fund's HIV information note,[5] which provides wider context for HIV funding requests. This technical brief is based on the latest normative and implementation guidance, including the four implementation tools for HIV programming with key populations,[iii] which translate into practical steps both the clinical guidance and the critical enablers (addressing barriers to services) contained in the WHO *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (2016). The implementation tools were compiled through a process of close collaboration between key-population-led organizations and networks, United Nations agencies, and other international partners.

This technical brief is also based on lessons learned from an assessment of programs for key populations across 65 countries. The assessment was commissioned by the Global Fund to examine how HIV service packages are designed, delivered, and monitored during the 2017–2019 allocation period (it is referred to in this document as the "assessment report").

Section 1 of this brief outlines **why key populations are especially vulnerable to HIV**. **Section 2** presents **principles and approaches** that must underlie all aspects of programming. **Section 3** describes the **components that should be part of National Strategic Plans and national programs for key populations**, covering strategic information, program design, program implementation, and monitoring. It includes the comprehensive package of interventions, and the "critical enablers" defined by WHO to address rights-related barriers to services. The annexes provide **examples of approaches and programs** from around the world, a list of **representative networks of key populations**, **key reference documents**, and a **glossary of terms**.

1.1 Key populations and HIV vulnerability

In every setting key populations are disproportionately affected by HIV, and have higher morbidity and mortality rates than the general population. In most countries inadequate coverage and poor quality of services for key populations continue to undermine responses to HIV. Members of all key populations continue to experience intense stigma and discrimination,

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iii *Implementing comprehensive HIV and STI programmes with sex workers: practical guidance from collaborative interventions* (WHO, 2013) – informally known as the SWIT; *Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions* (UNFPA, 2015) – the MSMIT; *Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions* (UNDP, 2016) – the TRANSIT; *Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions* (UNODC, 2017) – the IDUIT.

legal barriers and constraints to accessing services, and often low prioritization by the public health systems.[6]

A number of structural barriers discourage or prevent key populations from accessing health care, and violate their right to health[6] and to non-discrimination. In many countries, the criminalization of sex between men, sex work, or drug use, and the lack of legal recognition of gender identities other than male or female, are a severe barrier to services. These are often made worse by illegal police practices such as harassment, arbitrary arrest, extortion, and violence. Key population members who are imprisoned or in detention experience the same restricted access to prevention and health services that all prisoners face, and may experience additional discrimination and vulnerability to HIV.

Members of key populations may face stigma and discrimination from service providers themselves, ranging from disrespect to verbal or physical abuse, or denial of services. Health professionals may lack knowledge and training about the specific sexual-health needs of key populations, or about drug dependence.

Key population members who are excluded from employment opportunities because of their sexual or gender identity, or their use of drugs, may face poverty and homelessness, making health services harder to access. People selling sex may face legal sanctions as well as violence and economic exploitation.

Vulnerabilities relating to gender, age, or HIV status affect certain members of every key population:

- **Women** often have less access to health and social services than men, are more economically marginalized, and are more vulnerable to gender-based violence. The sexual and reproductive rights of female members of key populations are often ignored or denied, with forced sterilization and forced abortion occurring (see Section 2.1).
- **Young key population members** (aged 10-24 years) face the additional vulnerabilities of their youth, power imbalances in relationships, and their vulnerability to exploitation or violence. These factors increase their risk of engaging in behaviors that may expose them to HIV. Those under the age of 18 may have difficulty accessing health services because of laws that require parental consent, policies that disregard the concept of respecting the best interests and evolving capacities of the child,[7] or a lack of age-appropriate services within programs designed for key populations.
- **Key population members living with HIV** may experience additional stigma because of their HIV status (including stigma from within their own key population community). They may face even greater difficulties accessing treatment and other needed services. People living with HIV are at greater risk of developing active tuberculosis – and of TB-related mortality – than those who are HIV negative, particularly if they are in prison or other closed settings, or live and work in cramped conditions. Among people who inject drugs who are living with HIV, co-infection with viral hepatitis C is very common.

Many key population members experience overlapping vulnerabilities to HIV infection and to the impact of HIV, and programs must be attentive to these, so that all their needs can be addressed. For example, a person may sell sex in order to procure drugs, or a person suffering stigma or violence because of their sexual orientation or gender identity may use alcohol or drugs as a coping mechanism.

2. Guiding principles and approaches

2.1 Principles

Programming must meet Global Fund human-rights standards: Strategic Objective 3 in the Global Fund's 2017-2022 strategy commits the fund to "introduce and scale up programs that remove human-rights barriers to accessing HIV, tuberculosis and malaria services and promoting and protecting gender equality".[4] Human-rights norms and principles must be integrated into programs, and programs must be implemented to remove human-rights-related barriers to HIV services (see Section 3.3). Governments,[1,8] UNAIDS,[9] WHO,[6] the Global Fund, and civil society have recognized specific programs to integrate human-rights norms and principles into HIV services and remove rights-related barriers, including for key populations. For a description of these programs, see the Global Fund's technical brief on *HIV, Human Rights and Gender Equality*,[iv] and the UNAIDS guidance on *Key Programs to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*. These approaches should also form part of the comprehensive package of services for key populations.

The Global Fund Framework Agreements include five human-rights standards to which all grantees must adhere. These are: (a) non-discriminatory access to services for all, including people in detention; (b) employing only scientifically sound and approved medicines or medical practices; (c) not employing methods that constitute torture or cruel, inhumane, or degrading treatment; (d) respecting and protecting informed consent, confidentiality, and the right to privacy concerning medical testing, treatment, or health services rendered; and (e) avoiding medical detention and involuntary isolation, which are to be used only as a last resort.

Programming must address underlying issues contributing to inequity in access, including gender-related barriers to services: Programs must recognize and appropriately address a broad range of issues impacting inequity in access for key populations, such as age, social and economic marginalization, cultural and gender norms, and stigma, among others. Within key populations, as within the population at large, gender is a critical factor in risk for disease and how people are able to access and receive services. Programs must be designed, implemented, and monitored with the greatest possible understanding of the gender-related disparities in access to critical services, and the reasons for these disparities. It is also important to understand and respond concretely to the gender dimensions within key populations. For example, harm reduction services should understand the specific needs of women who use drugs, including how to build rapport with women who inject drugs and provide comprehensive, safe services. Transgender women should not be grouped with gay men and other men who have sex with men for the purposes of gathering strategic information, outreach, service delivery, or program monitoring. In addition, sexual and reproductive health services should be offered to women and men, regardless of which key population(s) they belong to, as part of the comprehensive package of interventions (see Section 3.2.2).

Programs must do no harm: The participation of key population members in all aspects of

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[iv] In this technical brief, hyperlinks are to the English-language versions of Global Fund publications, but they are available in other languages at https://www.theglobalfund.org/en/funding-model/applying/resources/.

program planning (including country dialogues and country coordinating mechanisms), program delivery, and monitoring should always be designed to ensure they are not exposed to danger of harassment, abuse, or violence. Programs must have policies and procedures to prevent, mitigate, and respond to threats to the safety of key population members who seek or receive services, and those who deliver services (see the FHI 360/LINKAGES *Safety and Security Toolkit*). It is also essential to ensure the confidentiality of client data (see Section 3.5).

2.2 Approaches

The following approaches are key to successful programs and should be integrated into design, implementation, and monitoring. Examples of how this applies are given in Section 3.4 and Annex 1.

Scale and sustainability: Global Fund funding exists to help countries plan, design, and deliver comprehensive services. It should be the goal of each country to scale these services up so that 90% of key populations are covered. This requires partnering with civil-society organizations, including community- and key-population-led organizations and networks, that are able (or have the potential) to implement large-scale programming, with strong management to incorporate strategic information and use monitoring data, and the flexibility and the capacity to adapt rapidly if the environment for service delivery changes suddenly (see the Global Fund's *technical brief on community systems strengthening and the HIV information note*).

The long-term sustainability of programs must be considered from the initial planning stage. Funding from external donors is never permanent, and countries must therefore consider from a policy point of view how key population programming and financing can be integrated within national health and welfare programs and budgets, for example through social contracting (see Annex 1, example A, and *The Global Fund Sustainability, Transition and Co-financing Policy*). This should include services that are provided by key-population-led nongovernmental organizations (NGOs) or community-based organizations (CBOs), which often suffer cuts if resources become limited. In order to safeguard against this, key populations must be central not only as planners and recipients of programming, but as advocates for well-planned, data-driven transitions that maintain and expand strategic programming, including harm reduction, as well as advocating for an enabling environment to promote access to services. Applicants should build into their plans adequate time, funding, and structures to maintain and scale up programs. National plans must include a costed transition plan to show how programs will be sustained once Global Fund funding comes to an end.

