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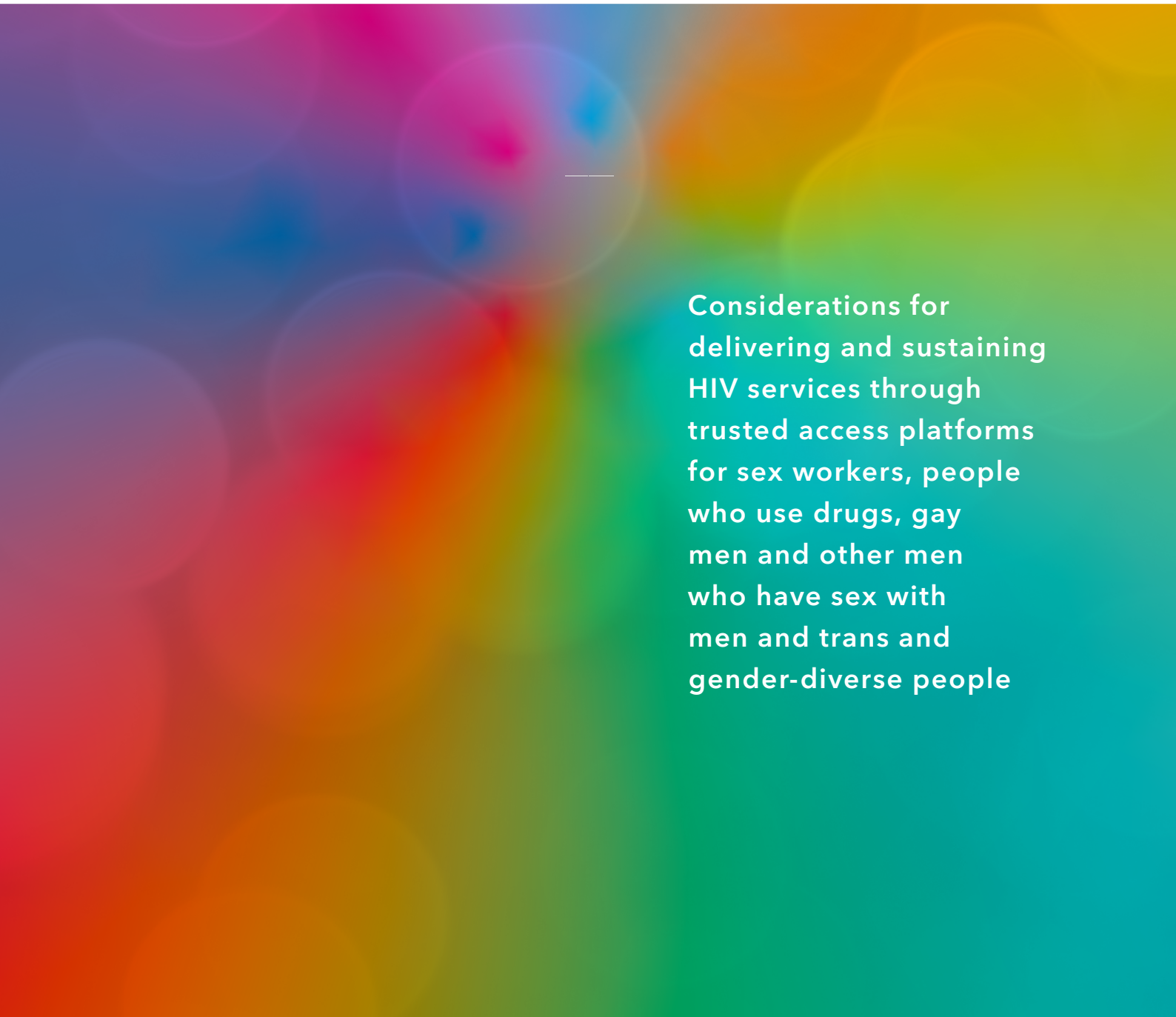
Global HIV Prevention Coalition

PLANNING AND MANAGING

HIV PROGRAMMES

WITH KEY POPULATIONS



Considerations for delivering and sustaining HIV services through trusted access platforms for sex workers, people who use drugs, gay men and other men who have sex with men and trans and gender-diverse people

