Technical Brief

Addressing sex workers, men who have sex with men, transgender people, people who use drugs, and people in prison and other closed settings in the context of the HIV epidemic

Contents

ART	antiretroviral therapy
CCM	country coordinating mechanism
ICT	information and communication technology
IDUIT	people who inject drugs and HIV implementation tool
MSMIT	MSM and HIV implementation tool
NSP	needle and syringe program
OST	opioid substitution therapy
STI	sexually transmitted infection
SWIT	sex workers and HIV implementation tool
TB	tuberculosis
TRANSIT	transgender people and HIV implementation tool
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

This technical brief uses terminology and definitions adapted from the *UNAIDS terminology guidelines 2015*, unless otherwise indicated.

People who use drugs describes people who use nonmedically sanctioned psychoactive drugs, including drugs that are illegal, controlled, or prescription.[i]

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.

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 concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men.

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 them. Universal access to HIV prevention, treatment, care and support ideally should extend to these settings.[ii]

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 occasionally. Sex work may vary in the degree to which it is "formal" or organized. It is important to note that sex work is consensual sex between adults, takes many forms, and varies between and within countries and communities.[iii]

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. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response.

The burden of HIV does not fall equally across all populations. In all countries, HIV disproportionately affects certain key populations, including:

- sex workers
- men who have sex with men
- transgender people (especially transgender women)

- people who inject drugs
- people in prison and other closed settings[1]

Many national HIV strategies and programs overlook some or all of these key populations, or fail to provide effective services to them with designated funds. This results in lower rates of diagnosis and treatment of HIV and prevents countries from reaching prevention targets[iv] and the UNAIDS 90-90-90 diagnosis and treatment targets.[v]

The Global Fund's strategic investment approach[vi] and the Global Fund Strategy 2017–2022: investing to end epidemics stress the importance of targeting investments on the locations and populations where they will have maximum impact, and of scaling up rights-based, evidence-informed interventions. This means that national programs should place appropriate emphasis on reaching key population members with services that are accessible, acceptable, affordable and of high quality. These services should take into account the differing needs of each key population, the overlapping vulnerabilities to HIV, and stigma and discrimination or other human rights violations that individuals may experience.

The purpose of this technical brief is to provide information to help countries prepare funding requests for comprehensive programs that address the continuum of HIV prevention, diagnosis, treatment and care for key populations.[2] It should be read in conjunction with the Information Note on Strategic investments for HIV programs [http://www.theglobalfund.org/en/applying/funding/resources/] (2016). Section 2 outlines the rationale for key population programming. Section 3 presents the key components of comprehensive programming that should be included in funding requests. It describes evidence-based interventions and approaches recommended by the Global Fund and its technical partners, and which the Global Fund expects to see presented in funding requests. It also describes the guiding principles that should underlie programming – especially a human-rights based approach and the participation and leadership of key population communities in designing and implementing programs. These interventions, approaches and principles are based on a recently published series of implementation tools on programming with four of the key populations:

- 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) – known as 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, forthcoming in 2017) – the **IDUIT**.

These tools translate into practical steps both the clinical guidance and the critical enablers (addressing barriers to services) contained within the WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (2014, updated 2016). They were compiled through a process of close collaboration between United Nations agencies, key population organizations and networks, and other international partners.[3]

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[1] For detailed definitions, see the Glossary.

[2] Throughout this technical brief, "key populations" refers to the groups listed at the beginning of this Introduction, rather than to other populations specifically affected by HIV, tuberculosis or malaria.

[3] These include the Global Network of Sex Work Projects (NSWP), Global Forum on MSM and HIV (MSMGF), IRGT: A Global Network of Transgender Women and HIV, International Network of People who Use Drugs (INPUD), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), World Health Organization (WHO), United States Agency for International Development (USAID), the World Bank and the Bill & Melinda Gates Foundation.

II. Rationale: Why a key populations focus is needed

In every country where data are reliably collected and reported, sex workers, men who have sex with men, transgender people, people who inject drugs and people in prison and other closed settings are shown to be at higher risk of contracting HIV than the general population. They also have higher morbidity and mortality rates, and lower access to HIV-related services. Governments have historically allocated inadequate resources to HIV programming for key populations, and despite high prevalence and incidence of HIV among them, they suffer from low coverage with HIV prevention interventions, including information, support and commodities for risk reduction, and other health and social services.