The HIV treatment cascade: As well as robust interventions for HIV prevention, programs must provide a comprehensive package of services for HIV diagnosis, treatment, and care, to ensure that those who test HIV positive are quickly provided with an opportunity to initiate antiretroviral therapy (ART), provided with psychosocial support as needed, and supported to stay on ART so that they remain virally suppressed, thus preventing onward transmission and keeping them healthy. Program monitoring should be designed to track individuals across this cascade. For more information, see the WHO *Consolidated Strategic Information Guidelines for HIV in the Health Sector*.

Strengthening community systems (CSS): Many of the most effective HIV responses for key populations – including interventions to promote safer sex behaviors, consistent condom use, pre-exposure prophylaxis (PrEP), regular HIV testing, HIV treatment, retention in care,

harm reduction, and advocacy – are delivered in community-based settings. However, many key population communities and organizations lack the resources and systems needed to deliver and manage HIV and healthcare services. Funding applications that include a focus on strengthening these networks and organizations can strengthen their leadership, and can help these networks and organizations be effective partners in national HIV responses by creating access platforms that are trusted by key populations. Specific interventions can be considered as part of CSS: community-based monitoring, community-led advocacy, social mobilization, building community linkages, and collaboration and coordination. Community systems should be designed from the outset to allow for scale-up of key population programs to meet national targets. For further information, see the Global Fund *technical brief on community systems strengthening*. CBOs and NGOs should receive adequate and consistent financial support to maintain the breadth and quality of their services. Wherever feasible, countries should consider funding these organizations from within national budgets, rather than relying on donors to sustain them. Models for this include social contracting, and funding NGOs to provide services to key populations through government insurance schemes (see Annex 1, example A).

Community participation and leadership: Participation and leadership help build key populations' trust in Global Fund-related processes and their ownership of them, and create more enabling environments for HIV prevention, testing, treatment, and care.[10] This applies throughout country dialogues and country coordinating mechanism deliberations, developing funding requests, and grant making. Key population members should choose how they are represented, and by whom, taking into consideration issues of gender diversity and parity. Communities can seek support to strengthen participation from the Global Fund Secretariat through the *Community, Rights and Gender (CRG) Technical Assistance Program* or through technical partners. See Annex 1, example B, and also Section 3.3.3 and the list of key population networks in Annex 2. Key population participation and leadership is also essential for the design, implementation, monitoring, and evaluation of effective programs. Services delivered by members of key populations (or in close collaboration with key populations) are more likely to be respectful and acceptable to the beneficiaries. This means employing key population members as staff, including – but not limited to – community outreach workers (peer educators, peer counsellors, peer providers of HIV testing and peer distributors of ART for stable clients, peer supervisors, peer navigators, peer human-rights educators, and peer paralegals); gathering regular feedback from service beneficiaries; and implementing effective accountability mechanisms, such as community-led oversight committees.

Accessibility and affordability: Co-locating services makes them more accessible and reduces loss to follow-up. Where social or health services designed for a key population already exist, adding services from the comprehensive package may be considered, either by cross-training existing staff, or by supplying staff who can work at the location. Services should be flexible to accommodate the needs of non-citizens or internal migrants who may not have the documentation that is normally required. Services should also be free of charge or affordable. Countries should ensure that out-of-pocket expenses do not present barriers to access for key population members.

Differentiation: In order to make the most effective and efficient use of funds, countries should consider differentiating service design and delivery in several ways. These include:

- **Geography:** According to the distribution and density of key population members.

- **Health systems:** With different responsibilities according to the type or location of provider.
- **Demographics:** For example, age, gender, migrant status, language, educational level.
- **Service package:** Tailored to individual key populations, or subgroups within key populations.
- **Individual characteristics of key populations:** Tailored to varying risk profiles, sexual practices and patterns of behavior.
- **Human-rights-related and gender-related barriers:** Programs to address these barriers should be tailored to the needs of each key population.

3. Developing, implementing, and monitoring programs for key populations

Table 1 on the following page summarizes key components of HIV programs for key populations. Funding requests should incorporate these, and the other components outlined below. It is particularly important that funding requests also reflect the principles and approaches listed in Section 2 above.

3.1 Strategic information

The security of key populations is paramount in all activities related to collection, analysis, and use of strategic information. Since collecting individual-level data on key populations can be dangerous in hostile environments, it is always critically important to assess whether key population members can confidentially and safely participate, and to include measures to ensure their security throughout the process (see the FHI 360/LINKAGES *Programmatic Mapping Readiness Assessment*). This includes ensuring that data gathered on key populations is stored securely.

Countries should conduct epidemiological and demographic assessments to set realistic targets. Epidemiological assessments include sero-prevalence surveys and needs assessments. Demographic assessments include population size estimation, which wherever possible should be accompanied by mapping (site-based only, as well as online for certain subsets of key populations) to identify areas where services should be provided, as well as suitable operating times (See the UNAIDS and WHO *guidelines on population size estimation* and the guidelines on *biobehavioral surveys for key populations*.) However, since size estimation and biobehavioral surveys can be time-consuming and resource-intensive, countries should adopt a pragmatic approach (for instance, community mapping) and begin programs where they are clearly needed, iteratively making adjustments as more rigorous data become available.

Strategic information must be disaggregated when it is analyzed to ensure that services reach people in need and no one is left behind. Differentiated services can only be designed and provided effectively and efficiently if there is information on key populations in

all their diversity at the local level. Data generated from surveys and programs must therefore be disaggregated by gender and age within each key population, where possible. This is particularly important for sex workers and for people who inject drugs: within these key populations, subgroups by gender, gender identity, and age experience different vulnerabilities, service needs, and obstacles to accessing those services. For the same reason, key population members under the age of 18 should be differentiated from those who are legal adults. (However, it should be remembered that the United Nations considers children under 18 who sell sex to be sexually exploited children, not sex workers.[8,9]) Data should also be disaggregated subnationally on a regular basis for use at district and site levels.

Table 1. *Summary of comprehensive service package and key delivery approaches for key populations (adapted from the WHO key populations consolidated guidelines and the key population implementation tools)*

Comprehensive package	Interventions/key populations	Sex workers	Men who have sex with men	Transgender people	People who inject drugs	People in prison or
Health-sector interventions	HIV prevention: • Condom and lubricant programming • Pre-exposure prophylaxis (PrEP)* • Post-exposure prophylaxis (PEP)	X	X	X	X	X
	Harm reduction interventions (needle and syringe programs, opioid substitution therapy, and naloxone)				X**	
	Behavior change interventions to understand risk and support risk reduction	X	X	X	X	X
	HIV testing services	X	X	X	X	X
	HIV treatment and care, including adherence support for retention	X	X	X	X	X
	Prevention and management of co-infections and co-morbidities	X	X	X	X	X
	Sexual and reproductive health interventions	X	X	X	X	X
	Other health services for specific needs of key populations (e.g. gender-affirming care for transgender people, adolescent-friendly services for young key population members, mental-health and drug dependence programs)	X	X	X	X	X
Critical enablers	Supportive legislation and policy	All key populations				
	Addressing stigma and discrimination	All key populations				
	Community empowerment	All key populations				
	Addressing all forms of violence	All key populations				
	Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.	All key populations				
Program planning and delivery	Adequate funding, and planning for funding sustainability	All key populations				
	Strong management and supervision at all program levels	All key populations				
	Community-based approach to service planning and delivery, creating a "trusted access platform" for key population members	All key populations				
	Tailored service delivery approaches: internet-based information, social-marking strategies, sex-venue-based outreach, drug-venue-based outreach, as appropriate	All key populations, as appropriate				

	Use of data for monitoring, problem-solving, and improvement at all program levels, including with key population program monitoring groups	All key populations

*PrEP for populations at substantial risk of HIV.[11]
**Harm reduction interventions should be provided to all key population members who inject drugs.

Needs assessments should be conducted to identify determinants of risk and service needs specific to key populations. They should take into account age- and gender-specific behaviors, and sexual orientation, to determine who should provide services and how, as well as to identify where there are gaps and barriers in service provision. The WHO rapid assessment and response (RAR) approach,[12,13] and the UNAIDS *Gender Assessment Tool* (GAT) can be used to assess contexts and make national responses more gender-transformative, equitable and rights-based for key populations.