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ACKNOWLEDGEMENTS

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ABBREVIATIONS AND ACRONYMS

ABYM	adolescent boys and young men
AGYW	adolescent girls and young women
ART	antiretroviral treatment
CBO	community-based organization
CLM	community-led monitoring
CLO	community-led organization
FP	family planning
GBV	gender-based violence
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	hepatitis B virus
HCD	human-centred design
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IRB	Institutional Review Board
KP	key population
KPLHS	key population-led health services
KVP	key and vulnerable population
MSM	gay men and other men who have sex with men
NACO	National Aids Control Organization
NSP	needle–syringe programme
OAMT	opioid agonist maintenance treatment
PEPFAR	United States President's Emergency Plan for AIDS Relief
PEP	post-exposure prophylaxis
PPM	participatory programme mapping
PrEP	pre-exposure prophylaxis
PSE	population size estimate
PWID	people who inject drugs
PWUD	people who use drugs
RRR	reach, recruit and retain
RRTR	reach, recruit, test and retain
RRTTPR	reach, recruit, test, treat, prevent and retain
SACS	State AIDS Prevention and Control Societies
STI	sexually transmitted infection
SW	sex worker
TAP	trusted access platform
TB	tuberculosis
TG	trans and gender-diverse people
TSU	technical support unit
U=U	Undetectable = untransmittable
UIC	unique identifier code
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

FIGURES

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OVERVIEW

This guidance provides a comprehensive view of how to plan and manage HIV programmes with key populations. It need not be read chronologically or in its entirety; programme planners may refer to the relevant sections that are most useful to them. The purpose of this overview is to help the reader navigate the report for selective reading.

Part 1: Building Trusted Access Platforms

Section	What is included
1.1. Understanding trusted access platforms	Explains what is meant by a 'trusted access platform' approach, emphasizing the importance of different types of service providers working together to provide access to a broad a range of the services/interventions recommended by the World Health Organization.
1.2. Key elements of a trusted access platform approach	Provides detailed descriptions of the different types of service providers that can be built into a trusted access platform. This includes peer outreach, virtual service delivery, community safe spaces, health facilities, mobile clinics and others.
1.3. Planning and adapting trusted access platforms and structural considerations	Describes the main principles for planning trusted access platforms, including how to ensure that the different elements work together. It discusses how planners—including key population representatives—need to balance the optimal situation to overcome barriers with the resources available when designing a trusted access platform.
Part 2: Management for Scale and Impact	
2.1. Updating mapping and population size estimates	Outlines different methods for estimating population sizes and mapping key population communities. It offers alternatives to large-scale surveys and proposes segmenting by risk profile for refined size estimates of those in need.
2.2. Conducting effective programme oversight	Offers a framework of key questions for programme planners to determine the effectiveness of a trusted access platform. It covers the relevant monitoring and evaluation tools that are needed to conduct effective programme oversight.
2.3. Monitoring selected outcomes and impact	Expands programmatic monitoring to include key outcomes (i.e. viral load suppression) and even impact (i.e. new infections). A series of light-touch survey methodologies are proposed, which may be regularly repeated at low cost.
2.4. Embedding community-led monitoring	Emphasizes the importance of CLM, led by key populations, to improve the availability, accessibility, acceptability and quality of services in trusted access platforms. Different CLM methodologies are listed.
2.5. Strengthening community capacity and leadership	Draws the link between community empowerment and effective key populations programming. It focuses on providing technical support and formalized training with a view to sustaining trusted access platforms within the public system.
2.6. Sustaining programmes for lasting impact	Situates key populations trusted access platforms within the broader sustainability agenda, underscoring the need for social contracting, integration into primary care and other strategies.
Annexes	
Part 1 Annexes (1–3)	Provides added guidance on cost benchmarking, outreach roles and responsibilities, and how access platforms evolve.
Part 2 Annexes (4–6)	Offers some examples and templates for costing and budgeting different monitoring activities.

PREFACE

Since the Global HIV Prevention Coalition (GPC) began updating this guidance in late 2024, there have been profound shifts in the HIV funding landscape. The United States of America abruptly cancelled more than a third of its bilateral HIV budget in Fiscal Year 2025 (FY25), and has proposed to maintain these cuts in FY26.[2,3,4] The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) reduced country allocations by 11% for Grant Cycle 7 amid a shortfall in pledge conversions.[5] Other countries such as France, the Netherlands and the United Kingdom have also announced reductions in foreign aid of 40–70% in 2026.[6]

The full nature and extent of these funding cuts are unclear, but programmes for and with key populations appear to be heavily impacted. By some estimates, as many as 3.5 million key population members are no longer covered by specialized HIV prevention services.[7] The relative increase in new HIV infections could be 1.3 to 6.0 times higher among key populations compared to non-key populations (outside of Africa), depending on the funding cut scenario.[8]

