



# **Technical Brief**

## **HIV Programming at Scale for and with Key Populations**

**Allocation Period 2023-2025**

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# Key Messages of this Technical Brief

## Prioritize key populations to achieve the global goals for HIV prevention and treatment

### 1. Prioritization

**Focus on Programming Essentials** described in the Global Fund HIV Note (2022).

### 2. Targeting for scale, coverage and impact

**Ambitious targets** based on realistic and updated population size estimates (95-95-95 by 2025).

### 3. Meaningful engagement of key population communities in all aspects of the response

Communities are engaged as stakeholders at all levels – national to local – in program planning, implementation, and monitoring and evaluation.

### 4. Key population leadership in program planning, delivery and monitoring

By 2025, community-led organizations deliver 80% of HIV prevention services, 30% of testing and treatment services and 60% of programs supporting societal enablers.

### 5. Tackle structural barriers to service access for key populations

- Stigma, discrimination and violence.
- Health inequities, harmful gender norms.
- Laws and policies criminalizing key population identities or behaviors.

### 6. Strengthen community systems

- Community-led monitoring.
- Safety and security of beneficiaries and implementers.
- Increase funding for key populations – especially domestic – via social contracting.

# 1. Introduction

This technical brief provides information for countries preparing funding requests for comprehensive programs that address the continuum of HIV prevention, diagnosis, treatment, and care for the following key populations<sup>i</sup>:

- Male, female, and transgender sex workers<sup>ii</sup>.
- Gay men and other men who have sex with men<sup>iii</sup>.
- Transgender people.
- People who use drugs (especially people who inject drugs).
- People in prisons and other closed settings

Key populations have vulnerabilities to HIV, described in Section 1.1. They account for 70% of new HIV infections globally<sup>1</sup> yet only a small percentage of global HIV funding is spent to address their HIV prevention, treatment and care needs<sup>2</sup>. To achieve the 95-95-95 targets for HIV diagnosis, treatment, and viral suppression agreed to in the 2021 UN [Political Declaration on HIV and AIDS](#) and set out in the [Global AIDS Strategy 2021-2026](#), national HIV programs must prioritize interventions for and with key populations.<sup>iv</sup> **The [Global Fund Strategy 2023-2028](#) calls for particular emphasis on key populations in efforts to close gaps in coverage of HIV prevention and treatment.**

This technical brief describes the essential interventions and approaches for key populations that should be incorporated in HIV funding requests. It is based on the latest normative and implementation guidance, including the World Health Organization (WHO) [Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#) (2022) and other guidance documents.<sup>v</sup> This brief complements and should be read in conjunction with the Global Fund's [HIV Information Note](#), which provides wider context, and with the technical briefs on human rights, gender equality, Resilient and Sustainable Systems for Health (RSSH), Community Systems Strengthening (CSS), harm reduction, and addressing HIV and TB in prisons and other closed settings. The Global Fund's [Modular Framework Handbook](#) (2022) also details specific interventions for key populations.

Figure 1 shows how this technical brief relates to the HIV Information Note, and how the interventions and service delivery approaches outlined in the Information Note and, in this brief, will help accomplish the objectives of the Global Fund Strategy. It also serves as a visual guide to where information on each topic can be found within the brief.

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<sup>i</sup> 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 2.

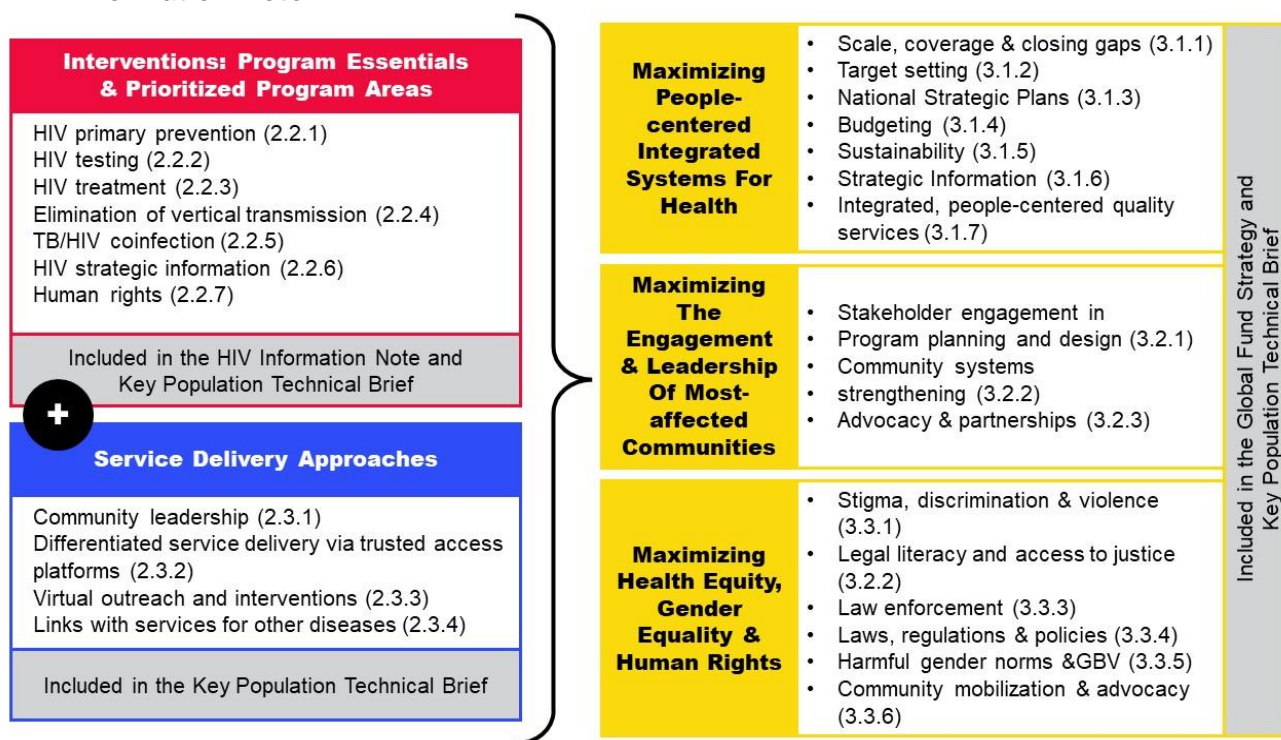
<sup>ii</sup> Note that while key populations may include young people (aged 10-24), the United Nations considers children under 18 who sell sex to be sexually exploited children, and not sex workers.

<sup>iii</sup> The use of these terms is not intended to exclude other affirming ways in which people may describe their sexual orientation or behavior.

<sup>iv</sup> The targets are that by 2025, 95% of people living with HIV know their HIV status, 95% of these are on antiretroviral therapy (ART), and 95% of those on ART have a suppressed viral load.

<sup>v</sup> These include the four implementation tools for HIV programming with key populations, informally known as the SWIT, MSMIT, TRANSIT, and IDUIT. For details, see Annex 3.

**Figure 1. How the content of this technical brief relates to the Global Fund Strategy and the HIV Information Note.**



**Note:** All numbers in parentheses refer to sections of this technical brief.

This Introduction outlines **why key populations are especially vulnerable to HIV**.

**Section 2** examines the **HIV Program Essentials and the prioritized interventions** in the HIV Information Note, provides details relevant to key populations, and considers **service delivery approaches**.

**Section 3** shows **how to incorporate key population interventions into Global Fund proposals**. It is structured around three of the Global Fund Strategy’s objectives: 1) maximizing people-centered integrated systems for health, 2) maximizing the engagement and leadership of most-affected communities (including key populations), and 3) maximizing health equity, gender equality and human rights.

The annexes provide a **list of abbreviations**, a **glossary of terms**, and a list of **key resource documents**.

### 1.1 Key populations and vulnerability to HIV

Key populations are disproportionately affected by HIV and have higher morbidity and mortality rates than the general population. Stigma and discrimination, violence and harassment, restrictive laws and policies, and criminalization of behaviors or practices marginalize key populations, undermine their access to services and put them at heightened HIV risk. In most countries inadequate coverage and poor quality of services for key populations continue to undermine responses to HIV. The COVID-19 pandemic has further exacerbated health inequities faced by key populations.



Several structural barriers discourage or prevent key populations from accessing healthcare and violate their right to health and to non-discrimination.<sup>3</sup> In many countries, the criminalization of sex between men, sex work, drug possession or drug use, HIV status, and gender expression, and the lack of legal recognition of a person's self-identified gender, including for non-binary people, are severe barriers to access services. These barriers are often made worse by abusive 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 as all prisoners and may experience additional discrimination and vulnerability to HIV.