Population size estimation and mapping should be designed to identify the numbers of people who correspond to the populations defined for the programs. For example, whether women or men who inject drugs are "active", i.e. have done so within the past 6 months; or whether men who have sex with men are at high risk, i.e. have had more than one same-sex sexual partner in the past six months. (See the WHO *tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations*.)

Programmatic definitions of key populations should take into account overlapping vulnerabilities: Key population members may self-define in ways that do not reflect all their vulnerabilities. For example, a gay man or man who has sex with men may not mention that he sells sex; or a woman who sells sex from her home may not identify herself as a sex worker. An individual's patterns of drug use may shift from injecting to non-injecting and back again, which can make it difficult to obtain an accurate population size estimate. Surveys and mapping must therefore take these overlapping or changing identities into account, and services should be designed to be flexible enough to accommodate key populations in all their diversity.

Countries should include virtual sites in the mapping of key populations, where it is appropriate and safe to do so. Social media are an increasingly important way for some key populations, such as gay men and other men who have sex with men, to meet sexual contacts. Programs should consider mapping these networks. However, policies on privacy, security, and ethics for online mapping should be developed to ensure the safety of those who are contacted online.

Factors affecting the reliability of data should be considered. If integrated biobehavioral surveys (IBBS) are used for size estimates, they should be of the general population, and not just key populations already served by programs. Caution should be used in extrapolating from small-scale surveillance studies or programmatic data, as these can skew population size estimates. It is important to note that sampling for population size estimation may be confounded in hostile social or legal environments, because members of key populations may conceal their identity, resulting in underestimates.

Meaningful community engagement in data collection, analysis, and use must be ensured. Representatives of key populations should participate in all aspects of strategic information, i.e. developing and validating population size estimates, conducting needs

assessments, identifying human-rights-related and gender-related barriers to services, and routine use of programmatic data, including indicators, for problem-solving and program improvement. If key population networks or organizations exist within the country, their participation will enhance the accuracy and validity of strategic information (see Annex 1, example B).

Potential Programming Gaps: Strategic Information

The assessment report on service packages for key populations in 65 countries identified a number of significant gaps in service package design, implementation, and monitoring that were observed frequently across a significant number of countries. Countries preparing funding requests are urged to consider these common flaws to ensure that proposed programs are truly comprehensive.

- Many national plans do not acknowledge all the key populations that are present in the country, especially transgender people, people who inject drugs, and prisoners; they also ignore the gender, sexual orientation, and age dimensions of key populations.
- Key populations are inadequately represented in the process of designing service packages.
- The available data on key populations are not disaggregated by sex, making it difficult to design gender-responsive programs.
- There is insufficient detail on what constitutes coverage, in either national plans or standard operating procedures.

3.2 Program design

3.2.1 Program stewardship

National HIV Strategic Plans, and operational plans to guide programmatic implementation, should be designed to create a trusted platform for service access, i.e. one that strengthens community-based organizations to scale up data-driven, responsive, accountable, high-quality programming across the cascade of HIV prevention, diagnosis, treatment, and care. In order to be comprehensive, plans must:

- **Recognize all the key populations** that are present in the country, and define the populations precisely (e.g. does "sex worker" refer to a male, female, or transgender sex worker, or to all three?).
- **Clearly define the goals and objectives** for the key populations program, including gender and other types of disaggregation, as appropriate.
- **Include a comprehensive package of evidence-based interventions**, identified per key population, including both health-sector interventions and critical enablers (see Sections 3.2.2 and 3.3), and tailored to address specific vulnerabilities.
- **Address differentiated services** for individual key populations or subgroups within these populations (see Section 3.4.2), as well as community empowerment and sustainability.
- **Show how programs will be taken to scale.** The plan should also show how policy, administrative, human-rights-related and gender-related barriers to scale-up will be addressed.
- **Provide structures and support for strong management and accountability.** This includes accountability to key populations by supporting key-population-led organizations to take ownership of interventions.
- **Provide a clear and costed operational plan** with timelines for implementation.
- **Include a monitoring and evaluation framework** with core indicators and targets. This includes a clear definition of reach and coverage. (See the UNAIDS *Global AIDS Monitoring indicators*.) A national monitoring system should collate data from all subnational projects, and programmatic data should be reviewed and used routinely at national and subnational levels for management and problem-solving.
- **Provide for the collection, recording, and monitoring of data** at local, regional, and national levels to show results across the full cascade of prevention, diagnosis, treatment, and care (including treatment outcomes, i.e. viral load monitoring).
- **Be updated every 3-5 years** to ensure that they reflect changes in the HIV epidemic, any recent population size estimates, advances and innovations in the health field, and that relevant services are being provided.

National strategic plans should ensure inclusive participation of all stakeholders, including CBOs whose staff, leadership, and governance are predominantly key population members and who are primarily accountable to their beneficiaries. Other CBOs and NGOs with a track record of working in a participatory manner with their beneficiaries, particularly if these include key populations, should also be considered. In both cases, programs should actively work to strengthen and support these organizations (see Section 2.2 and the Global Fund *technical brief on community systems strengthening*). Although community-led services are integral to community empowerment, in some contexts it may be illegal or dangerous for key populations to form CBOs or NGOs. Even here, however, key population representatives

should be involved as much as possible in program planning, implementation, and monitoring and safe spaces be provided to facilitate their engagement.

CBOs that are principal recipients or subrecipients should be aligned with national processes to ensure sustainability, and national strategic plans should show how key population programming is integrated as part of the national program. For more information, see the Global HIV Prevention Coalition's *HIV Prevention 2020 Road Map*.

Plans should delineate the respective roles of public and private health providers, NGOs, CBOs, and community- and key-population-led organizations. Plans should also specify which services are to be provided (and how) outside urban areas or other areas with a high HIV burden (see Annex 1, example C). In countries with decentralized healthcare systems, standard operating procedures should be drawn up for service delivery, quality standards, and monitoring.

The service package should be designed with the participation of key population networks and representatives. Key population representatives should participate in national-level planning, for example by inclusion in the country coordinating mechanism and the design of National Strategic Plans. Client feedback gained during program implementation can be used for the next cycle of the design process.

Programs should be overseen by a group with comprehensive representation of stakeholders, including key populations. It is essential to work to ensure support for HIV programming across all relevant government ministries and departments. A CCM Oversight Committee can ensure the active participation of all relevant government departments, along with private-sector and non-governmental implementers and key population representatives. Among the group's roles should be developing a plan to mitigate the negative impact of laws, regulations, and policies upon access to services for key populations. The group should also ensure that relevant detailed implementation guidance is in place (e.g. standard operating procedures for PrEP, or for opioid substitution therapy) to support effective implementation of comprehensive programs for key populations. The group should also develop plans to close financial gaps in areas that are underfunded, such as HIV prevention, and ensure that resources are adequately distributed according to priority needs.

3.2.2 Comprehensive package of health-sector interventions

The comprehensive package of health-sector interventions for key populations, i.e. sex workers, MSM, transgender, people who inject drugs and people in prisons and other closed settings, is outlined in the WHO *key populations consolidated guidelines*, and the interventions are further detailed in the four implementation tools addressing *sex workers (the SWIT)*, *men who have sex with men (MSMIT)*, *transgender people (TRANSIT)*, and *people who inject drugs (IDUIT)*. The package includes not just biobehavioral interventions for HIV prevention, diagnosis, treatment, and care, but also interventions to address comorbidities such as tuberculosis and viral hepatitis, and sexual and reproductive health needs. The comprehensive package also includes approaches (called "critical enablers") that address the legal, policy, gender, and social barriers that prevent key population members from accessing the services they need. These are described in Section 3.3.

The health-sector interventions and critical enablers are relevant to all key populations,[v] and they must be viewed as interdependent. This means that it is insufficient to choose to implement only some of them. The Global Fund resources alone may not be sufficient to cover each of these interventions but they should be planned for within the broader national health financing landscape. Therefore, funding requests should demonstrate plans to ensure that services are available, accessible, and acceptable to key population members, and develop appropriate methods to measure service coverage.