However, not all countries are equally affected by the funding crisis. Many of the GPC's upper middle-income countries, especially those in Latin America and Asia, face minimal adjustment. Even in Africa, the cuts vary significantly, from more than 50% in some countries to less than 25% in others.[9]

This guidance aims to strike a balance—describing how to optimally plan and manage HIV programmes for and with key populations while acknowledging the severe funding constraints that many countries face. It does not venture into prioritization, which is well covered elsewhere.[10,11,12] Instead, the update contains new guidance on sustainability (Section 2.6), cost benchmarking (Annex 1) and how to combine service delivery approaches depending on available resources (Figure 10). These aim to support countries to confront funding challenges.

INTRODUCTION

What is this guidance about?

Sex workers, people who inject drugs, gay men and other men who have sex with men, and trans and gender-diverse people are disproportionately affected by HIV in almost every part of the world. Their heightened vulnerability to the acquisition of HIV, viral hepatitis and other sexually transmitted infections (STIs) arises from a range of behavioural, social, legal, structural and other contextual factors, and obstructed access to health and other essential services that would enable them to protect themselves. The same factors mean that members of those groups are less likely to obtain the effective treatment and support they need when they are HIV positive. In addition, within each of these groups there are complex intersections between the factors described above and their age, gender, disability, education, race, religion and socioeconomic status.

These groups are all considered to be 'key populations' in the HIV response. Addressing their needs is critical for their health and well-being and is central to local, national and global efforts to end AIDS as a public health threat by 2030.[a] For responses to HIV to work for key populations, the different factors described above must be addressed effectively, and at scale. This report provides guidance on how to achieve this.

Central to the approach described in this guidance are the concepts of access and trust. To meet the needs of key populations, it is essential to ensure that they can access the information, services and support they need, when and where they need it, and from sources and providers that they can trust.

What trust means varies for different individuals and for different types of service; this means that people from key populations must be involved in the planning, delivery and monitoring of services and programmes. It also means addressing the structural factors that affect access to services and vulnerability to HIV and other infections, including stigma, discrimination and violence. Part 1 of this report describes a *trusted access platform* (TAP) approach to doing this.

Also central to this guidance is scale, because ending AIDS as a public health threat means ensuring that individuals from key populations are able to access what they need. Achieving scale requires robust data and careful planning and allocation of resources. Considerations related to achieving scale and allocating resources are addressed in Part 2.

Sound public health has become more challenging in many contexts due to societal stigma and the introduction of policies and legislation that go against global human rights and equity standards. This report also describes how to incorporate structural interventions that are needed to achieve trusted access to services for key populations.

a. While people in prisons and other closed settings are generally also considered key populations in the context of HIV, they are not covered in this report.

Who is this guidance for?

Parts 1 and 2 of this guidance focus on developing and supporting TAPs from two different perspectives. Part 1 focuses on the individual, community and local or operational perspective, while Part 2 concentrates on the national or strategic perspective. As such, they will be useful for different audiences, with Part 1 aimed at local-level implementers and managers, including community-led organizations (CLOs) and public sector health-care providers as well as strategic decision-makers. Part 2 is aimed at national level strategic decision-makers (including members of key populations) and those responsible for allocating resources to end AIDS as a public health threat.

PART 1
BUILDING TRUSTED ACCESS PLATFORMS

1.1. Understanding trusted access platforms

1.1.1. What is a trusted access platform approach?

A TAP approach seeks to ensure that members of key populations can safely access the HIV prevention and treatment and related services they need. In this approach, members of key populations benefit from, and have access to, the services that meet their needs. For access to be effective, key populations need to have high levels of trust in both the service and those providing it. One of the most effective ways of achieving and maintaining this trust is to engage key populations in the design, delivery and monitoring of services.

This approach recognizes that services can be delivered through multiple modalities and in different ways. Depending on the service, this can include: public or private health facilities; dedicated drop-in centres and safe spaces; community outreach workers; virtual outreach and service provision; local businesses, including pharmacies; and social protection services. They work together to build trust, to meet the needs of diverse key populations and encourage their uptake and retention in services. All of the services, facilities and implementers that are trusted by key populations can be thought of collectively as the platform.

Platforms will differ between countries and key populations and even within countries since in any given location there will be a different set of actors providing services. Moreover, key population trust in these actors also varies in each location and can change over time. The platform also provides a mechanism for making changes to meet needs such as bringing on board new trusted providers, or incorporating new interventions as needs evolve (Box 1).