The vulnerability of key populations to HIV is made worse by structural barriers which may violate their right to the highest attainable standard of physical and mental health.[vii] Within the health-care arena, these barriers include not only gender inequalities in the availability of and access to services, but also insensitivity, lack of awareness or rejection from service providers. Such behaviors may be motivated by homophobia, transphobia, or other prejudice towards key populations. In addition, many health-care providers lack knowledge and training about the specific sexual-health needs of key populations, especially men who have sex with men and transgender people. Key population members may suffer verbal abuse or physical violence from health-care providers. Past experiences of stigma, discrimination or violence can prevent members of key populations from attempting to access the services they need.

In countries that criminalize sex between men, sex work or drug use, or that do not recognize nonconforming gender identities, the negative impact on access to services can be even greater. In its most recent guidelines on key populations and HIV, WHO calls for countries to "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."[viii] This echoes similar calls by numerous other bodies.[ix,x]

In addition to these barriers, key populations face more general social marginalization and economic disenfranchisement, which can increase their vulnerability to HIV and decrease access to needed services. These factors are often still more extreme for key population members living with HIV.

01 Vulnerabilities of specific key populations

Beyond the general vulnerabilities listed above, key populations have specific vulnerabilities that must be taken into account when designing programs and service-delivery approaches. These are outlined here; the resources listed in the references at the end of this technical brief provide further detail which countries should consider.

The ability of **sex workers** to negotiate condom use may be constrained by their working environment, economic need, or by lack of individual empowerment. Sex workers are also vulnerable to extortion and to violence, including rape, from clients, controllers, brothel owners and law-enforcement personnel, especially in contexts where sex work (or, in the case of male sex workers, homosexual sex) is criminalized.[xi] Even where sex work or same-sex behavior are not technically illegal or criminalized, they may be sufficiently stigmatized that seeking legal redress for violence is useless, or in itself risks subjecting the victim to further violence. Experiencing violence has been correlated with greater vulnerability to HIV.[xii]

Men who have sex with men experience increased HIV risk if they practice unprotected anal sex,[xiii] but in many countries they are also vulnerable to violence, including sexual violence, because they are seen as contravening gender and sexual norms.[9,xiv]

Levels of violence against **transgender people** are extremely high, and social and economic marginalization forces many of them into sex work, further exposing them to HIV risk.[xv,xvi] Lack of access through official health-care services to gender-affirming treatments such as hormone replacement therapy or silicon injections may lead transgender women to self-treat with consequent health risks such as using unsterile needles, or

People who use drugs are at high risk of HIV and viral hepatitis C in contexts where sterile injecting equipment is not readily available, accessible or used.[xvii] Lack of other harm reduction services, especially opioid substitution therapy (OST) for those dependent on opioids, and the harshly punitive environment in most countries towards people who use drugs, make them particularly vulnerable.[xviii,xix] The HIV rate among women who use drugs is often higher than among their male counterparts. Some people who do not inject but use stimulants and other psychoactive drugs can be at equally high risk of contracting HIV through unprotected sex as people who inject, and they are subject to similar structural barriers to harm reduction services.

People in prisons and other closed settings (such as jails, police detention, juvenile detention, pretrial detention, forced labor camps or involuntary drug "treatment" centers) are vulnerable to HIV through unprotected sexual contact, sexual violence, or the sharing of unsterile drug-injecting equipment – a significant risk given that many imprisoned people are people who use drugs, needle and syringe programs (NSPs) and OST are frequently not provided,[xx,xxi] and condom programs are even less prevalent in prisons than OST.[xxii]

02 Overlapping vulnerabilities

Many key population members experience overlapping vulnerabilities to HIV, and programs for key populations must be attentive to these, so that all their needs can be addressed. Thus 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. 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. In many contexts women have less access to health and social services than men, are more economically marginalized, and are more vulnerable to violence.