1. **Prevention:**

    a. **Comprehensive condom and lubricant programming,** ensuring that a) there is a widespread, consistent, and sufficient supply of free condoms and condom-compatible lubricant, of a quality acceptable to key population members, b) key population members have the knowledge, skills, and empowerment to use them correctly and consistently, and c) demand for condoms and lubricant is created among key populations.[14] Lubricant should be a part of services for female sex workers and transgender women, people who inject drugs, and prisoners and not just for gay men and other men who have sex with men. Female condoms should be part of the package for female sex workers at a minimum.

    b. **Pre-exposure prophylaxis (PrEP)** should be available as an option for people at "substantial risk" of HIV infection.[vi] PrEP is increasingly available in some countries and is being piloted in others. It should be included in national plans even if funding is uncertain when the plan is drawn up. Based on the available strategic information, the program should determine the segment of key populations who are at substantial risk, determine eligibility and interest, set targets and indicators, and ensure support for adherence and linkages to other health services.[13]

    c. **Post-exposure prophylaxis (PEP)** is recommended for those who have potentially been exposed to HIV, including via sexual assault. Services should be provided in combination with gender-based violence screening and redress, legal aid, and other non-health-sector interventions. PEP should also be available for outreach workers who suffer accidental needle-sticks.

2. **Violence prevention and response** complements screening and redress for violence and is considered a crucial component of HIV prevention, because violence against key population members increases their vulnerability to HIV. Programs to respond to incidents of violence, often organized and led by key population members themselves, can help support a platform for service access that is trusted by the community.

3. **Harm reduction interventions for people who use drugs**, in particular needle and syringe programs for those who inject drugs, opioid substitution therapy for people dependent on opioids, and other evidence-based drug dependence therapy, and the provision of naloxone to treat overdose.[15] Standards should meet those set in the 2012 *WHO, UNODC, UNAIDS technical guide* (especially for a sufficient supply of prevention commodities). Programming should reflect the specific needs of women

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[v] The exception is that needle and syringe programs, opioid substitution therapy, and naloxone are specific only to people who inject drugs or who are dependent on opioids.

[vi] "Substantial risk" is defined by WHO as HIV incidence in the population of more than 3% (see the WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*).

who use drugs, and any changing patterns of drug use, such as the use of stimulant drugs, and resulting changes in sexual risk behaviors. Harm reduction services and linkages to drug dependence treatment services should be considered for users of non-injecting drugs, such as amphetamine-type substances, which are linked in some cases to increased risk behaviors for HIV.[16] Note that the other interventions in this numbered list are also part of the WHO-recommended comprehensive harm reduction package.

4. **Behavioral interventions** providing evidence-based information and skills to improve personalized risk perception, support risk reduction, prevent HIV transmission, increase uptake of services, and promote health-seeking behaviors. These include social and behavior change communication, both for individuals and groups, delivered in healthcare facilities or community settings (including mobile outreach), and adapted to the local context.

5. **HIV testing services** in community, clinical, and closed settings.[17] These should include rapid testing by trained lay providers[18] and the provision of self-testing kits, as well as support services for partners.[19]

6. **HIV treatment and care**, including immediate access to ART for people testing HIV positive, viral-load monitoring, and retention across the treatment and care cascade.[20] These services are essential to achieving the 90-90-90 targets, and **national plans must include the provision of HIV testing, ART, and clinical monitoring specifically for key populations**. It is not enough to assume that if these services are available to the general population, they will also be accessible to key population members.

7. **Prevention and management of co-infections and other co-morbidities**, including viral hepatitis,[21,22,23] tuberculosis,[24] human papilloma virus, and mental-health conditions (see Annex 1, example D).[25] In particular, linkages to testing, prevention, and management of tuberculosis must be consistently available.[26,27]

8. **Sexual and reproductive health interventions**, including screening and treatment of asymptomatic sexually transmitted infections (STIs), syndromic case management of symptomatic STIs in the absence of laboratory tests,[28] cervical cancer screening and treatment, as well as other sexual and reproductive health services.

Services within each element of the comprehensive package should be differentiated to meet the needs of specific key populations. For example, it will not be effective to provide the same number of condoms and lubricant per individual without regard to which key population they belong to, their pattern of sexual practices, their location, and so on. Additional aspects of differentiation include:

• **Comprehensive sexual and reproductive health needs** within key populations must be addressed. For example, services for female sex workers should include comprehensive contraception access, care for safe pregnancy, including the prevention of mother-to-child transmission of HIV,[29,30] screening and treatment of STIs, and screening and treatment for cervical cancer.[31] Reproductive health services are also needed by women who inject drugs, and the service package for people who inject drugs should reflect this. Similarly, the sexual health needs of gay men and other men

who have sex with men and transgender people should be sensitively assessed and comprehensively addressed, and must include easy access to condoms and lubricants, screening and treatment of STIs, immunization, screening and treatment for hepatitis B, HPV screening and vaccination, and general anal and penile health education. Gender-affirming hormone therapies should be included for transgender men and women.

- **Adolescents and young key population members** should be offered differentiated interventions that reflect that their knowledge of HIV and sexual and reproductive health may differ from that of adults, and that respect their preferred methods of receiving information (e.g. via social media, and using age-appropriate language). Plans must also consider how to address barriers to services for those under 18 where parental-consent laws apply, or who face other legal barriers to accessing services. In addition, initiatives to keep young people in school, and comprehensive sexuality education, should be offered in public and private schools as prevention strategies.

- **Prisoners** should be differentiated from other key populations, since some services, especially for HIV prevention, and critical enablers (see Section 3.3) are unlikely to be achievable for them. However, countries should ensure that there are sufficient resources for 90% coverage of prisoners with a defined package of services. The UN-recommended package of services includes, in addition to the comprehensive package listed above, interventions for the prevention of sexual violence, and prevention of HIV transmission through medical or dental services, and through tattooing and piercing. It also emphasizes that prison health is part of public health, and the importance of a human-rights-based approach (the principle of equivalence of health in prisons). For more information, see the UN publication *HIV Prevention, Treatment and Care in Prisons and Other Closed Settings*.

- **Additional interventions for some individuals within key populations** are recommended by WHO and/or described in the key population implementation tools, and should be included in national plans. They are: screening for ano-rectal cancer (for men or transgender people who engage in anal sex);[32] risk-reduction and harm-reduction counseling for transgender individuals taking hormone replacement therapy, especially those who do so informally because of lack of access through established health services; and clinical care for survivors of sexual assault, including emergency contraception, post-exposure prophylaxis for HIV and other STIs, hepatitis B immunization and psychosocial care and support.[33] Supportive services also include hotlines staffed by trained peer counsellors to offer psychosocial support, as well as crisis-response interventions, with multi-disciplinary teams, linking survivors to various services and safe spaces.

Potential Programming Gaps: Intervention Package

Countries preparing funding requests are urged to consider these common flaws to ensure that proposed programs are maximally functional and truly comprehensive.

- In some cases, service packages are not differentiated (eg. The same intervention package and delivery approaches for all KPs irrespective of age and gender)and do not allow implementing organizations flexibility to address local conditions or meet the specific needs of individual key population members.
- High-quality condoms, female condoms, and lubricant are often not consistently available in sufficient numbers, are not promoted, or barriers to consistent condom use are not addressed. Lubricant is not seen as essential to condom programming.
- There is inadequate provision of needle and syringe programs, opioid substitution therapy, and overdose prevention for people who inject drugs, including those in prison.
- PrEP has not been added to prevention packages.
- HIV testing and ART are not specified for key populations, even though they may be less accessible to key population members. Inadequate use is made of lay providers for HIV testing and ART provision, even though these may increase access for key populations and are recommended by WHO.
- Prevention and health benefits of early treatment and retention in care among key population are not sufficiently leveraged, including the dissemination of information about U=U (undetectable=untransmittable).
- Co-morbidities and other health needs (such as mental-health services) are not given proper consideration.
- There is inadequate attention to gender-responsive service provision (i.e. addressing the specific needs of women who use drugs, or male and transgender sex workers). There is inadequate effort to prevent, mitigate, and respond to the effects of violence on key populations, even though violence is a major deterrent from seeking services.