Members of key populations often face stigma and discrimination from service providers, who may lack knowledge and training about the health needs of key populations. Key population members are also frequently ill-treated or disowned by their family members. Those who are excluded from employment opportunities because of their sexual or gender identity, their use of drugs, or their history of imprisonment are at greater risk of poverty and homelessness, making it harder to access health services.

Collectively, these laws, policies, cultural norms, and practices increase the risk of HIV infection that is often instead ascribed simply to the behaviors of key populations.

Certain members of key populations are particularly vulnerable to these structural causes of HIV risk:

- **Young key population members** (aged 10-24 years) face the additional vulnerabilities of their youth, power imbalances in relationships, economic dependence, 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 services for sexual health, mental health, and gender-affirming care because of laws that require parental consent, policies that do not respect the best interests and evolving capacities of the child,<sup>4</sup> or a lack of age-appropriate services within programs designed for key populations.
- **Women who are key population members** often have less access to health and social services than men, face greater economic marginalization, stigma and discrimination, and are more vulnerable to gender-based violence. The sexual and reproductive health and rights of female members of key populations are often ignored or denied.
- **Key population members living with HIV** may experience additional stigma because of their HIV status (including 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. Among people who inject drugs, and men who have sex with men who are living with HIV, co-infection with viral hepatitis C is very common.<sup>3</sup>

**Many key population members experience overlapping vulnerabilities** to HIV infection and to the impact of HIV, such as selling sex to procure drugs, or using alcohol to cope with stigmatization or violence, and programs should be attentive to these, so that all their needs can be addressed.

## GUIDING PRINCIPLES FOR GLOBAL FUND HIV PROGRAMS

These principles underlie the Global Fund Strategy and must be clearly addressed in funding applications. They are explained in detail in this technical brief.

Scale, results and impact	Section 3.1.1
Key population participation and leadership	Sections 2.3.1, 3.1.6.a, 3.2.1, 3.2.2
Human rights	Sections 3.3.1 – 3.3.6
People-centered services	Section 3.1.7
Do no harm	Sections 2.3.1.b, 3.1.6. e

## 2. Priorities for HIV investments

### Key Takeaways

- ✓ National Strategic Plans must address the Global Fund’s HIV Program Essentials.
- ✓ Other prioritized interventions specific to key populations should also be considered in funding requests.

### 2.1 Global Fund HIV Program Essentials

While HIV programs should strive to be as comprehensive as possible, the Global Fund’s HIV Information Note identifies a list of Program Essentials – critical parts of a country’s HIV response that are required as a minimum in national programs (see Table 1). Almost all Program Essentials are relevant to key populations and are part of the recommended package of interventions in the WHO Key Population Consolidated Guidelines. HIV funding applicants are asked to provide an update on their country’s status towards achieving the Program Essentials in their applications, and applicants from Core and High Impact Countries are also asked to describe in their funding request any plans to address Program Essentials that are not yet fully implemented.

### 2.2 Prioritized HIV Interventions

This section describes specific HIV interventions and considerations for key populations for the first five program areas in Table 1. It addresses the HIV Program Essentials as well as other prioritized interventions that should be considered in funding requests. This section complements the information in the [HIV Information Note](#) on prioritized interventions (HIV Information Note, Section 3.2) and new technologies (HIV Information Note, Section 2.3.a),

and it should be read in conjunction with these. The two final program areas in Table 1 are addressed in detail later in this technical brief: HIV strategic information (Section 3.1.6) and human rights (Section 3.3).

## 2.2.1 HIV Primary Prevention

The Global Fund’s Modular Framework includes the following HIV prevention interventions both for key populations and for their sexual partners.

**Comprehensive condom and lubricant programming** (*Program Essential 1*), ensuring that a) there is a widespread, consistent, and sufficient supply of free condoms and condom-compatible lubricant for all key populations, of a quality acceptable to them, 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.<sup>5</sup> Female condoms should be part of the package for female sex workers at a minimum.


**Table 1. Global Fund HIV Program Essentials**

<b>PROGRAM AREA</b>	<b>PROGRAM ESSENTIAL</b>
<b>Primary prevention</b>	1. Condoms and lubricants are available for all people at increased risk of HIV infection. 2. Pre-exposure prophylaxis (PrEP) is available to all people at increased risk of HIV infection, and post-exposure prophylaxis (PEP) is available for those eligible. 3. Harm reduction services are available for people who use drugs. 4. Voluntary medical male circumcision (VMMC) is available for adolescent boys (15+ years) and men in high HIV incidence settings*.
<b>HIV testing and diagnosis</b>	5. HIV testing services include HIV self-testing, safe ethical partner (index) testing, and social network-based testing. 6. A three-test algorithm is followed for rapid diagnostic test-based diagnosis of HIV. 7. Rapid diagnostic tests are conducted by trained and supervised lay providers in addition to health professionals.
<b>Elimination of vertical transmission</b>	8. Antiretroviral therapy (ART) is available for pregnant and breastfeeding women living with HIV to ensure viral suppression. 9. HIV testing, including early infant diagnosis (EID), is available for all HIV-exposed infants*.
<b>HIV treatment and care</b>	10. Rapid ART initiation follows a confirmed HIV diagnosis for all people irrespective of age, sex or gender. 11. HIV treatment uses WHO-recommended regimens. 12. Management of advanced HIV disease is available. 13. Support is available to retain people across the treatment cascade including return to care. 14. CD4 and viral load testing, and diagnosis of common comorbidity and co-infections are available for management of HIV.
<b>TB/HIV</b>	15. People living with HIV with active tuberculosis (TB) are started on ART early. 16. TB preventive therapy is available for all eligible people living with HIV, including children and adolescents.




<b>Differentiated service delivery (DSD)</b>	17. HIV services (prevention, testing, treatment, and care) are available in health facilities, including sexual and reproductive health services, and outside health facilities including through community, outreach, pharmacy, and digital platforms. 18. Multi-month dispensing is available for ART and other HIV commodities.
<b>Human rights</b>	19. HIV programs for key and vulnerable populations integrate interventions to reduce human rights- and gender-related barriers. 20. Stigma and discrimination reduction activities for people living with HIV and key populations are undertaken in healthcare and other settings. 21. Legal literacy and access to justice activities are accessible to people living with HIV and key populations. 22. Support is provided to efforts, including community-led efforts, to analyze and reform criminal and other harmful laws, policies, and practices that hinder effective HIV responses.

\* This Program Essential is not directly relevant to key populations.




[HIV Information Note](#), Section 3.2.1.a.i  
[Modular Framework Handbook](#), pp.63,66,69,73,76  
[Global HIV Prevention Coalition resources on condom programming](#)

**Antiretroviral-based pre-exposure prophylaxis (PrEP)** (*Program Essential 2*) should be available as an option for people at increased risk of HIV infection. See the HIV Information Note for information on the range of PrEP modalities supported by the Global Fund, which can include daily and event-driven oral PrEP, but also new technologies such as Long-Acting Cabotegravir (LAC), the Dapivirine Vaginal Ring (DVR) and other products as recommended by WHO. Based on the available strategic information, the program should determine the segment of key populations who are at increased risk, determine eligibility and interest, set targets and indicators, and ensure support for adherence and linkages to other health services.



[HIV Information Note](#), Section 3.2.1.a.ii  
[Modular Framework Handbook](#), pp.63,66,70,74,77  
[Differentiated and Simplified Pre-exposure Prophylaxis for HIV Prevention: Update to WHO Implementation Guidance \(WHO, 2022\)](#)

**Post-exposure prophylaxis (PEP)** (*Program Essential 2*) is recommended for all key population individuals 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-stick injuries



[HIV Information Note](#), Section 3.2.1.a.ii  
[Modular Framework Handbook](#), pp.65,68,71,75,78

**Sexual and reproductive health services should be provided as part of HIV prevention services, and HIV services as part of SRH service delivery.** This includes:

- Contraception and family planning, pregnancy testing, and safe abortion.
- Syndromic case management of sexually transmitted infections (STIs), screening and treatment for viral hepatitis,<sup>6,7,8</sup> including rapid diagnostic tests, hepatitis C self-tests,<sup>9</sup> and hepatitis B and C antiviral medication.
- Screening and treatment for cervical and anal cancer.
- Provision of gender-affirming care for transgender people.
- Provision of post-violence counseling and care.