Box 1

Features of a Trusted Access Platform

The features of TAPs include the following:

- They provide safe and secure access to HIV and broader health services for people who face the greatest barriers.
- They offer a range of services and options for obtaining them by combining different providers or means of access.
- They facilitate continued service use.
- They build on the capacities that exist in a given location.
- They address human rights related barriers to services.
- They provide information for communities to lead healthy lives.
- They are person and community-centred, responding to needs quickly and identifying and adapting to new issues.
- They recognize and respond to the needs of different individuals, including young key populations and individuals who are part of more than one key population.

- Individuals from key population communities are involved both as service users and as service implementers: a TAP relies on cooperation between these two groups, and key population-led organizations are often part of a TAP.

In any given location, there may be more than one option that key populations trust. Platforms can range from a 'one stop shop'—a dedicated key population-led provider providing a wide range of services—to a mix of different providers, some key population-specific and some serving the broader population which provide a narrower range of services. These options for accessing services reflect the needs and preferences of different key population communities and community members. The range of options available will depend on the capacities and resources of local actors, available funding and the environment (for instance, social attitudes, legal contexts and the behaviour of law enforcement officials towards key populations). Having a range of options for service access is a critical component of maximizing reach, uptake and retention (Figure 1).

Whatever the make-up of a platform, coordination and collaboration between the different entities and actors involved helps to ensure that individuals from key populations receive confidential and safe referrals and supports ongoing follow-up and joint efforts to reach individuals who are not accessing services. It also enables the different entities within the platform to share information and to identify and adapt to any changes (Box 2).