Young key population members (between the ages of 10 and 24 years) face the additional vulnerabilities of their youth, power imbalances in relationships and their vulnerability to exploitation or violence. These factors increase the risk that they may engage in behaviors that put them at risk of HIV. Although research into young key populations is relatively sparse, there is evidence that some young people engage in risk behaviors from their early teens. Young people's relative lack of economic independence, and their reliance on family or school environments that may be hostile to their gender or sexual identity, are further vulnerabilities. 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,[2] or a lack of age-appropriate services within programs designed for key populations. For more information on young key populations and HIV, see the four technical briefs published by WHO.[xxiii,xxiv,xxv,xxvi]

Key population members living with HIV may be doubly stigmatized on account of their key population status and their HIV status. They may face even greater difficulties accessing and adhering to treatment and other needed services. Sometimes they also face stigmatization from within their own key population community for being HIV positive.

People living with HIV are also at greater risk of contracting tuberculosis – and of dying from it – than those who are HIV negative. The risk is particularly high for those in prison or other closed settings, or who 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.

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[4] TRANSIT, Section 2.2.6.

The Global Fund expects countries applying for funding to develop a comprehensive program for key populations based on the recommendations in the 2016 WHO [Key Populations Consolidated Guidelines](#) and the principles and approaches highlighted in the SWIT, the MSMIT, the TRANSIT and the IDUIT. This section of the technical brief summarizes the interventions and approaches described in the implementation tools to show how countries should address key populations programming in their funding requests.

01 Guiding principles for a human-rights based approach

The protection of human rights for all members of each key population must be fundamental to programming, and human-rights norms and principles should be integrated into programs. [xxvii,xxviii] Several aspects of this are outlined below. See also the Global Fund [HIV Information Note](#) (2016), Sections 4.2 and 5.2, and the section on [addressing stigma, discrimination and violence](#), as well as the HIV, Human Rights, and Gender Equality [Technical Brief.](#)

Community participation and leadership are essential. This applies throughout the process of country dialogues and country coordinating mechanisms (CCMs), developing funding requests and making grants, and in the design, implementation, monitoring and evaluation of programs. Participation and leadership help to build trust with those whom programs are intended to serve, create ownerships of the process by key populations, make programs more comprehensive and more responsive to their needs, and create more enabling environments for HIV prevention.[xxix] Communities can seek support from the Global Fund Secretariat through the [CRG Strategic Initiative](#) or through technical partners to strengthen participation and outreach. Key population members should choose how they are represented, and by whom. See also the list of networks in [Section 5](#).

Service providers must respect the rights of the individual. Global Fund-supported programs must ensure non-discrimination, respect for the autonomy of the individual and informed consent in medical services, and respect for medical confidentiality. These practices are core parts of the ethical obligations to beneficence (doing good or providing benefit), non-maleficence (avoiding the infliction of harm), and justice.[xxx]

Programming should address gender inequality. Within key populations, as within the population at large, women are often at higher risk of HIV than men because of unequal and discriminatory gender norms, high levels of gender-based violence, greater economic marginalization, and poorer access to risk reduction services and health care. Services should be designed and delivered in ways that address the circumstances and needs of women. The same is true of transgender people: transgender women, in particular, should not be grouped with men who have sex with men for the purposes of outreach or service delivery. For more information, see the [HIV Information Note](#) (Section 4.2), the Global Fund Technical Brief on HIV, human rights and gender equality, and the Information Note on [Addressing gender inequalities and strengthening responses for women and girls](#) (2014).

Acceptability of services is a key aspect of effectiveness. To enlist the participation of key population members and ensure their retention in care, HIV interventions must be of high quality, respectful, appropriate and affordable. Ensuring service acceptability requires consulting with organizations or networks of key populations, employing key population members as staff, including – but not limited to – community outreach workers (peer educators), gathering regular feedback from service beneficiaries, and implementing effective accountability mechanisms such as community-led oversight committees.

Do no harm: The participation of key population members in country dialogues and CCMs should always be designed to ensure they are not exposed to danger of harassment, abuse or violence. Similarly, their participation in services – whether planning, delivering, monitoring or receiving them – should not expose them to harm.