[HIV Information Note](#), Section 3.2.1.b.iii

[Modular Framework Handbook](#), pp.65,68,71,75,78,102

**Harm reduction interventions for people who use drugs.** (*Program Essential 3*). The Global Fund supports the comprehensive package of harm reduction services recommended by WHO. Priority interventions for the harm reduction Program Essential include needle and syringe programs for those who inject opioid or stimulant drugs, opioid substitution therapy (OST)<sup>vi</sup> for people dependent on opioids, and other evidence-based drug dependence therapy, and the provision of naloxone and training to reverse opioid overdose.<sup>10</sup> Prevention, diagnosis, treatment, and care of viral hepatitis C should also be provided, along with the other Program Essentials and prioritized interventions in this section of the technical brief. HIV programming should address the specific needs of women and adolescents who use drugs. Linkages to drug dependence treatment should be considered for users of non-injecting drugs, such as amphetamine-type stimulants, which may increase vulnerability to sexual acquisition or transmission of HIV and other STIs.<sup>11</sup>



[HIV Information Note](#), Section 3.2.1.a.iv

[Modular Framework Handbook](#), pp.72-73

**Prevention communication, information, and demand creation<sup>vii</sup>.** Evidence-based information on HIV and STI prevention, when delivered by healthcare providers or peer outreach workers alongside other interventions, can help increase knowledge of HIV prevention, drive demand for services and commodities, and empower key population members to make decisions about using them. The 2022 WHO Key Population Consolidated Guidelines notes that conventional behavioral counselling interventions (i.e., counselling to encourage abstinence from sex, sex work, or drug use) have not been shown to have an effect on risk reduction or the incidence of HIV, viral hepatitis, and STIs.

<sup>vi</sup> Opioid substitution therapy (OST) is also referred to as opioid agonist therapy (OAT) or opioid agonist maintenance treatment (OAMT).

<sup>vii</sup> This is the terminology now used in the Global Fund Modular Framework, in place of “behavioral interventions”.



[HIV Information Note](#), Section 3.2.1.a.vi

[Modular Framework Handbook](#), pp.64,67,71,74,77

[WHO Key Population Consolidated Guidelines](#), p.44

**Interventions for people in prisons and other closed settings:** People in prison and other closed settings should have access to the same interventions for HIV prevention, diagnosis, treatment, and care as those in the community.<sup>12</sup> This includes all the harm reduction interventions for people who use drugs (see above), as well as condoms, PrEP and PEP, and SRH services. Rates of TB are higher in prisons and other closed settings, and people there should also have access to services for TB screening, preventive therapy, and treatment. The Global Fund can support treatment of viral hepatitis for people in prison and other closed settings, as well as violence prevention and response services, including mental-health or medico-legal support.



[HIV Information Note](#), Section 3.2.1.a.v

[Addressing HIV and TB in Prisons, Pre-Trial Detention and Other Closed Settings technical brief](#)

[Modular Framework Handbook](#), pp.76-79

[HIV Prevention, Testing, Treatment, Care and Support in Prisons and Other Closed Settings](#), United Nations, 2020.

**Interventions to address chemsex:** The WHO defines chemsex as when individuals engage in sexual activity while taking primarily stimulant drugs, typically involving multiple participants over a prolonged time. This increases vulnerability to HIV when there is no access to, and use of, prevention, diagnosis, and treatment services. Some members of key populations may engage in chemsex, and the WHO 2022 Key Population Consolidated Guidelines recommend a comprehensive, non-judgmental, and person-centered approach to addressing it. This includes ensuring access to PrEP, PEP, integrated services for SRH, mental health, sterile needles and syringes and OST, with linkages to other evidence-based prevention, diagnostic, and treatment interventions.



[WHO Key Population Consolidated Guidelines](#), p.33

[Modular Framework Handbook](#), pp.63-79, 95-96

[HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs. Technical Guide](#), pp.16, 48-49. UNODC, 2019

## 2.2.2 HIV Testing

HIV testing services should be provided and accessible in community, clinical, and closed settings, with linkage to prevention, care, and treatment services.<sup>13</sup> A three-test algorithm is required for rapid diagnostic tests (*Program Essential 6*). Because key population members may fear stigmatization at mainstream services, and may benefit from frequent testing, programs should accelerate implementation of HIV self-testing (*Program Essential 5*), with linkages to confirmatory testing for those who test positive,<sup>14</sup> as well as rapid testing by trained lay providers (*Program Essential 7*).<sup>15</sup> HIV testing, including self-testing, should always be voluntary and with full informed consent. People who have tested or self-tested should not be forced to disclose the results of that test to anyone and do so on a voluntary basis only. Healthcare professionals and others who come to know the test results must maintain strict confidentiality.

Safe, ethical, and voluntary partner testing of those who test positive for HIV – also known as index testing (*Program Essential 5*) – can be conducted, but support services for partners should be available.<sup>14</sup> Targeted testing of the partners of those who are at increased risk of HIV can be done by a social network-based approach (*Program Essential 5*). For more information, see the guide and supplemental information on the Linkages Enhanced Peer Outreach Approach.

Regular testing of key population members who are particularly vulnerable to HIV and 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 rapidly link any individuals who test HIV positive to ART and related services, especially through peer navigators; 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 particularly vulnerable to HIV. 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.<sup>viii</sup>



[HIV Information Note](#), Sections 3.2.2.iii, iv, ix

[Modular Framework Handbook](#), pp.94-97

[Consolidated Guidelines on HIV Testing Services](#). WHO, 2019.

[LINKAGES Enhanced Peer Outreach Approach](#). FHI 360/LINKAGES

<sup>viii</sup> In the new allocation cycle, the Global Fund also includes a stand-alone indicator (HTS-4: Percentage of HIV-positive results among the total HIV tests performed during the reporting period). Further information about this indicator can be found in the Modular Framework Handbook.

## 2.2.3 HIV Treatment

HIV treatment and care is essential to achieving the 95-95-95 targets, and **national plans must include the provision of HIV testing, antiretroviral therapy (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. Services must include immediate access to ART for people testing HIV positive, using WHO-recommended ART regimens, viral-load monitoring, and management of advanced HIV disease (*Program Essentials 10, 11, 12, 14*).

**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 key population members who are also living with HIV. WHO recommends that HIV programs support trained peer navigators working within key population-led NGOs or CBOs to connect individuals with confirmatory testing and treatment, and provide psychosocial support. The WHO 2022 Key Population Consolidated Guidelines note that peer navigators can increase treatment uptake and adherence. Placing peer navigators in government-funded ART clinics can help reduce stigma and discrimination against key population members seeking services there.

**Support for adherence** (*Program Essential 13*) is also essential to retain people living with HIV across the continuum of treatment and care, or for return to care. This includes systems to identify those lost to follow-up, and those entering or leaving prisons or other closed settings; treatment literacy programs; and tailored support via counselling, support groups, and peer navigation, as part of differentiated service delivery (see Section 2.3.2).



[HIV Information Note](#), Sections 3.2.3.a

[Modular Framework Handbook](#), pp.97-98, 100-103

[WHO Key Population Consolidated Guidelines](#), p.64

[Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring](#). WHO, 2022.

## 2.2.4 Elimination of Vertical Transmission

HIV testing should be integrated into ante-natal care, and into post-natal care for breast-feeding women and trans men, with rapid initiation of ART for those testing HIV positive (*Program Essential 8*), and testing and post-natal prophylaxis for infants exposed to HIV (*Program Essential 9*). Coordinating and integrating these interventions with those for preventing vertical transmission of syphilis and hepatitis B can make services more people-centered and cost-effective. It is important that service providers are trained to be sensitive to the context and needs of women from key populations (Section 3.3.5).



[HIV Information Note](#), Sections 3.2.4  
[Modular Framework Handbook](#), pp.92-94

## 2.2.5 TB/HIV Coinfection

Linkages to testing, prevention, and management of TB must be consistently available.<sup>16,17</sup> Integrated and coordinated TB/HIV prevention and treatment is encouraged.<sup>18</sup> People with active TB who are diagnosed with HIV should be started rapidly on ART as well as TB treatment (*Program Essential 15*), and those diagnosed with HIV who test negative for TB should be offered TB preventive therapy (TPT) (*Program Essential 16*).



[HIV Information Note](#), Sections 3.2.5  
[Modular Framework Handbook](#), pp.103-105

## 2.3 Service Delivery Approaches

### Key Takeaways

- ✓ Key population participation and leadership is essential for effective HIV programs.
- ✓ Key population-led organizations and networks should be supported and funded to plan, implement and monitor services.
- ✓ Programs must ensure the safety and security of those seeking and delivering services.
- ✓ Differentiated service delivery makes services more accessible and acceptable to key populations.
- ✓ Where possible, consider virtual outreach and online interventions to complement in-person programming and expand reach.
- ✓ HIV services should provide linkages to other health services that key populations need.