3.3 Critical enablers and programs to remove human-rights-related barriers to services

The WHO *consolidated guidelines for key populations* define critical enablers as "strategies, activities, and approaches that aim to improve the accessibility, acceptability, uptake, equitable coverage, quality, effectiveness, and efficiency of HIV interventions and services. Enablers operate at many levels – individual, community, institutional, societal and national, regional, and global. They are crucial to implementing comprehensive HIV programs for key populations in all epidemic contexts."[6]

The five critical enablers identified in the guidelines are described briefly in the three sections below, and they must be addressed in order to create an enabling environment that will allow programs for key populations to be planned, implemented, and monitored – and for key population members to feel safe using the services. Examples are given of how critical enablers should be included, but countries should also analyze their own contexts in depth to determine additional ways to address them. The critical enablers complement, and in some cases include, the programs described in the Global Fund's technical brief on *HIV, Human Rights and Gender Equality*.

3.3.1 Reviewing laws, policies, and practices, including decriminalization and the age of consent

The WHO *consolidated guidelines for key populations* state that countries should "work toward decriminalization of behaviors such as drug use/injecting, sex work, same-sex activity, and nonconforming gender identities, and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men, and transgender people."[6] This echoes similar calls by numerous other bodies.[34,35] In addition, countries should:

- Address laws that criminalize the identity or behaviors of key populations, or that restrict access to services, e.g. by prohibiting or limiting access to harm reduction services, or requiring parental consent for testing or treatment of those aged under 18.
- Address law-enforcement practices that violate the human rights of key population members or increase their HIV risk, such as confiscating condoms or sterile needles, and forced anal examinations of gay men and other men who have sex with men and transgender people.
- Hold institutions to account for following existing laws and practices that uphold the rights of key populations.
- Move to close compulsory drug "treatment and rehabilitation" centers, in line with the joint United Nations entities' statement on such facilities,[36] as well as detention centers that aim to "rehabilitate" sex workers or children who have been trafficked, or to "treat" sexual orientation or gender identity. The Global Fund does not fund compulsory treatment programs. In addition, the Global Fund does not support coercive medical practices, including but not limited to mandatory registration and testing and partner notification, forced sterilization, and forced anal exams.

Advocacy can include public campaigns, sensitization workshops (see below), working with media to improve coverage of key populations and HIV issues, or partnering with organizations that have similar civil-rights objectives.

3.3.2 Addressing stigma, discrimination, and violence against key population members

The WHO *consolidated guidelines for key populations* treat stigma and discrimination separately from violence, but they are described together here, since they are closely related. Violence includes physical, sexual, economic, and psychological abuse, as well as structural and other human-rights violations.

Perpetrators of stigma, discrimination, and violence may include representatives of the state, such as police, law-enforcement or military personnel, border guards, and prison guards; institutional representatives such as employers, healthcare providers, educational staff, and landlords; members of the public, family members, and intimate partners; and religious leaders or groups, gang members, and militias.

Applicants should demonstrate an approach that addresses stigma, discrimination, and violence as public-health and human-rights issues, and removes barriers to services. While the approach should be tailored to the country context, it is likely to include support for interventions that:

- **Foster police accountability:** This can include regular sensitization workshops on

human rights and the laws relevant to key populations and HIV, and engaging police officials at the local level to support program implementation, for example by not harassing outreach workers and program clients, or designating liaison officers for key populations.

- **Sensitize healthcare workers** and other staff of clinical facilities through training on the legal rights, HIV risk, and clinical and psychosocial needs of key populations, and on respectful service delivery, especially respecting client confidentiality and voluntary informed consent for treatment. There should be feedback mechanisms for service users who experience discrimination or other rights violations. In environments hostile to key populations, attention must be given to how services are promoted and labeled outside and within the facility.

- **Build the capacity and self-efficacy of key population members**: This includes raising key population members' awareness of their human rights and their rights as citizens under national constitutions and laws. Approaches include legal literacy and "know your rights" workshops, and integrating community paralegals or other legal-aid services into outreach programs (see also Section 3.3.3). Service providers should also be capacitated to make referrals to legal aid, where available, for victims of discrimination or violence.

- **Gather data on discrimination and violence faced by key population members**: this is important both for legal redress in individual cases, and for building an evidence base that can be used in advocacy for legal and policy reform.

- **Promote the safety and security of key population members** by establishing safe spaces/drop-in centers, fostering sharing of practical safety tips, working with brothel owners, and integrating inquiring about violence into HIV prevention counseling and clinical services.

- **Provide an effective, immediate response for victims of violence**: this includes supporting community-led crisis response systems; and providing health services and psychosocial and legal support to those who experience violence.[35]

For more information, see the Global Fund's technical brief on *HIV, Human Rights and Gender Equality*, and FHI 360/LINKAGES' guidance on *responding to acute violence against key populations*.

3.3.3 Community empowerment

Community empowerment is the process whereby key population members are empowered and supported to address for themselves the structural constraints to health, human rights, and well-being that they face, and to improve their access to services to reduce the risk of acquiring HIV. It is foundational to human-rights-based programming and should underlie all the approaches and interventions presented in funding requests. Practical aspects of community empowerment are described below, or in other sections of this brief:

- **Meaningful participation of key population representatives:** See Sections 2.2 and 3.4.2.

- **Fostering formation of key population groups or networks:** See Sections 2.2 and 3.2.1.

- **Fostering outreach by key population members:** See Sections 3.2.1 and 3.4.2.

- **Promoting a human-rights and gender-responsive approach to HIV interventions:** See Sections 2.1 and 3.3.2.

- **Community systems strengthening:** See Section 2.2.
- **Advocating for policy change and enabling environments:** See Sections 3.3.1 and 3.3.2.
- **Sustainability:** See Section 2.2.

3.4 Program implementation

3.4.1 Implementing programs across the HIV prevention, testing, and treatment cascade

Services are provided through a combination of outreach, community-based services, and at clinics. Services and facilities may be public (government-run), private, or led by community- and key-population-led organizations and networks.

Outreach and delivery for HIV testing should be designed to ensure that those most at risk, and the hardest to reach, are being contacted. Regular retesting of key population members at high risk of HIV who are already enrolled in the program provides an important opportunity to connect people to prevention services, reinforce the benefits of knowing one's HIV status, and of early treatment if HIV positive; to link any individuals who test HIV positive to ART and related services; and to provide referrals to services and support more generally. However, it is equally important to reach those key population members who have not previously received prevention services or been tested, and who may be HIV positive or at high risk of HIV. With increasing numbers of people on treatment, prevalence alone will no longer be a good indicator of expected yield. Thus, it is important to monitor not just testing coverage targets, but also positivity (the proportion of those tested who test HIV positive), so that testing strategies can be adapted to reach the most vulnerable segment of key populations[vii]; linkage to comprehensive, differentiated prevention, treatment, and care; and service use across the HIV continuum.

Community-based prevention, testing and treatment is necessary to reach key populations. Drop-in centers provide an accessible, safe, and welcoming venue for the delivery of many prevention and testing services, and they are an important means of fostering community empowerment and cohesion. Programs should support their creation where needed. Services may also be provided at regular or occasional "pop-up" centers (rotating between hotspots), or via mobile outreach. In addition to provider-initiated testing and counseling, WHO recommends community-based HIV testing and counseling in all epidemic settings, including by lay providers, with linkage to prevention, care, and treatment services for key populations.[20] Where available, HIV self-testing kits should also be offered, with linkages to confirmatory testing for those who test positive.[21] HIV services for key population members may be integrated within an existing ART clinic, as a standalone clinic within an existing health facility, or standalone in a community-based or mobile facility. For instance, ART distribution can be done by peers at community-based clinics.

Programs should use and analyze data at the micro level to monitor and improve outreach and follow-up. Peer outreach workers can use microplanning to record data on the people they reach, in order to adjust outreach and service delivery to follow up with established contacts and reach new ones. Alongside traditional microplanning, the enhanced peer

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[vii] In the 2020 – 2022 allocation cycle, the Global Fund also includes a stand-alone indicator (HTS-5: HTS volume and positivity). Further information about this indicator can be found in the Modular Framework Handbook.

outreach approach (developed by programs such as *FHI 360/LINKAGES*) should be considered to contact populations at high risk who may not be reachable by traditional hotspot-based outreach. Great care should be taken to protect the confidentiality and security of data. Program planners should weigh the benefits of data collection procedures at the local or grassroots level against the risks, especially in contexts where key populations are criminalized.

Those who are HIV negative should be supported to stay negative and be regularly tested for HIV. Programs should provide consistent access to prevention commodities, regular support and education as needed, and encourage regular HIV testing in accordance with national guidelines. Where PrEP is offered, counselling should be provided to support PrEP use and adherence.