Flexibility and capacity for rapid adaptation are required, since unforeseen events can lead to major changes in the environment for service delivery to key populations.

workers, or drug detention centers. However, consistent with its commitment to addressing gaps in life-saving treatment for key populations, the Global Fund may finance scientifically sound medical services in facilities in exceptional circumstances, e.g. ensuring access to life-saving treatment to detainees in voluntary, community-based treatment programs located outside of such facilities. These exceptions will be determined based on consultation with UN partners, for instance in cases where it is possible to independently oversee and verify the conditions and use of the financing.

02 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. In practical terms, this means:

- **Meaningful participation of key population representatives** (see section on community participation and leadership): Programs should also pay attention to the inclusion of young key population members, and key population members living with HIV.
- **Fostering formation of key population groups or networks**, or strengthening existing ones, by providing infrastructure, technical assistance, and funding. This includes supporting the formation of registered organizations, where the group or network wishes and local circumstances allow.
- **Fostering outreach by key population members** (see section on community-led services)
- **Promoting a human-rights approach to HIV interventions** (see sections on guiding principles for programs and addressing stigma, discrimination and violence)
- **Community systems strengthening:** Key populations often depend more upon community systems than do members of the general population. Applicants should budget and plan for interventions that engage systematically in community mobilization, community-led service delivery, monitoring and advocacy, and institutional capacity-building. For more information, see the Information Note on Building resilient and sustainable systems for health (RSSH) through Global Fund investments (2016), especially Section 3.1, and the related technical brief, Maximizing impact by strengthening community systems and responses (2016).
- **Advocating for policy change and enabling environments** (see the following section)

those targeted at key populations or implemented by civil-society or community-based groups. 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. Applicants should build into their plans adequate time, funding and structures to maintain and scale up programs, and to transition ownership of them to key population communities or other stakeholders, as appropriate. For more information, see The Global Fund Sustainability, Transition and Co-Financing Policy (2016).

03 Addressing stigma, discrimination and violence

The 2016 WHO Key Populations Consolidated Guidelines identify four critical enablers to address barriers to uptake of HIV services: 1) supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations; 2) addressing stigma and discrimination; 3) community empowerment; and 4) addressing violence against key population members. All four are addressed by interventions described in this section.

The wide range of perpetrators of stigma, discrimination and violence may include:

- **Representatives of the state**, such as police and other law-enforcement personnel, military or paramilitary personnel, border guards, prison guards
- **Perpetrators at large**: members of the public
- **Institutions**: employers, health-care providers, landlords, staff and leaders of schools and higher-education institutions (including bullying, and exclusion from school)
- **Intimate partners or family members**
- **Non-state groups**: militias, gang members, religious leaders or religious groups

Applicant countries should demonstrate an approach that addresses stigma, discrimination and violence as a public-health and human-rights issue, and removes barriers to services.[5] While the approach should be tailored to the country context, this is likely to include support for interventions that:

- **Build the capacity and self-efficacy of key population members**: This includes raising the awareness of key population members 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.
- **Gather data on 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.
- **Work for legal and policy reforms:**
  o 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 such as NSPs or OST for people who inject drugs, or requiring parental consent for testing or treatment of those aged under 18.
  o Address law-enforcement practices that violate the rights of key population members or increase their HIV risk, such as confiscating condoms or sterile needles.
  o Build institutional accountability for existing laws and practices that uphold the rights of key populations.

  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. For further information on legal and policy reform, see the Global Commission on HIV and the Law's report Rights, risk and health (UNDP, 2012).
- **Foster police accountability:** This can include regular sensitization workshops for police on human rights and the laws relevant to key populations and HIV; the inclusion of such topics in training at police academies; 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

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[5] The interventions listed below are detailed in the implementation tools, and are also aligned with those outlined in *Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses* (Geneva: UNAIDS; 2012).