### 2.3.1 Community Leadership

**Key population participation and leadership is essential for effective HIV programs.** People and communities are at the center of the Global Fund’s Strategy, which is aligned with the 2022 WHO Key Population Consolidated Guidelines in stating that “communities must be supported to lead in service planning, implementation, monitoring, advocacy, and



the provision of expert technical support” (Global Fund Strategy, p.14). The strategy calls for the expansion of community-based and community-led programs to create strong, sustainable community systems, and for the integration of these systems into national health and social systems to optimize programs and increase impact. National HIV programs and partners must therefore work together with key populations in the HIV response. Key populations are best placed to guide, and in many instances lead, the implementation of programs tailored to their circumstances. Key populations’ participation and leadership help build their trust in Global Fund-related processes and their ownership of them, and can create more enabling environments for HIV prevention, testing, treatment, and care.

An essential component of improving access to services for key populations is to identify, fund, strengthen, and support civil-society organizations, community-based organizations (CBOs), community-led (i.e., key population-led) organizations and networks to provide large-scale programming. **The 2021 Political Declaration on HIV and AIDS and the Global AIDS Strategy 2021-2026 call for community-led organizations to deliver 80% of HIV prevention services, 30% of testing and treatment services and 60% of programs supporting societal enablers by 2025.** The Global Fund Strategy calls for countries to prioritize institutional capacity-building for community-led organizations and networks where these exist, and support for policy advocacy and reform, to enable them to provide services (Sections 3.2.2 & 3.2.3). Key population-led organizations and networks can also play key roles in training health service staff, law enforcement, and social-service agencies (see Section 3.3.1). These organizations also play roles in monitoring programs (Section 2.3.1.a) and should be funded adequately for these activities.

Although community-led services are integral to community empowerment and an effective HIV response, in some contexts community-led organizations and networks are not able to lead programs themselves. This is either because they are not yet institutionally developed enough to do so, or because it is dangerous or illegal for them to form their own CBOs or NGOs. In these cases, HIV programs may need to rely more on organizations that are community-based but not community-led for service delivery. However, this should not be an excuse not to advocate for the formation of community-led organizations and networks, nor to support the strengthening of those that exist as well as the legal and policy changes that may be required for them to operate.

**When service delivery is by CBOs rather than community-led organizations, key populations should be involved to the extent possible.** This means placing key population representatives on boards and governing bodies; employing them as staff, including community outreach workers (i.e. as peer educators, counsellors, providers of HIV testing and peer distributors of ART for stable clients, supervisors, peer navigators, legal and human-rights educators, and paralegals); gathering regular feedback from service beneficiaries; and implementing effective accountability mechanisms, such as community-led oversight committees.<sup>ix</sup> This is also true of people in prisons and other closed settings, and for organizations and networks led by those formerly in prison. Services provided by

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<sup>ix</sup> 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 should be provided to facilitate their engagement.

key population members should not be limited to community outreach, and can also include service delivery, and administrative support and program management.

**Rigorous management systems are required to ensure the success of community-led services.** This includes ensuring that resources and staffing are adequate for manageable caseloads (both the ratio of peer outreach workers to key population members, and of peer navigators to people living with HIV); 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 (see Section 3.3.1); 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 HIV program, but also to key population members themselves.



[Global Fund Strategy](#), pp.32-33

[Modular Framework Handbook](#), pp.10,14-16

[WHO Key Population Consolidated Guidelines](#), pp.21-23,63-64

[Key Population Trusted Access Platforms](#), pp.53-54

[HIV Prevention 2025 Road Map](#), p.16

[Global AIDS Strategy](#), pp.63-65

[Working in Partnership with Networks of People Living with HIV in Asia and the Pacific: A Guidance Note for Development Practitioners](#). APN+, 2015.

### 2.3.1.a Community-led Monitoring

The **Global Fund Strategy** calls for **scaled-up approaches to monitoring** to improve service availability and quality, and to identify and address human-rights and gender-related barriers to services. HIV programs should have mechanisms for key population members to provide oversight and give feedback on their experience as service recipients. At the local level this can happen through community-led monitoring, in which community committees meet regularly to discuss service delivery, including analyzing program data, 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.



[HIV Information Note](#), Section 3.2.6.ix

[RSSH Information Note](#), Section 4.3

[Modular Framework Handbook](#), p.13

[Establishing Community-led Monitoring of HIV Services](#). UNAIDS, 2021.

[Key Population Trusted Access Platforms](#), pp.46-49

[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.

### 2.3.1.b Security of Beneficiaries and Implementers

**HIV programs serving key populations, supported by the Global Fund must incorporate safety and security measures into how the programs are designed and implemented.**

Threats or actions against the safety and security of implementers may come from law enforcement, health-care providers, community groups, and individuals. To an extent, the safety of implementers overlaps with that of key population members as service users, but implementers may be more vulnerable because of their visibility as the face of the program. This is especially true for peer outreach workers and advocates. Programs should work with local implementers to assess risks to individuals through harassment, violence or discrimination, and to the program as a whole through wider backlash. Programs should draw up plans and protocols to proactively address these risks, for example through engagement and sensitization work with law enforcement, health providers, teachers, parents, and religious groups. Particular consideration is also needed for those seeking and delivering services in situations of civil emergency (e.g., war) or humanitarian settings.

Security should be addressed in the program design and budgeting process, and not seen as an unfunded add-on. This includes, but is not limited to, assessing security risks of CLO/CBO implementers, appropriately resourcing activities and interventions that can mitigate the risks identified and including crisis response activities in the budget, in line with the available implementation tool (ref: security toolkit) and the revised budgeting guidance.

An important element of program security is the ability to respond when an incident occurs, in order to provide immediate assistance to affected program workers. This could include emergency accommodation, evacuation, health care or legal assistance. As with any activity being proposed for Global Fund support, including a budget line for such a fund in a funding request needs to be demonstrated to be necessary, reasonable and contributing directly or indirectly to the program objectives. Including within funding requests evidence of prior incidents and threats and of their impact on the program will therefore be important. The use of emergency budget lines will need to follow applicable laws and regulations, and transparent and equitable criteria and conditions for their allocation to beneficiaries will be required.

[HIV Information Note](#), Section 3.2.1.a.viii

[Technical Brief on Removing Rights-Related Barriers to HIV Services](#), Sections 2.2 and 3.2.6

[Safety and Security Toolkit: Strengthening the Implementation of HIV Programs for and with Key Populations](#) (FHI 360/LINKAGES, 2018).

### 2.3.2 Trusted Access Platforms and Differentiated Service Delivery

HIV programs with a single focus – e.g., testing or condom delivery or PrEP – often suffer from low service uptake, retention, and impact. Much greater impact can be achieved if these services are offered on top of a “**trusted access platform**” – a continuous program presence in communities, particularly in locations where key population members are most present. Trusted access platforms offer frequent contact through peer-led outreach, promote regular medical check-ups, provide safe spaces and structural interventions, and address community concerns in a holistic manner (Figure 2). Because trusted access platforms increase program access and confidentiality, they build key population trust and participation, which increases retention, lowers loss to follow-up, and makes it easier to add new interventions.

Trusted access platforms also facilitate differentiated service delivery, an approach to services that respects and accommodates the differing characteristics and preferences among and within key populations, to make services more accessible and acceptable. This is important to increase coverage of those most in need of services. It can also increase health-system efficiencies. 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.

Countries should consider differentiating service delivery in several ways. These include:

- **Service package:** Tailored to individual key populations, or subgroups within key populations. For example, while some individuals can easily adhere to a daily oral PrEP regimen, this may be challenging for others, and a long-acting formulation (long-acting cabotegravir or LAC) – or, for women, a dapivirine vaginal ring (DVR) – may be a more acceptable option. Virtual outreach (see Section 2.3.3) can complement in-person outreach. Services should also be age-appropriate, and when serving children should take into consideration the best interests and evolving capacities of the child<sup>4</sup> as well as existing law.
- **Venues for service delivery:** HIV services for key population members may be integrated within an existing ART clinic, as a standalone clinic within an existing health facility, or in a community-based or mobile facility. For instance, ART distribution can be done by peers at community-based clinics. Services delivered in places other than medical facilities – e.g., at pharmacies, drop-in centers or safe spaces, “pop-up” centers (rotating between hotspots), mobile outreach vans, teenagers’ clubs, or by peer outreach workers provide a greater range of options to suit the varying needs and preferences of key populations, and help to de-medicalize the perception of HIV prevention (*Program Essential 17*). While the full integration of HIV services for key populations into mainstream HIV services is a goal, at fixed-site facilities separate services or service-delivery spaces may be needed for different key populations. Designated or extended service hours for specific key populations can help accessibility. Drop-in centers provide an accessible, safe, and welcoming

venue for the delivery of many prevention and testing services, while being an important means of fostering community empowerment and cohesion.