Programs should ensure that those who test HIV positive are linked to ART as quickly as possible. This is particularly important for those tested in the community, if a referral to a health facility is required for a confirmatory test and initiation of treatment. Peer navigators can provide important support to facilitate the link to further testing and ART. Providing ART initiation and/or maintenance at peripheral health facilities, including KP focused CBO clinics, can improve access to ART.

Case management of people living with HIV should be built into service plans to maximize retention in care and viral suppression. Key population members who test positive for HIV will often benefit from being case-managed by the key-population-led NGO or CBO that they have previously had contact with, rather than being passed on to an organization of people living with HIV. Trained peer navigators working within key-population-led NGOs or CBOs can help connect individuals with confirmatory testing and treatment, provide psychosocial support, and improve retention in treatment. Placing peer navigators in government-funded ART clinics can help reduce stigma and discrimination against key population members seeking services there. Organizations and community networks and groups providing such support to people living with HIV must be sufficiently resourced to have manageable caseloads, and the data systems they use should ensure that treatment outcomes and viral suppression can be tracked.

Rigorous management systems must be implemented. This includes ensuring that staffing is adequate, including the ratio of peer outreach workers to key population members; regular, supportive supervision and training are provided at each level of the implementing organization, including for peer outreach workers; facility-based or clinic-based staff are sensitized to deliver care to key populations; key population members who are active in program delivery are remunerated fairly, and given opportunities for professional advancement; and structures are in place to ensure that civil-society organizations are accountable not only to the national program, but also to key population members themselves.

> **Potential Programming Gaps: Outreach across the Prevention, Testing, and Treatment Cascade**
>
> Countries preparing funding requests are urged to consider these common flaws to ensure that proposed programs are truly comprehensive.
>
> - Insufficient attention is paid to high-quality prevention programming to keep those who are HIV-negative negative, including the promotion and sufficient supply of prevention commodities.
> - Peer outreach workers have limited impact because of poor supervision and management.
> - Insufficient attention is paid to linking people to care who test positive for HIV, and supporting adherence to ART.
> - Support and case management for people living with HIV is under-developed.
> - Social media are increasingly being used for outreach to some key populations, but there is a lack of guidance and standards for ethics, privacy, and data security.
> - Policy conflicts can lead to gaps in service packages, such as omission of harm reduction for people who inject drugs.
> - Linkages between HIV and tuberculosis services are inconsistent.
> - There are substantial gaps in service provision for those in prison or detention, leading in particular to gaps in treatment continuity for those on ART or opioid substitution therapy.
> - Insufficient attention is paid to community empowerment which is essential to their long-term sustainability.

3.4.2 Differentiated service delivery and community-based services

Differentiated service delivery is an approach to services that respects and accommodates the differing characteristics and preferences among and within key populations, in order to make services more accessible and acceptable. Although decisions to plan and resource differentiated services may be made at a regional or national level, in practice differentiated service delivery mostly operates at the local level. It therefore goes hand in hand with community-based and community-led services.

Services should reflect the needs, preferences, and expectations of key populations. Separate services or service-delivery spaces may be needed for different key populations, or for different groups within key populations. (For example, transgender people should not be grouped for services with gay men and other men who have sex with men; and teenagers who inject drugs may not feel comfortable at a center providing harm reduction services to adults.) Designated service hours for specific key populations, or extended service hours, can help accessibility. Services available for HIV prevention and treatment in the general community should also be available in prisons and other closed settings.[37,38,39] Services should also be age-appropriate, and when serving children should take into consideration the best interests and evolving capacities of the child[7] as well as existing law. For more information on differentiated delivery of specific services, see the International AIDS Society's decision frameworks on *HIV testing services* and *ART delivery for key populations*.[viii]

[viii] These documents are also available in French and Portuguese at https://www.iasociety.org/HIV-Programmes/Programmes/Differentiated-Service-Delivery/Resources.

Key-population-led services are an effective way of reaching key population members and an important part of a trusted access platform. Key population members with the knowledge, skills, and life experience to build rapport and trust with other key population members can provide behavioral interventions, risk-reduction and harm-reduction commodities, HIV testing, ART distribution, referrals to services, supportive response to violence, peer education on human and legal rights, and peer paralegal services. This is also true of people in prisons and other closed settings. Gender should be a critical programmatic consideration in terms of the key populations delivering and receiving the services. (For examples of community-led services, see Annex 1, example E.)

Services provided by key population members should not be limited to community outreach. Nor should they be engaged only as volunteers. Programs should provide systematic training, remuneration, and ongoing support for key population members in staff positions (including peer outreach workers), including in service delivery, administrative support, and program management. Policies, procedures, and training must include ethics, privacy, and data security as they relate to key populations being served by programs, and also security to ensure the safety of key population members engaging in outreach (see the FHI 360/LINKAGES *Safety and Security Toolkit*).

Programs should have mechanisms for key population members to provide oversight and give feedback on their experience as service recipients. This may include the quality of service delivery, acceptability of prevention commodities, and any incidents of denial of services or violations of the right to confidentiality or informed consent. At the local level this can happen through *community-based monitoring*, in which community committees meet regularly to discuss service delivery, including analyzing program data, and with the authority and channels to give feedback to program management. Information from multiple sites can be aggregated at the national level and used as part of the program-planning cycle. (For more information, see the WHO *tool on target-setting for key populations and the manual on HIV patient monitoring and case surveillance*.)

3.5 Using data for monitoring

Monitoring and programmatic review systems should be established to report data on coverage of key populations with the comprehensive service package, disaggregated by key population (or subgroups within key populations), by gender (including transgender people), and by age, where possible. This is essential to track progress and plan for scale-up. Countries should plan coordinated reporting systems with agreed-upon indicators, with the necessary infrastructure, budget, training, supervision, and monitoring to ensure that grant recipients are reporting in the same way. Coordination also requires considering the reporting requirements of national programs, the Global Fund and, potentially, other donors. Systems should be designed to track individuals across the cascade of HIV prevention, diagnosis, treatment, and care, and across care providers (see unique identifier codes, below). It is important to train and supervise key population members providing peer-led outreach, so that they can use data to create micro-plans for comprehensive outreach and to track and improve their own performance.

Monitoring includes not only programmatic or administrative data, but also data from behavioral and sero-surveillance surveys of key populations, and data on critical enablers. These data can be used to monitor indicators on program reach and coverage, as well as risk behaviors, experiences of stigma, discrimination, violence, and levels of community

empowerment.

Data should be routinely reviewed by the program, including with key population members (e.g. through program oversight committees), and used to improve program services.

Data security, confidentiality, and informed consent: Programs should have policies and procedures in place for all staff on the collection, storage, and use of data that identifies key population individuals (or that could be used to identify them). Individuals should give informed consent to the collection, storage, and use of their personal data. Information that allows an individual to be easily identified should not be recorded unless absolutely necessary to facilitate clinical care, and in these cases it must be stored securely and carefully safeguarded (see Annex 1, example F). Data collection activities (including for strategic information and service delivery) must be done in a way that does not result in arrests and prosecutions, harassment and violence, or worsened discrimination and stigma against key populations.

Unique identifier codes (UICs): A UIC is a code that an individual can use when accessing services across service providers and geographic regions. The UIC is constructed using data specific to each individual (such as name, gender, date, or place of birth), but this information is encoded alphanumerically so that the identity cannot easily be deciphered. This ensures the anonymity and confidentiality of the individual and their program data.

UICs help prevent duplication when reporting the number of people who have received HIV services, because they allow programs to accurately track the number of unique individuals receiving a service, rather than just the number of occasions on which that service was provided. This is particularly useful when an individual receives services from multiple providers. (For those receiving medical services, including ART, a national ID or medical insurance number may be required, and this should be explained to the service user, but all normal standards of confidentiality must apply.)

Countries should move toward a unified UIC system for all key populations. Where the UIC includes an element representing the holder's gender, countries should consider a non-binary response option so that transgender individuals are included, which can help ensure that monitoring data on transgender service recipients are disaggregated. National programs should include prisoners in the UIC system, since most serve short sentences and may seek community-based services upon release.

Recording data: Wherever possible, data should be recorded electronically, rather than using paper-based records. Electronic record-keeping reduces errors from data re-entry and keeps data more secure (paper records are easier to lose, and more accessible to people who are not authorized to see them). Data stored online must be securely backed up and password-protected, and anonymized as far as possible. In all formats – paper-based or electronic – data security and confidentiality is of paramount importance.