- **Sensitize health-care 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. This should take place in the context of suitable investments in human resources for health (see the Information Note on Building resilient and sustainable systems for health (RSSH) through Global Fund investments (2016), Section 3.4).
- **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.[xxxi]

04 Health services for key populations

The 2016 WHO Key Populations Consolidated Guidelines list a comprehensive package of interventions for key populations:

1. **Prevention: comprehensive condom and lubricant programming** that ensures that condoms and condom-compatible lubricant acceptable to key populations are widely and freely available, and that key population members have the knowledge, skills and empowerment to use them correctly and consistently.[xxxii,xxxiii] In addition, **pre-exposure prophylaxis (PrEP)** is recommended as an option for people at substantial risk of HIV infection, and **post-exposure prophylaxis (PEP)** for those who have possibly been exposed to HIV.[6]

2. **Harm reduction interventions for people who use drugs**, in particular NSPs for those who inject drugs, and OST for people dependent on opioids. The provision of naloxone has recently been added to the list of key interventions. The six other interventions in this numbered list are also part of the WHO-recommended comprehensive harm reduction package. For more information see the Information Note on Harm reduction for people who use drugs (2015).[xxxiv]

3. **Behavioral interventions** providing evidence-based information and skills to support risk reduction, prevent HIV transmission and increase uptake of services. These include targeted information, education and communication, both for individuals and groups, delivered in health-care facilities or community settings (including mobile outreach), and adapted to the local context.

4. **HIV testing services** in community, clinical and closed settings.[xxxv] These may include testing by trained lay providers,[xxxvi] and self-testing.[xxxvii]

5. **HIV treatment and care**, including immediate access to antiretroviral therapy (ART) for people testing HIV positive, and retention across the continuum of care.[xxxviii]

6. **Prevention and management of co-infections and other co-morbidities**, including viral hepatitis,[xxxix,xl,xli] tuberculosis (TB),[xlii] human papilloma virus and mental-health conditions.[xliii]

7. **Sexual and reproductive health interventions**, including (but not limited to) screening and treatment of asymptomatic sexually transmitted infections (STIs), and syndromic case management of symptomatic STIs in the absence of laboratory tests.[xliv]

These interventions are relevant to all key populations (although NSPs and OST are specific only to people who inject drugs or are dependent on opioids), and WHO stresses that they must be viewed as interdependent, i.e. it is insufficient to choose to implement only some of them. While individual key population members may not require all these services at all times, funding requests should demonstrate plans to ensure these services are available, accessible and acceptable when needed, and develop appropriate methods to measure service coverage. (See also Section 3.5 and the HIV Information Note, Box 2.) Within each category of the comprehensive package, services – and the way they are delivered – should be tailored to the needs of specific key populations, also taking into account age- and gender-specific considerations.

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[6] "Substantial risk" is defined by WHO as HIV incidence in the population of more than 3%. (See the *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Geneva: World Health Organization; 2016).

plans:

- services for safe pregnancy, including prevention of mother-to-child transmission of HIV[xlv,xlvi]
- screening for cervical cancer (for women and possibly for trans men)[xlvii]
- screening for ano-rectal cancer (for men or transgender people who engage in anal sex)[xlviii]
- clinical care for survivors of sexual assault[31]
- community distribution of naloxone for rapid response to opiate overdose[xlix]
- 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.[7]

Among other services. See the chapter on services in each implementation tool for the relevant key population for further guidance. These services should also be included in national plans.

05 Considerations for service delivery

The Global Fund emphasizes differentiated models of care and service delivery that reflect the needs, preferences and expectations of key populations. For more information, see the [HIV Information Note](#), Section 5.1. Approaches to service delivery that should be addressed in funding requests include:

Making facility-based services acceptable, accessible, affordable and equitable: Whether clinics are government-run, private, or operated by an NGO or community organization, they must do more than train staff to treat key population members respectfully, skillfully and with confidentiality. For example:

- Services available to the general population may need to be adapted for key populations, e.g. dedicated service times within the week or extended opening hours, and take-home doses of OST for people who inject drugs.
- In environments hostile to certain key populations, attention must be given to how services are promoted and labeled, outside and within the facility.
- Services should be tailored to the needs of specific key populations. For example, teenagers who inject drugs may not feel comfortable at a center providing harm reduction services to adults; transgender people may feel they have nothing in common with men who have sex with men, despite frequently being grouped with them in service planning.
- The content of behavioral interventions, and of material published in print or online, should be adapted to take into account the needs, culture and language of the key population in question.
- Consideration should be given to flexibility in service provision to accommodate the needs of non-citizens or internal migrants who may not have the documentation that is normally required. Services should also be age-appropriate, and when serving children should take into consideration the best interests and evolving capacities of the child,[2] as well as existing law.
- Services should be free of charge or affordable. Countries should ensure that out-of-pocket expenses do not present barriers for key population members to access services.