- **Individual characteristics of key populations:** Services should be tailored to individuals' practices and patterns of behavior, which can be determined using risk assessment tools. For example, the frequency and context of sex, or of drug injecting, can affect the quantity of condoms and lubricants or needles and syringes required; whether PrEP should be offered on an event-driven or ongoing basis; and multi-month dispensing of ART and take-home doses of OST. This proved a successful intervention in several countries during the COVID-19 pandemic (*Program Essential 18*). Peer outreach workers and peer navigators should reflect the key population identity and gender the people they are working with.
- **Addressing 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; a transgender person may need mental-health services as well as HIV services; and a young gay person may also be homeless, making them more vulnerable to sexual exploitation and therefore to HIV. An individual's patterns of drug use may shift from injecting to non-injecting and back again.

[HIV Information Note](#), Section 3.2.3.c

[Modular Framework Handbook](#), pp.94-98

[Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring](#). WHO, 2021.

[Key Population Trusted Access Platforms](#). Global HIV Prevention Coalition, 2020.

[Decision frameworks on HIV Testing Services and ART Delivery for Key Populations](#). International AIDS Society.



### 2.3.3 Virtual Outreach and Interventions

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. HIV programs should consider mapping these networks in order to reach key population members who may be especially vulnerable to HIV but who may not be accessible via face-to-face outreach, in order to offer them services. It is essential that policies on privacy, security, and ethics for online mapping are developed to ensure the safety of those who are contacted online, including adolescents and young members of key populations.

Online interventions are recommended by WHO and offer the opportunity to target health information to specific key populations or demographic subgroups within key populations (e.g., by age or geography). Established interventions, as well as the experience of the COVID-19 pandemic, have shown that some aspects of case management, such as

appointment scheduling and reminders, and adherence counseling, can also take place online and may reduce loss to follow-up and increase program efficiency. However, not all key population individuals have access to online services, and some may find in-person services more effective. Therefore, virtual outreach and support should complement, and not replace, in-person contact and services for key populations.



[HIV Information Note](#), Sections 3.2.1. c. iv & 3.2.2.xiii

[WHO Key Population Consolidated Guidelines](#), pp.66-68

[Virtual Interventions in Response to HIV, Sexually Transmitted Infections and Viral Hepatitis](#). UNAIDS and WHO, 2022.

[Web-Outreach for People who Use Drugs](#). UNODC Regional Office for Eastern Europe, 2021.

### **2.3.4 Links with Services for Diagnosis and Treatment of Other Diseases**

Measures to address HIV and TB coinfection are described in Section 2.2.5. Linkages to testing, prevention, and management of TB must be consistently available<sup>16,17</sup>. Screening for COVID-19 and monkeypox should be available, with linkages to treatment where needed. Providing screening and treatment of STIs as part of HIV prevention services is a strategy proven to be effective, and HIV prevention interventions should similarly be provided as part of SRH services. Many SRH services can be integrated into HIV service delivery (see Section 2.2.1). Where such integration is not possible, programs should provide referrals and linkages to providers who are respectful of key populations. Referrals should also be available for mental health counseling,<sup>19</sup> and for evidence-based, voluntary interventions for drug or alcohol dependence.<sup>20</sup> People in prisons and other closed settings should be provided with linkages to these services if not available in the place of detention, and programs should provide linkages for continuation of services upon release.



[HIV Information Note](#), Sections 3.2.1.a.iii & 3.2.2.v

[Modular Framework Handbook](#), pp.65,68,71,75,102

[HIV Prevention 2025 Road Map](#), p.18



## 3. Incorporating key population interventions into Global Fund funding requests.

### Key Takeaways

- ✓ HIV programs should be designed for scale and coverage.
- ✓ Programs must set ambitious targets based on accurate data.
- ✓ National strategic plans and budgets must be comprehensive to support effective programming.
- ✓ Sustainability means securing financing, social contracting, and building the capacity of community-led organizations and networks.
- ✓ Strategic information, gathered and analyzed with the engagement of key populations, is essential for planning and monitoring services.
- ✓ Services should be integrated and people-centered.

### 3.1 Maximizing people-centered integrated systems for health to deliver impact, resilience and sustainability.

The success of an HIV program depends on the steps taken from the planning stage all the way through design, delivery, monitoring, and evaluation. This section of the brief discusses scale and coverage, target-setting, National Strategic Plans, budgeting, sustainability, strategic information, and delivering people-centered services.

#### 3.1.1 Scale, Coverage and Closing Gaps

The Global Fund Strategy emphasizes scale and coverage of HIV programs, with a highly targeted approach for key populations to produce specific results for HIV prevention, treatment, and care. It should be the goal of each country to scale up services so that 95% of key populations are covered. This means **identifying and closing gaps in coverage** – both in terms of geographic availability of services, and of key populations identified and provided with services.

Programs should prioritize interventions that can be delivered at sufficient scale to achieve maximum uptake, use and impact rather than spread investments across interventions that have limited potential for sustainability and value for money. Key approaches include:

- Maintaining support for products, technologies and service delivery approaches whose effectiveness has been proven (Section 2.2), and accelerating access to and use of new HIV prevention, testing and treatment options (Section 2.2).
- Expanding the range of platforms for service delivery (Section 2.3), and delivering integrated, people-centered services (Section 3.1.7).

- Supporting an enabling environment for HIV and related services through laws and policies, and their reform where needed (Section 3.3.4).
- Partnering with civil-society organizations, including key population-led organizations and networks, that are able (or have the potential) to implement large-scale programming (see below, and Section 2.3.1).
- 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 (Section 3.1.6).

### 3.1.2 Target-Setting

**Targets for HIV program coverage should be both ambitious and realistic.** Ambitious means that they should be designed to achieve a population-level reduction in the number of new HIV infections, in line with the Global Fund’s HIV Primary Prevention Results Framework (see Annex 6 of the HIV Information Note). Realistic means that targets should consider available resources – but also that they must reflect the actual numbers of key population individuals. HIV grant reporting showing program coverage greater than 100% of key populations often implies that denominators and possibly targets have been set unrealistically low. Usually this is because the population size has been underestimated, though it may also indicate that targets did not accurately reflect the capacity of implementing partners.

To achieve national-level impact, programs should:

- Base their targets on the **most accurate available size estimate** for each key population.
- Assume that **all key population members are particularly vulnerable to HIV** (i.e., “high-risk”).
- Set targets for the **frequency of outreach that correspond to the actual needs** for effective delivery of HIV prevention and treatment services (e.g., once per month, not “once per reporting period” if the reporting period is infrequent).

Targets should be aligned with the disaggregated targets in the Global AIDS Strategy, unless a compelling rationale for adopting different targets is presented.

Program planning should also address the risk of double-counting if a key population individual receives services from more than one provider. Unique identifier codes (UICs, see Section 3.1.6.c) are one way to avoid this risk.



[Global AIDS Strategy](#), Annex 1 (Disaggregated 2025 targets and commitments)

[Tool to Set and Monitor Targets for HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#). WHO, 2015.

[WHO Key Population Consolidated Guidelines](#), pp.81-83

### 3.1.3 National Strategic Plans

National HIV Strategic Plans, and operational plans to guide programmatic implementation, should integrate key population programming across the continuum of HIV prevention, diagnosis, treatment and care. Plans must:

- Recognize needs of all five key population groups present in the country.
- Clearly define the goals and objectives for the key populations program.
- Have all HIV Program Essentials in place and include a package of prioritized interventions.
- Plan for differentiated service delivery.
- Ensure the inclusive and meaningful participation of all stakeholders in program delivery and monitoring, including key population-led organizations.
- Show how programs will be taken to scale, and how structural barriers to scale-up will be addressed.
- Provide structures and support for strong management and accountability, including accountability to key populations.
- Integrate considerations of the safety and security of program implementers – especially those from key populations – in all aspects of program design and budgeting.
- Provide a clear and costed operational plan with timelines.
- Include a monitoring and evaluation framework with core indicators and targets.
- Provide for collecting, recording, and monitoring data at local, regional, and national levels to show results across the continuum of prevention, diagnosis, treatment, and care.



[HIV Information Note](#), Section 3.2.1.e

[Modular Framework Handbook](#), p.91

[Technical Brief on Community Systems Strengthening](#)

[Global AIDS Strategy](#), p.90

[HIV Prevention 2025 Road Map](#), pp.12-15

[Global AIDS Monitoring 2022](#). UNAIDS, 2021.

### 3.1.4 Budgeting

Finance and budget experts should be part of program planning from the start. Budgeting should take into consideration community and key population-led services, and not only those provided by public health facilities. Illustrative components to be covered in budget plans include:

- Strategic information (including surveys, programmatic mapping, and others).
- Biomedical services, commodities and supplies.