Using data: Programs should provide training and support to grantee organizations to visualize, analyze, and use routine data to improve performance at the local level on a regular basis. This requires clear definitions of reach and coverage,[ix] and data disaggregated by key population, gender, and age – for treatment as well as prevention – in order to construct cascades. Data should be reported up to regional and national levels. Data from donor-funded

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[ix] Reach refers to the total number of individuals contacted. Coverage is the number of individuals who have received a specific service, or a defined set of services.

programs should be fed into national data systems in order to give a comprehensive view of programming. (See Annex 1, example G.)

Potential Programming Gaps: Monitoring

Countries preparing funding requests are urged to consider these common flaws to ensure that proposed programs are truly comprehensive.

- There are no nationally defined indicators, and no single authority is nationally accountable for the program.
- Program data are not routinely reviewed at all levels with implementers, community, and government for problem-solving and program improvement.
- Programmatic coverage data are often inaccurate and do not allow clear disaggregation of service coverage by key population, especially by gender. Data on prisoners, in particular, are poor.
- Coverage of a defined package of services is rarely recorded well.
- Data collection and data entry are often inefficient, with paper forms resulting in duplicated input.
- Data security is often weak and threatens the safety of key population members.
- Data analysis is often not carried out at the local level to inform program improvement.

Annex 1. Examples of approaches and programs

These examples are drawn from the assessment of programs for key populations across 65 countries commissioned by the Global Fund to assess how HIV service packages are designed, delivered, and monitored during the 2017–2019 allocation period. They are intended to show how programs have addressed some of the challenges of designing and implementing comprehensive interventions.

A. Sustainable funding

Social contracting is the use of government resources to fund civil-society organizations to deliver health services which the government has a responsibility to provide. Some countries like Brazil, India and Papua New Guinea have long-established NGO contracting mechanisms in their health systems. Other countries that have taken steps to open up opportunities for social contracting in HIV include Belarus, China, Croatia, the Former Yugoslav Republic of Macedonia, Guyana, Kazakhstan, the Kyrgyz Republic, and Ukraine.

NGOs funded through insurance schemes: Love Yourself, an NGO in Manila provides prevention and care services for HIV, sexually transmitted infections, and tuberculosis to men who have sex with men. It is accredited by the Philippines health insurance agency and receives an annual allocation for each person living with HIV on its register, which it uses to provide a range of health and welfare services. Love Yourself is partially funded by a Global Fund allocation but is likely to move to full funding from health insurance in the medium term.

B. Community leadership and participation

A strategy for addressing critical enablers in Madagascar is the use of provincial, county and/or ward committees to guide local key population programming. Each region of Madagascar has a regional task force responsible for improving coordination at a local level. In the city of Mahajanga, the task force brings together the chief of the region, the regional director of health, other health personnel, NGOs, and key population representatives to discuss key population issues.

In Kenya, county-level key population technical working groups regularly bring together implementers, county government representatives, local chiefs, and community leaders. This has facilitated service provision and reduced community backlash and interference from law enforcement during outreach.

C. Specifying levels of service delivery

South Africa's National Sex Worker HIV Plan (2016) has three tiers of service delivery: 1) peer outreach as the backbone of the response; 2) dedicated clinics in areas with a high density of sex workers (more than 3,000 per district); 3) mobile services in low-density areas (fewer than 3,000 sex workers per district), delivered at hotspots with support from outreach teams.

The Papua New Guinea National STI and HIV Strategy outlines "essential" and "enhanced" service packages for key populations, specifies which provinces will receive which package, based on the HIV burden, and outlines how demand creation and community follow-up will be integrated into broader community health programs in lower-burden provinces.

D. Mental-health services for key populations

In countries where adequate mental-health services for the general population do not exist, HIV programs should address key populations with cost-effective, evidence-informed interventions. Depression and anxiety are prevalent among key populations, and effective treatments improve HIV-related outcomes.[40,41] Group psychotherapy with people living with HIV in northern Uganda has improved related outcomes such as treatment adherence, which ultimately contributes to the reduction in stigma experienced by people living with HIV.

Where professional mental-health services are not well established, services may be provided by trained lay people. In Kenya, interpersonal psychotherapy is provided to women living with HIV, via 10-12 sessions, held weekly, that address interpersonal issues in depression and help participants build social skills and gather social support. No educational criteria or experience were required for those who were trained to deliver the therapy.[43]

E. Models of community-supported and community-led testing services

In the Dominican Republic, Indonesia, and Peru, trained key population members accompany government staff providing HIV testing services in the community or at government clinics in order to provide pre- and post-test counselling. In some models, NGOs and CBOs are funded to provide outreach staff at government or private clinics to provide counseling and adherence support (e.g. Guyana, Papua New Guinea, the Philippines, South Africa, and Thailand).

The Competent Clinics program implemented by Anova in South Africa provides training and coaching to government clinics on providing services to men who have sex with men, particularly in rural areas where NGO outreach is likely to be less available. Under this initiative the entire staff of a government clinic is trained and coached over time toward certification of the clinic as an "MSM Competent Clinic".

In several countries (for example, India, Indonesia, Kenya, the Philippines, and South Africa), strong and experienced key-population-led NGOs run their own clinics providing the entire cascade of services for HIV, sexually transmitted infections and tuberculosis, from prevention to care.

F. Data management and security

Alliance for Public Health in Ukraine uses open-access software (SyrEx) to record and monitor information on clients reached and services provided in community-based programs. It allows project implementation partners to uniquely register project clients with an agreed-upon unique identifier code, and to record commodities and services provided, as well as other key deliverables such as trainings.

In South Africa, where there is a requirement that people testing for HIV sign consent forms, forms signed by people in community-based settings are sealed in envelopes before being taken back to the office. The forms and other identifying data are locked away, with access only by approved monitoring and evaluation staff.

G. Using data for performance improvement

In Georgia, a new prevention database will enable real-time data entry when key population members are enrolled in HIV prevention services and assigned a unique identifier code (UIC). The prevention database will be able to link these data with medical data in the country's

databases on ART, hepatitis C, tuberculosis, and sexually transmitted infections for services provided to HIV-positive key population members. When these medical data are downloaded to the prevention database, they will be automatically stripped of the patient's identifying information to preserve anonymity. The new database will make it possible to construct complete cascades for key populations, including viral load suppression. By linking UIC data with HIV medical data, it will allow planners to see whether key population members diagnosed with HIV are accessing the services they need.

In South Africa, the Global Fund's Principal Recipient for sex worker programs, NACOSA, has devised two online platforms to help Sub-Recipient organizations (SRs) manage and use data for decision-making. SRs use Orbit, a cloud-based data system, to enter data from outreach forms and data on HIV testing, referrals, and participation in meetings. The SRs are trained by NACOSA to extract basic data for their own information and planning needs, and NACOSA holds quarterly meetings for SRs to review graphs and data drawn from Orbit and determine how to improve programming. NACOSA is also developing ZENESIS, an analytics platform that will help SRs analyze data for strategy and decision-making.

Annex 2. Key population networks and groups

The websites of these organizations provide information, published resources, and contacts that can be of use in program planning and implementation.

Global networks

- **Global Network of Sex Work Projects (NSWP)** – www.nswp.org
- **MPACT: Global Action for Gay Men's Health and Rights** *(formerly MSMGF)* – www.mpactglobal.org
- **IRGT: A Global Network of Transgender Women and HIV** – transglobalactivism.org
- **GATE** (gender identity, gender expression, and bodily diversity) – transactivists.org
- **International Network of People who Use Drugs (INPUD)** – www.inpud.net
- **International Network of Women who Use Drugs (INWUD)** – www.idpc.net/profile/inwud
- **Youth RISE** (young people who use drugs) – www.youthrise.org
- **Global Network of People Living with HIV (GNP+)** – www.gnpplus.net
- **International Treatment Preparedness Coalition (ITPC) –** itpcglobal.org

Regional networks

Africa and the Middle East
- **African Sex Workers Alliance (ASWA)** – aswaalliance.org
- **African Men for Sexual Health and Rights (AMSHeR)** – www.amsher.org
- **Middle East and North Africa Network of People who Use Drugs (MENANPUD)** – www.menahra.org/en/about-menanpud
- **M-Coalition** (men who have sex with men in the Arab world) – www.m-coalition.org