Community-based prevention and testing services: Decentralized services delivered close to where key population members live increase their accessibility and acceptability, and facilitate linkages to referral services. In all HIV epidemic settings, WHO recommends community-based HIV testing and counseling with linkage to prevention, care and treatment services for key populations, in addition to provider-initiated testing and counseling. Drop-in centers provide an accessible and welcoming venue for the delivery of many services in addition to HIV testing and 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 (by van, bicycle, moped or on foot). This enables them to adapt to changing circumstances on the ground, e.g. changing location of hotspots or seasonal

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[7] TRANSIT, Section 3.2.3.

Differentiated ART delivery: In order to address low rates of access to and retention in HIV treatment programs by key population members, different ways of delivering ART should be considered. Decentralizing HIV treatment and care — i.e. providing ART initiation and/or maintenance at peripheral health facilities, and supporting adherence at community sites (including through outreach) between regular clinic visits — can strengthen community engagement and may improve access to services, care-seeking behavior and retention in care. Task-shifting and service integration (see below) are further approaches to differentiated ART delivery.

Community-led (peer-led) services: Outreach to key population members is often most effective when done by trained key population members themselves, who have the knowledge, skills and life experience to build rapport and trust with their peers and provide behavioral interventions, risk-reduction and harm-reduction commodities, referrals to services and supportive response to violence. This is also true of people in prisons and other closed settings. Trained peer navigators can act as mentors and guides to help those living with HIV access and adhere to the full range of services they need. Community-led services may also support task-shifting — the appropriate reassignment of tasks, such as HIV testing and dispensing ART, from highly qualified staff to community health workers with shorter training and fewer qualifications). Task-shifting not only can increase the effectiveness and efficiency of available personnel at testing and ART sites, but importantly for key populations it can allow peers to provide additional support, strengthen community responses to HIV treatment, and improve retention in treatment. As this implies, services provided by key population members should not be limited to community outreach, nor should they be engaged only as volunteers. Programs should provide training, financial resources and ongoing support for key population members in staff positions including service delivery, administrative support and program management.

Service integration ("one-stop-shops"): Co-locating services (and cross-training providers, where necessary) makes them more accessible and reduces loss to follow-up. These services can include HIV testing services, ART, treatment of HIV-related infections, opioid substitution therapy and other drug dependence treatment, distribution of condoms and lubricant and of needles and syringes, sexual and reproductive health, TB and viral hepatitis.

Using key-population specific services as a point of entry for HIV care: Where social or health services designed for a key population already exist, adding services from the comprehensive package may be considered, either by training existing staff, or by supplying staff who can work at the location.

Services in prisons and closed settings: Services available for HIV prevention and treatment in the general community should also be available in prisons and other closed settings. For further information, see publications by the United Nations Office on Drugs and Crime (UNODC) and other UN partners,[20,l,li,lii] the WHO Evidence for Action series of technical papers on addressing HIV in prisons, and the 2016 WHO Key Populations Consolidated Guidelines (Section 3.2.1).

Linkages: Where services are not integrated, it is essential to have a robust referral system that makes it as simple as possible for a client to access the services they need, including non-program run services. Interagency cross-training, seconding staff and quality improvement initiatives can facilitate this. Case management systems (or peer navigation) should be designed to facilitate linkages across the continuum of diagnosis, treatment and care, and to support clients in making decisions about disclosing their HIV status. (For more information, see the 2016 WHO Key Populations Consolidated Guidelines, Section 4.3.) There is a related need for sharing information between providers, while meeting strict criteria for data confidentiality (see Section 4). Program collaboration should be designed at every level of the health system, including mobilizing and allocating resources, training and sensitizing health-care workers, managing supplies, and monitoring and evaluation.

Use of information and communications technology (ICT): Programs should consider carefully how ICT increasingly affects the way key population members interact – e.g. how sex workers contact clients, or men who have sex with men contact sexual partners – and the challenges and opportunities this poses to effective outreach. For example, some key population members who use ICT platforms extensively may not be contactable face to face at "traditional" hotpots, but they may be reachable via social media.