- Recruitment and ongoing training of implementing partner staff.
- Recruitment, training and remuneration of sufficient key population workers (i.e., various peer roles), including measures for their safety and security.
- Data collection and analysis systems (including sufficient investment in data security).
- Enabling interventions, including violence prevention and response, training, advocacy and partnerships to remove barriers to access.
- Monitoring and evaluation.

Budgets should consider the costs of providing integrated services. Planners should also consider how the local context may affect budget needs. For example, in areas that are particularly hostile to key populations, peer outreach workers may need to work in pairs for safety, which has a budgetary impact.



[Key Population Trusted Access Platforms](#), pp.56-69

[WHO Key Population Consolidated Guidelines](#), p.81

### 3.1.5 Sustainability

Sustainability is a key consideration for HIV program design in order to achieve lasting impact and use resources efficiently. Globally, domestic expenditure on key population prevention programs accounts for only a very small proportion of HIV domestic funding. Countries should consider funding community-led organizations and networks 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. Investments should be directed at strengthening health and community systems including supporting key population-led organizations and networks (see Section 3.2.2), integrating HIV and SRH services into universal health coverage packages and addressing human rights.



[RSSH Information Note](#)

[Guidance for Sustainability and Transition Assessments and Planning for National HIV and TB Responses](#), 2021.

### 3.1.6 Strategic Information

#### 3.1.6.a Engaging key populations in strategic information.

**Meaningful community engagement in data collection, analysis and use must be ensured.** If key population-led networks or organizations exist within the country, their participation will enhance the accuracy and validity of strategic information. 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.

**The security of key populations is paramount in all activities related to the collection and use of strategic information.** Since collecting individual-level data on key populations can be dangerous, 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. This includes ensuring that data gathered on key populations is stored securely (Section 3.1.6.e).

### 3.1.6.b Data for Program Planning

Countries should conduct epidemiological and demographic assessments to set realistic targets. Since some approaches (e.g., bio-behavioral surveys and population size estimation) can be time-consuming and resource-intensive, countries should adopt a pragmatic approach (such as community mapping) and begin programs where they are clearly needed, making adjustments as more rigorous data become available. Population size estimates for key populations are incomplete or outdated in many contexts and it is important to address this, above all with the participation of community-led organizations. However, **lack of strong data is not a reason to stop, or to not initiate, a key population HIV prevention program.**

**Epidemiological assessments** include sero-prevalence surveys, bio-behavioral surveys and needs assessments to identify determinants of risk and service needs specific to key populations, as well as to identify where there are gaps and barriers in service provision. The WHO rapid assessment and response (RAR) approach,<sup>21,22</sup> and the UNAIDS Gender Assessment Tool<sup>23</sup> (2018) can be used to assess contexts and make national responses more gender-transformative, equitable and rights-based for key populations. **Demographic assessments** include population size estimation and mapping to identify the numbers of people who correspond to the populations defined for the programs. **Population size estimation should, wherever possible, be accompanied by site-based mapping** (as well as online mapping for certain subsets of key populations) to identify areas where services should be provided, and suitable operating times.

**Factors affecting the reliability of data should be considered.** If integrated bio-behavioral 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 data 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. Note that UNAIDS and WHO guidance calls for countries using population size estimates for men who have sex with men that are less than 1% of the total adult male population to revise their estimates.



[HIV Information Note](#), Sections 2.1.a, 3.2.6

[WHO Key Population Consolidated Guidelines](#), pp.76-78

[Tool to Set and Monitor Targets for HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#), pp.16-17. WHO, 2015.

[Guidelines on Estimating the Size of Populations Most at Risk to HIV](#). UNAIDS, 2011.

[Recommended Population Size Estimates of Men who have Sex with Men](#). UNAIDS & WHO, 2020.

[Biobehavioral Survey Guidelines for Populations at Risk for HIV](#). WHO, 2017.

[Key Population Trusted Access Platforms](#), pp.36-41

[Programmatic Mapping Readiness Assessment for Use with Key Populations](#). FHI 360/LINKAGES, 2017.

### 3.1.6.c Data for Monitoring

Systems should be designed to track individuals across the continuum of HIV prevention, diagnosis, treatment and care, and across care providers. Monitoring includes not only programmatic or administrative data, but also data from behavioral and sero-surveillance surveys of key populations, and data on enabling interventions. These data can be used to monitor indicators on program reach and coverage, as well as sexual or drug-use behaviors, experiences of stigma, discrimination, violence, and levels of community empowerment. Forthcoming guidance includes directives on “BBS-lite” (WHO and UNAIDS), and a prevention outcome monitoring tool for program implementers.

Countries should move toward a **unified unique identifier code (UIC) system** for all key populations. A UIC is a code that an individual can use when accessing services across service providers and geographic regions. 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. UICs must be designed to ensure the anonymity and confidentiality of the individual and their program data.

**HIV programs should use and analyze data at the micro level to monitor and improve outreach and follow-up.** Peer outreach workers can target services most effectively through microplanning, i.e., recording data on the needs of the people they reach and the services provided, in order to adjust outreach and service delivery to follow up with established contacts

Wherever possible, **data should be recorded electronically**, rather than using paper-based records, to reduce errors from data re-entry and to keep data more secure. Data



stored online must be securely backed up, password-protected and anonymized as far as possible. See also Section 3.1.6.e on data security.

**Programs should provide training and support to grantee organizations on data use** to visualize, analyze and use routine data to improve performance at the local level on a regular basis. This requires clear definitions of coverage and data disaggregated by key population, gender and age – for treatment as well as prevention. Data should be reported up to regional and national levels. Data from donor-funded programs should be fed into national data systems in order to give a comprehensive view of programming.



[HIV Information Note](#), Sections 2.1.b & 3.2.6

[Modular Framework Handbook](#), pp.49-51

[Global Fund Strategy](#), pp.34-35

[WHO Consolidated HIV Strategic Information Guidelines](#), Sections 1.2.3 & 1.3

[Tool to Set and Monitor Targets for HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#). WHO, 2015.

[Unique Identifier Codes: Guidelines for Use with Key Populations](#). FHI 360/LINKAGES, 2016.

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

[Key Population Trusted Access Platforms](#), pp.42-52

[LINKAGES Enhanced Peer Outreach Approach](#). FHI 360/LINKAGES.

[WHO Key Population Consolidated Guidelines](#), pp.80-82

### 3.1.6.d Data Disaggregation

**Strategic information must be disaggregated when it is analyzed to ensure that services reach all 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. The Global Fund Strategy emphasizes the need for “disaggregated, people-centered data to plan and inform equitable responses, to support decision-making, and improve program management and quality at the point of care” (p.34). Data generated from surveys and during service delivery for both prevention and treatment must therefore be disaggregated by gender and age within each key population, where possible. 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.<sup>24,25</sup>) Data should also be disaggregated sub nationally on a regular basis for use at district and site levels.



[WHO Consolidated HIV Strategic Information Guidelines](#), Section 2.4

### 3.1.6.e Data Security

HIV 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) to ensure the safety and health of all individuals and build trust around data collection. 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 it is absolutely needed to facilitate clinical care. In these cases it must be stored securely and carefully safeguarded. 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.



[WHO Consolidated HIV Strategic Information Guidelines](#), Section 2.5.6

### 3.1.7 Integrated People-centered Quality Services (IPCQS)

People-centered services are ones that do not focus solely on HIV but are organized in a way that considers individuals' needs holistically, placing people and communities at the center. The goal is to increase service uptake by making services more accessible, convenient and respectful. Integrated people-centered quality services (IPCQS) complement the transition toward Universal Health Coverage. The Global Fund Strategy, Global AIDS Strategy and the 2022 WHO Key Population Consolidated Guidelines require countries to program their resources to promote and increase access to and utilization of IPCQS. Elements of IPCQS are listed below and described in the relevant sections of this technical brief:

- Community-based prevention, testing and treatment (Section 2.3.2)
- Support for those testing HIV negative to stay negative and be regularly tested for HIV (Section 2.2.2)
- Support for those who test HIV positive to be rapidly linked to ART (Section 2.2.2)
- Case management of people living with HIV for ART adherence and viral suppression including through peer navigators (Section 2.2.3)
- Analysis and use of data at the micro-planning level to monitor and improve outreach and follow-up (Section 3.1.6.c).



[HIV Information Note](#), Section 2.3.b

[Framework on Integrated, People-Centered Quality Services](#). WHO, 2016.

## 3.2 Maximizing engagement and leadership of most-affected communities to leave no one behind

### Key Takeaways

- ✓ Key population networks and representatives should participate in national-level planning and program oversight.
- ✓ Community systems should be strengthened, and advocacy supported to prioritize an effective HIV response.