Asia and the Pacific
- **Asia Pacific Network of Sex Workers (APNSW)** – apnsw.info
- **Asia-Pacific Coalition on Male Sexual Health (APCOM)** (men who have sex with men, and transgender people) – www.apcom.org

- **Asian Network of People who Use Drugs (ANPUD)** – www.anpud.org
- **Youth Voices Count (YVC)** (young men who have sex with men, and transgender women) – https://twitter.com/yvc_official?lang=en
- **Youth LEAD** (young key populations living with or at risk for HIV) – www.youth-lead.org

Eastern Europe and Central Asia
- **Sex Workers' Rights Advocacy Network (SWAN)** – www.swannet.org
- **Eurasian Coalition on Male Health (ECOM**) (men who have sex with men, and transgender people) – www.ecom.ngo
- **South Caucasus Network on HIV** (men who have sex with men, and transgender people) – https://eecaplatform.org/en/partner_assoc/the-south-caucasus-network-on-hiv-aids-scn/
- **Eurasian Network of People who Use Drugs (ENPUD)** – https://idpc.net/profile/eurasian-network-of-people-who-use-drugs

Europe
- **International Committee for the Rights of Sex Workers in Europe (ICRSE)** – www.sexworkeurope.org
- **European Network of People who Use Drugs (EuroNPUD)** – https://www.euronpud.net/home2

Latin America and the Caribbean

- **Plataforma LatinoAmerica de Personas que EjeRcen el Trabajo Sexual (PLAPERTS)** – https://plaperts.nswp.org/
- **Caribbean Sex Workers Coalition (CSWC)** – https://www.nswp.org/featured/caribbean-sex-work-coalition
- **Latin America Network of People who Use Drugs (LANPUD)** – www.lanpud.blogspot.co.uk
- **Caribbean Vulnerable Communities Coalition (CVC)** (key populations) – www.cvccoalition.org

Annex 3. Key documents

Global Fund[x]

HIV information note (Global Fund, 2019)

Addressing gender equity (Global Fund, 2019)

Community systems strengthening: technical brief (Global Fund, 2019)

HIV, human rights and gender equality: technical brief (Global Fund, 2017)

Addressing gender inequalities and strengthening responses for women and girls: information note (Global Fund, 2014)

Building resilient and sustainable systems for health through Global Fund investments:

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[x] Hyperlinks are to the English-language versions of Global Fund publications, but they are available in other languages at https://www.theglobalfund.org/en/funding-model/applying/resources/

information note (Global Fund, 2017)

Maximizing impact by strengthening community systems and responses: technical brief (Global Fund, 2016)

The Global Fund sustainability, transition and co-financing policy (Global Fund, 2016)

Harm reduction for people who use drugs: technical brief (Global Fund, 2017)

Global Fund support for co-infections and co-morbidities: board decision (Global Fund, 2015)

Global policy

HIV prevention 2020 road map (Global HIV Prevention Coalition, 2017)

Miles to go: global AIDS update 2018 (UNAIDS, 2018)

General

Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update (WHO, 2016)

HIV and young people who sell sex: technical brief (WHO, 2015)

HIV and young men who have sex with men: technical brief (WHO, 2015)

HIV and young transgender people: technical brief (WHO, 2015)

HIV and young people who inject drugs: technical brief (WHO, 2015)

Strategic information and program monitoring

Guidelines on estimating the size of populations most at risk to HIV (UNAIDS, WHO, 2010)

Biobehavioural survey guidelines for populations at risk of HIV (Global HIV Strategic Information Working Group, 2017)

Programmatic mapping readiness assessment for use with key populations (FHI 360/LINKAGES, 2017)

Consolidated strategic information guidelines for HIV in the health sector (WHO, 2015)

Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations (WHO, 2015)

Consolidated guidelines on person-centred HIV patient monitoring and case surveillance (WHO, 2017)

Monitoring guide and toolkit for key population HIV prevention, care, and treatment programs (FHI 360/LINKAGES, 2016)

Unique identifier codes: guidelines for use with key populations (FHI 360/LINKAGES, 2016)

Global AIDS monitoring 2019: indicators for monitoring the 2016 UN Political Declaration on Ending AIDS (UNAIDS, 2018)

Program design, implementation, and management

Implementing comprehensive HIV and STI programmes with sex workers: practical guidance from collaborative interventions (WHO, 2013) – informally known as the SWIT

Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions (UNFPA, 2015) – the MSMIT

Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions (UNDP, 2016) – the TRANSIT

Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions (UNODC, 2017) – the IDUIT

Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection (WHO, 2016)

Differentiated service delivery for HIV: a decision framework for HIV testing services (International AIDS Society, 2018)

Differentiated service delivery for HIV: a decision framework for antiretroviral therapy delivery for key populations (International AIDS Society, 2018)

Male latex condom: specification, prequalification and guidelines for procurement, 2010 – 2013 revision (WHO, UNAIDS, UNFPA, FHI 360, 2013)

Female condom: generic specification, prequalification and guidelines for procurement, 2012 (WHO, UNAIDS, UNFPA, FHI 360, 2013)

WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision (WHO, UNODC, UNAIDS, 2012)

Harm reduction and brief interventions for ATS users (WHO, 2011)

HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions (UNODC, ILO, UNDP, WHO, UNAIDS, 2013)

Peer navigation guide for key populations: implementation guide (FHI 360/LINKAGES, 2017)

LINKAGES enhanced peer outreach approach: implementation guide, addendum, & training curriculum (FHI 360/LINKAGES, 2017, 2019), also available in French and Portuguese here

Critical enablers

Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses (UNAIDS, 2012)

Rights, risk and health: report of the Global Commission on HIV and the Law (UNDP, 2012)

UNAIDS Gender Assessment Tool: towards a gender-transformative HIV response (UNAIDS, 2019)

When situations go from bad to worse: guidance for international and regional actors responding to acute violence against key populations (FHI 360/LINKAGES, 2018)

Safety and security toolkit: strengthening the implementation of HIV programs for and with key populations (FHI 360/LINKAGES, 2018)

Annex 4. Glossary of terms

This technical brief uses terminology and definitions adapted from the _UNAIDS Terminology Guidelines_ (2015), unless otherwise indicated.

Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body – which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means – as well as other expressions of gender, including dress, speech, and mannerisms.

Key-population-led organizations and networks are led by people living with HIV, female, male and transgender sex workers, gay men and other men who have sex with men, people who use drugs, and transgender people. Key populations share experiences of stigma, discrimination, criminalization, and violence and shoulder disproportionate HIV disease burden in all parts of the world. Key-population-led organizations and networks are entities whose governance, leadership, staff, spokespeople, members, and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies. Key-population-led organizations and networks and their expertise are anchored in our lived experiences, which determine our priorities. We speak for ourselves and are an intrinsic part of the global HIV response. This definition of key populations is not meant to preclude the ways that people describe themselves, including related to sexual orientation, gender, and gender identity.[xi]

Men who have sex with men describes males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This includes men who self-identify as heterosexual but who have sex with other men.

People who use drugs describes people who use nonmedically sanctioned psychoactive drugs, including drugs that are illegal, controlled, or prescription. The term includes drugs that are injected as well as those that are taken in other ways. (For further information, see the _INPUD Consensus Statement on Drug Use under Prohibition: Human Rights, Health and the Law_ [2015].)

Prisons and other closed settings refers to places of detention that hold people who are awaiting trial, who have been convicted, or who are subject to other conditions of security. These settings may differ in some jurisdictions, and they can include jails, prisons, police detention, juvenile detention, remand/pretrial detention, forced labor camps, and penitentiaries. Although the term does not formally cover persons detained for reasons relating to immigration or refugee status, those detained without charge, and those sentenced to compulsory treatment and rehabilitation centers as they exist in some countries, the same considerations around HIV apply to these individuals.

Sexual orientation refers to each person's capacity for profound emotional, affectional, and sexual attraction to (and intimate and sexual relations with) individuals of a different sex (heterosexual) or the same sex (homosexual), or more than one sex (bisexual).

Sex workers are female, male, and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or

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occasionally. Sex work may vary in the degree to which it is "formal" or organized. Sex work is consensual sex between adults, takes many forms, and varies between and within countries and communities. (For further information, see the *UNAIDS Guidance Note on HIV and Sex Work* [2012].)

Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders, or alternative genders. Transgender individuals may use one or more of a wide range of terms to describe themselves.

Young key populations refers to young people aged 10 to 24 years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people who inject drugs, and young people (18 years and older) who sell sex.

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