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 committees meeting regularly to discuss service delivery, with the authority and channels to give feedback to program management. Information from multiple sites can be aggregated at the national level.

IV. Using data

01 Using data for strategic investment planning and program design

The [HIV Information Note](#) (Section 3) lists types of data that are essential for strategic allocation of HIV investments, including for key populations.

02 Data for program monitoring

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. Monitoring includes not only programmatic or administrative data, but also data from behavioral and sero-surveillance surveys of key populations. These can be used to monitor important indicators on program reach and coverage, as well as risk behaviors and experiences of stigma and discrimination. For more information, see the WHO [Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations](#) (2015).

The Global Fund encourages countries to strengthen data systems to ensure they are able to report data on coverage of key populations with comprehensive HIV services. Programs may prioritize establishing systems to track individuals across the continuum of HIV testing, prevention, diagnosis, treatment and care services. A possible approach is a unique identifier code that is anonymous (i.e. does not reveal the identity of the holder to a casual observer) and can be used across service providers and geographic regions. Unique identifiers also help to prevent duplication of unique individuals when reporting the number of people who have received services, while ensuring safety and protecting confidentiality of individual clients. Surveys of various kinds may also be used to examine coverage of key populations by existing services.

03 Improving the evidence base

Global Fund grants can be used to help strengthen the evidence base around key populations and interventions that serve them successfully. Operational research should be built into the implementation process, and data shared and used rapidly to improve programming. For more information, see the [Global Fund Monitoring and Evaluation Toolkit](#) (HIV module, Section 3.1.1).

04 Data security

Funding requests must take into account the need for strict security procedures to ensure the safety of program clients and the integrity of data. Considerations for this include:

- ethics codes for data use
- clearances for those with the authority to use and share data
- controls on data flows
- secure databases and other systems for recording, reporting and storing data.
- an emergency response plan in case of data leaks.

V. Key population-led networks

Note that these lists are not exhaustive.

- Global Network of Sex Work Projects (NSWP) – www.nswp.org
- Global Forum on MSM & HIV (MSMGF) – www.msmgf.org
- IRGT: A Global Network of Transgender Women and HIV – www.transglobalactivism.org
- International Network of People who Use Drugs (INPUD) – www.inpud.net
- International Network of Women who Use Drugs (INWUD) – www.facebook.com/INWUD
- Global Network of People Living with HIV (GNP+) – www.gnpplus.net
- International Community of Women living with HIV (ICW) – www.icw.org
- Youth RISE (young people who use drugs) – www.youthrise.org

02 Regional networks

Africa and the Middle East
- African Sex Workers Alliance (ASWA) – www.aswaalliance.org
- African Men for Sexual Health and Rights (AMSHeR) – http://www.hivsharespace.net/organization/african-men-sexual-health-and-rights-amsher
- Middle East and North Africa Network of People who Use Drugs (MENANPUD) – www.menahra.org/en/about-menanpud
- M-Coalition (MSM 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 – MSM & transgender people) – www.apcom.org
- Asian Network of People who Use Drugs (ANPUD) – www.anpud.org
- Youth Voices Count (YVC – young MSM and transgender women) – www.youthvoicescount.org
- 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 – MSM and transgender people) – www.ecom.ngo
- South Caucasus Network on HIV (MSM and transgender people) – www.scnhiv.weebly.com
- Eurasian Network of People who Use Drugs (ENPUD) – www.enpud.org

Europe
- International Committee for the Rights of Sex Workers in Europe (ICRSE) – www.sexworkeurope.org
- European Network of People who Use Drugs (EuroNPUD)

Latin America and the Caribbean
- Plataforma LatinoAmerica de Personas que EjeRcen el Trabajo Sexual (PLAPERTS) – www.plaperts.nswp.org
- Caribbean Sex Workers Coalition (CSWC) – www.caribbeansexworkcollective.org
- Asociacion para la Salud Integral y Ciudadania en America Latina y el Caribe (ASICAL – MSM)
- Latin America Network of People who Use Drugs (LANPUD) – www.lanpud.blogspot.co.uk
- Caribbean Vulnerable Communities Coalition (CVC– key populations) – www.cvccoalition.org

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