### 3.2.1 Stakeholder Engagement in HIV Program Planning and Design

**Key population networks and representatives should participate in national-level planning**, for example by their inclusion in the Country Coordinating Mechanism (CCM). The Global Fund's review of CCM function considers the degree of engagement with key populations. Key population involvement in CCMs and in designing National Strategic Plans, developing funding requests and grant-making, strengthens the planning process and is an important element of community empowerment. Key population members should choose how and by whom they are represented, taking into consideration issues of gender diversity and parity. National-level planning processes should be designed to ensure the safety of key population members during their travel to and from and their participation in those meetings.

**HIV 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. Part of 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; ensuring that relevant detailed implementation guidance is in place to support effective program implementation; developing plans to close financial gaps in areas that are underfunded, such as HIV prevention; and ensuring that resources are adequately distributed according to priority needs.

### 3.2.2 Community Systems Strengthening (CSS)

Funding applications should include a focus on strengthening key population networks and organizations to be effective partners in national HIV responses. This includes supporting their registration as legal entities, creating or strengthening mechanisms to allow government to fund them, and strengthening their management, financial and administrative

capacities. Countries should also challenge laws, policies and practices that restrict the work of such networks and organizations.

Interventions that are part of CSS include community-led monitoring, community-led research and 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. CBOs and non-governmental organizations (NGOs) should receive adequate and consistent financial support to maintain the breadth and quality of their services. Refer to the CSS technical brief for a detailed description of CSS interventions that should be considered for key populations.



[Modular Framework Handbook](#), pp.13-16

[Technical Brief on Community Systems Strengthening](#)

[Key Population Trusted Access Platforms](#), pp.53-54

### 3.2.3 Advocacy and Partnerships

The Global Fund Strategy calls for support for advocacy by community-led and civil society-led organizations to reinforce the prioritization of health investments, and for partnerships with these organizations to support more inclusive, responsive and effective health systems. This includes supporting communities to be empowered to advocate for their health and rights and hold decision-makers accountable. Partnerships might include collaborating with government ministries, departments and agencies that work beyond health, such as justice ministries, to address access to justice for key populations and consider opportunities for decriminalization.



[HIV Information Note](#), Section 3.2.7. viii

### 3.3 Maximizing health equity, gender equality and human rights

#### Key Takeaways

- ✓ Activities to remove human rights-related barriers to service access should be integrated in HIV programs.
- ✓ HIV programs should work towards the elimination of stigma, discrimination and violence.
- ✓ HIV programs should build key populations' legal literacy and access to justice.
- ✓ HIV programs should support community-led efforts to reform laws, policies and practices that hinder an effective HIV response.

The 2021 Political Declaration and the Global AIDS Strategy call for reforms so that, **by 2025, less than 10% of countries have legal and policy frameworks that lead to the denial or limitation of access to HIV-related services; less than 10% of people living with HIV and key populations experience stigma and discrimination; and less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.** These human-rights targets are integral and essential to the Global Fund's person-centered strategy and to achieving the 95-95-95 goals for HIV prevention and treatment.

Governments,<sup>26</sup> UNAIDS,<sup>24</sup> WHO,<sup>3</sup> 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. Programs to remove human rights-related barriers to services should be an integral part of HIV prevention and treatment programs for key populations (*Program Essential 19*). The Modular Framework lists relevant activities, and this section of the technical brief describes how these approaches are applied to services for key populations to address a range of issues impacting human rights and equity in service access for key populations.



[HIV Information Note](#), Sections 2.3.c & 3.2.1.d

[Modular Framework Handbook](#), pp.65,69,71,76,79

[Technical Brief on Removing Rights-Related Barriers to HIV Services Global AIDS Strategy](#), pp.65-67

[HIV Prevention 2025 Road Map](#), p.17

#### 3.3.1 Eliminate stigma, discrimination and violence.

HIV programs should integrate and support interventions that work towards the elimination of stigma, discrimination and violence against key populations. 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.

The Global Fund is a co-convenor of the [Global Partnership on the Elimination of All Forms of HIV-related Discrimination](#). It has committed to supporting countries to scale up interventions in six settings: health care (see below), education, workplace, justice and legal systems, communities, and emergency and humanitarian settings. Interventions include activities to measure levels of stigma and discrimination, as well as activities to reduce them.

Applicants should demonstrate an approach that addresses stigma, discrimination and violence as public-health and human-rights issues and removes barriers to services (*Program Essential 19*). (Stigma includes internalized self-stigma among key population members.) While the approach should be tailored to the country context, it is likely to include support for interventions that:

- **Promote the safety and security of key population members:** Programs must have policies and procedures to prevent, mitigate and respond to threats to the safety of key population members, especially when seeking or receiving services, as part of the principle of “Do no harm”. Practical steps include 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.
- **Reduce stigma and discrimination in healthcare and other settings** (*Program Essential 20*). This includes sensitizing 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, including client confidentiality and voluntary informed consent for testing and treatment. Key population members should be involved as trainers to understand key populations’ circumstances and experiences. There should be feedback mechanisms for service users who experience stigma or discrimination.

Violence includes physical, sexual, economic and psychological abuse, as well as structural and other human-rights violations. **Programs should provide an effective and immediate response for victims of violence.** This includes supporting community-led crisis response systems and providing health services and psychosocial and legal support.<sup>27</sup>

**Programs should gather data on stigma, 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. Programs should also recognize the intersection of discrimination against key populations with other forms of oppression, based on ethnicity, poverty, language, or citizenship status. Community-led monitoring is an important source of data on experiences and levels of stigma, discrimination and violence. The People Living with HIV Stigma Index is also a significant resource.





[HIV Information Note](#), Sections 3.2.1.a.vii, 3.2.6.viii & 3.2.7.i,ii

[Modular Framework Handbook](#), pp.106,108

[Technical Brief on Removing Rights-Related Barriers to HIV Services](#),  
Section 3.2.1

[Technical Brief on Community Systems Strengthening](#)

[WHO Key Population Consolidated Guidelines](#), pp.19-21,23-24

[Global AIDS Strategy](#), pp.65-67

[Responding to Acute Violence against Key Populations](#). FHI 360 /  
LINKAGES, 2018.

[People Living with HIV Stigma Index](#)

### 3.3.2 Provide legal literacy and access to justice

Legal literacy and access to justice (*Program Essential 21*) is part of community empowerment and includes raising key population members' awareness of their human rights and their rights under national constitutions and domestic and international laws. Approaches include legal literacy and "know your rights" workshops, education on laws and policies that impact criminalized and key populations, and integrating community paralegals or other legal-aid services into outreach programs. Service providers should be capacitated to make referrals to legal aid, where available, for victims of discrimination or violence. Lawyers should also be trained to understand and support claims related to key populations.



[HIV Information Note](#), Sections 3.2.7.iii, iv

[Modular Framework Handbook](#), pp.107-8

[Technical Brief on Removing Rights-Related Barriers to HIV Services](#),  
Sections 3.2.3, 3.2.4

### 3.3.3 Ensure rights-based law-enforcement practices.

Police, judges, prosecutors and prison staff may be sources of stigma, discrimination, illegal law-enforcement activities and violence against key and vulnerable populations. Applicants are encouraged to include activities that mitigate the harm that law-enforcement officers may have on access to HIV services for key populations. Such activities can include:

- Regular sensitization workshops with police and other law-enforcement authorities 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 designating liaison officers for key populations.
- Addressing law-enforcement practices that violate the human rights of key population

members or increase their HIV risk, such as confiscating condoms or sterile needles or using their possession as evidence of a crime, and forced anal examinations of gay men, other men who have sex with men and transgender people.



[HIV Information Note](#), Sections 3.2.7.v

[Modular Framework Handbook](#), pp.109

[Technical Brief on Removing Rights-Related Barriers to HIV Services](#),  
Section 3.2.5

### 3.3.4 Improve laws, regulations, and policies relating to HIV

The WHO Key Population Consolidated Guidelines state that countries should “work toward decriminalization of drug use/injecting, drug possession, 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 trans and gender diverse people” (p.19).<sup>28,29</sup> The Global Fund recognizes that these efforts are a Program Essential for effective HIV responses (*Program Essential 22*). In addition to reforming criminal laws, countries should:

- Address laws 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.
- Ensure that institutions follow existing protective 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,<sup>28</sup> 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.

Countries should also support community-led advocacy efforts for these reforms.



[HIV Information Note](#), Section 3.2.7.vi

[Modular Framework Handbook](#), p.109

[Technical Brief on Removing Rights-Related Barriers to HIV Services](#),  
Section 3.2.6

[WHO Key Population Consolidated Guidelines](#), pp.17-19

### **3.3.5 Reduce harmful gender norms and gender-based violence against women and girls in all their diversity.**

Within key populations, as within the population at large, gender is a critical factor in risk for disease and people's ability to access and receive services. Programs should always be gender-responsive, i.e. 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. Where possible and relevant, programs should also be gender-transformative – actively seeking to build equitable social norms and structures. 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 them and provide comprehensive and safe services.



[HIV Information Note](#), Sections 3.2.7.vii

[Modular Framework Handbook](#), p.110

[Technical Brief on Removing Rights-Related Barriers to HIV Services](#),  
Section 3.2.7

[Technical Brief on Gender Equity](#)

### **3.3.6 Support community mobilization and human rights advocacy.**

Empowering communities through legal literacy and mobilization to protect and promote human rights strengthens the HIV response, civil society, and health systems. Supporting community mobilization and human rights advocacy, particularly when spearheaded by key population-led organizations, creates an enabling environment for access to, and uptake of, HIV services. Advocacy activities can include public campaigns, sensitization workshops, working with media to improve coverage of key populations and HIV issues, or partnering with organizations that have similar civil-rights objectives. Advocacy should always be planned and conducted with care for the safety and security of key population members taking part, as well as planning to address negative reactions against key populations that may result from advocacy.



[HIV Information Note](#), Section 3.2.7.viii

[Modular Framework Handbook](#), p.110

[Technical Brief on Removing Rights-Related Barriers to HIV Services](#),  
Section 3.2.8

## Annex 1: List of Abbreviations

<b>APN+</b>	Asia Pacific Network of People Living with HIV/AIDS
<b>ART</b>	Antiretroviral Therapy
<b>CBO</b>	Community-Based Organization
<b>CLO</b>	Community-Led Organization
<b>CCM</b>	Country Coordinating Mechanism
<b>CSS</b>	Community Systems Strengthening
<b>DVR</b>	Dapivirine Vaginal Ring
<b>GBV</b>	Gender-Based Violence
<b>IBBS</b>	Integrated Biobehavioral Survey
<b>IPCQS</b>	Integrated People-Centered Quality Services
<b>LAC</b>	Long-Acting Cabotegravir
<b>NGO</b>	Non-Governmental Organization
<b>OAMT</b>	Opioid Agonist Maintenance Treatment
<b>OAT</b>	Opioid Agonist Therapy
<b>OST</b>	Opioid Substitution Therapy
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PrEP</b>	Pre-Exposure Prophylaxis
<b>RSSH</b>	Resilient and Sustainable Systems for Health
<b>SRH</b>	Sexual and Reproductive Health
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>TPT</b>	Tuberculosis Preventive Therapy
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>WHO</b>	World Health Organization

## Annex 2: Glossary

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** (which in this technical brief are also referred to as **community-led organizations and networks**) are entities whose governance, leadership, staff, spokespeople, members and volunteers reflect and represent the experiences, perspectives and voices of 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. These organizations and networks and their expertise are anchored in their lived experiences as key populations, which determine their priorities.

**Gay men and other men who have sex with men** refers to all men who engage in sexual relations with other men, regardless of whether they also have sex with women or identify personally or socially as gay, bisexual or heterosexual.

**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** refer 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. 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. Nonetheless, 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, transgender and gender diverse adults (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, takes many forms, and varies

between and within countries and communities. Sex work may also vary in the degree to which it is “formal” or organized. For further information, see the [UNAIDS Guidance Note on HIV and Sex Work](#) (2012).

**Transgender and gender diverse people** are people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender and gender diverse 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** refer 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.

## Annex 3: Key Resource Documents

### The Global Fund<sup>x</sup>

[Global Fund Strategy 2023-2028](#), 2022.

[HIV Information Note](#), 2022.

[Gender Equality: Technical Brief](#), 2019.

[Removing Human Rights-related Barriers to HIV Services: Technical brief](#), 2022.

[Harm Reduction for People who Use Drugs: Technical Brief](#), 2022.

[Prisons and Other Closed Settings. Priorities for Investment and Increased Impact: Technical Brief](#), 2022.

[Resilient and Sustainable Systems for Health Information Note](#), 2022.

[Community Systems Strengthening: Technical Brief](#), 2022.

[The Global Fund sustainability, transition and co-financing policy](#), 2016.

[Prioritization Framework for Supporting Health and Longevity among People Living with HIV](#), 2022.

[Modular Framework Handbook](#), 2022.

### Global policy

[Global AIDS Strategy 2021-2026](#). UNAIDS, 2021.

[HIV Prevention 2025 Road Map](#). Global HIV Prevention Coalition, 2022.

[In Danger: UNAIDS Global AIDS Update 2022](#). UNAIDS, 2022.

[Political Declaration on HIV and AIDS](#). United Nations, 2021.

### General

[Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations](#). WHO, 2022.

[Implementing Comprehensive HIV and STI Programmes with Sex Workers: Practical Guidance from Collaborative Interventions](#) – informally known as the SWIT. WHO, 2013.

[Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men: Practical Guidance for Collaborative Interventions](#) – the MSMIT. UNFPA, 2015.

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



[Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions](#) – the TRANSIT UNDP, 2016.

[Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions](#) – the IDUIT. UNODC, 2017.

[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, 2011

[Recommended Population Size Estimates of Men Who Have Sex with Men](#). UNAIDS & WHO, 2020.

[Biobehavioural Survey Guidelines for Populations at Risk of HIV](#). Global HIV Strategic Information Working Group, 2017.

[Programmatic Mapping Readiness Assessment for Use with Key P](#). FHI 360/LINKAGES, 2017.

[Consolidated HIV Strategic Information Guidelines](#). WHO, 2020.

[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.

[Global AIDS Monitoring 2022: Indicators for Monitoring Progress on the 2021 Political Declaration on HIV and AIDS](#). UNAIDS, 2021.

[Establishing Community-led Monitoring of HIV Services](#). UNAIDS, 2021.

[Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs](#). FHI 360/LINKAGES, 2020.

[Unique Identifier Codes: Guidelines for Use with Key Populations](#). FHI 360/LINKAGES, 2016.

## **Program design, implementation, and management**

[Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring](#). WHO, 2022.

[Differentiated and Simplified Pre-exposure Prophylaxis for HIV Prevention: Update to WHO Implementation Guidance](#). WHO, 2022.

[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, 2012.

[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.

[Consolidated Guidelines on HIV Testing Services \(WHO, 2019\)](#)

[HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs](#). UNODC, 2019.

[Harm Reduction and Brief Interventions for ATS Users](#). WHO, 2011.

[HIV Prevention, Testing, Treatment, Care and Support in Prisons and Other Closed Settings: A Comprehensive Package of Interventions](#). UNODC, ILO, WHO, UNFPA, UNAIDS & UNDP, 2020.

[Key Population Trusted Access Platforms](#). Global HIV Prevention Coalition, 2020.

[Peer Navigation for Key Populations: Implementation Guide](#). FHI 360/LINKAGES, 2017.

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[Consolidated Guidelines on Person-centred HIV Patient Monitoring and Case Surveillance](#). WHO, 2017.

[Virtual HIV Interventions: A Budgeting and Programming Aid](#). FHI 360, 2022.

[Framework on Integrated, People-centred Quality Services](#). WHO, 2016.

## **Critical enablers**

[Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses](#). UNAIDS, 2012.

[Risks, Rights 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.

[LINKAGES Violence Prevention and Response Series](#). FHI 360/LINKAGES, 2019.

[Safety and Security Toolkit: Strengthening the Implementation of HIV Programs for and with Key Populations](#). FHI 360/LINKAGES, 2018.

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9. [Recommendations and Guidance on Hepatitis C Virus Self-testing](#). WHO, 2021.
10. [Community Management of Opioid Overdose](#). WHO, 2014.
11. [HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs](#). UNODC, 2019.
12. [Technical Brief 2020 update: HIV Prevention, Testing, Treatment, Care and Support in Prisons and Other Closed Settings: A Comprehensive Package of Interventions](#). UNODC, 2020.
13. [Consolidated Guidelines on HIV Testing Services](#). WHO, 2019.
14. [Guidelines on HIV Self-testing and Partner Notification](#). WHO, 2016.
15. [WHO Recommends HIV Testing by Lay Providers. Policy Brief](#). WHO, 2015.
16. [Global Plan to End TB 2023-2030](#). Stop TB Partnership, 2022.
17. [Key Populations Brief: People Living with HIV](#). Stop TB Partnership, n.d.
18. [WHO Policy on Collaborative TB/HIV Activities: Guidelines for National Programmes and Other Stakeholders](#). WHO, 2012.

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  20. [International Standards for the Treatment of Drug Use Disorders](#). WHO, 2020.
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  23. [UNAIDS Gender Assessment Tool: Towards a gender-transformative HIV response](#). UNAIDS, February 2019.
  24. [Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS](#). New York: United Nations, 2011.
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  26. [Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030](#). United Nations, 2021.
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