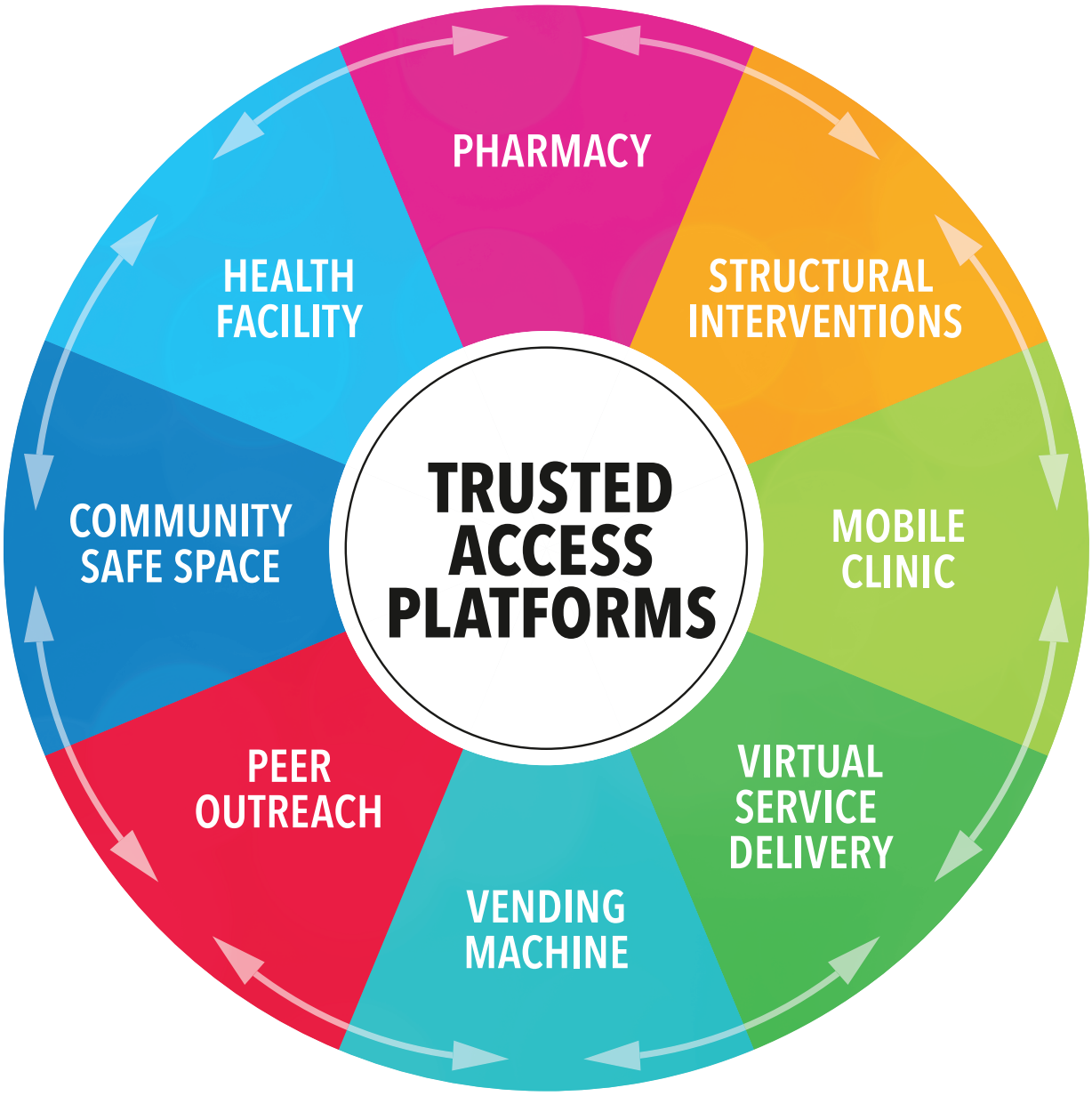
Box 2

Trusted Access Platforms: What's in a Name?

A trusted access platform is a conceptual approach, rather than a fixed programme design. Key population programmes have achieved trusted access in many different ways without necessarily using the term 'trusted access platform'. As such, the examples in this report illustrate how programmes and platforms have achieved trusted access rather than being limited to those referred to as TAPs.

TAPs derive their effectiveness from the engagement and involvement of key populations. Establishing and maintaining trust requires continuous work with members of key populations to understand and respond to their current, evolving and broader needs and to address barriers to access. This requires not only improving trusted entry points to services, but also close collaboration on programme design, implementation and monitoring, and on addressing structural and social barriers.

Figure 1. Key population trusted access platforms combine various service delivery approaches



1.1.2. Why adopt a trusted access platform approach?

When key populations can access support and services when and where they need them and in a way that they trust, there are much higher levels of service engagement and uptake—and therefore, positive health impact. The Prevention 2030 Global Access Framework elevates TAPs as an essential component of a person-centred approach.[13]

Examples from diverse settings report near optimal outcomes for condom use, HIV testing uptake, screening and treatment for other STIs, pre-exposure prophylaxis (PrEP) uptake, access to antiretroviral therapy and retention in care with minimal loss to follow-up.[14,15,16]

A TAP approach can help meet a wider range of needs by bringing together different providers. The approach lends itself to greater sustainability since it is based in the first

instance on the health facilities (primary, specialist and private) and other assets that already exist, such as community organizations and social and welfare services, and on adapting to the context to meet the needs of members of key populations.

In addition, a TAP provides opportunities to adapt how services are provided and to add new services over time. This is because direct key population involvement makes it possible to identify emerging needs and to identify how best to introduce innovations.

Moreover, routine data from well-designed community-based platforms can be reliable, easy to interpret and used to monitor access of key population members to the services they need. It also permits timely identification of problems, co-creation and implementation of solutions at local level. Community-led monitoring of service access, quality, stigma and discrimination, violence and more at local level facilitates continuous improvement of services and delivery approaches for key populations.

Because it is based on local knowledge and adaptation, the approach also enables key population representatives and service providers to better identify and address the needs of subpopulations such as young key populations and those who are part of multiple key population groups and therefore have a wider range of needs (Box 3).

Box 3

Smart Ladies in Kenya[17]

Smart Ladies started as an informal network of sex worker peer educators in Nakuru, Kenya, that facilitated the formation of a trusted platform for sex workers by:

- Developing partnerships across the county to scale their work.
- Partnering with other key populations and law enforcement to ensure greater protection of rights.
- Partnering with clinics and paralegals to provide emergency medical and legal responses to those affected by violence.
- Partnering with a range of health-care providers to ensure access to comprehensive HIV prevention and treatment services.

This approach enabled trusted access to HIV, broader health and human rights for thousands of sex workers. This success led to the ability to meet immediate community needs—related to violence—and ensure that key partner organizations were able to provide acceptable and trusted services.

1.1.3. What services and other interventions can be made available through a trusted access platform approach?

A number of services and other interventions have been identified as essential to an effective response to HIV for key populations. These interventions, and the evidence behind them, are set out in detail in WHO's *Consolidated guidelines on HIV, viral*

hepatitis and STI prevention, diagnosis, treatment and care for key populations (Consolidated Guidelines) (Box 4).[18]

The WHO *Consolidated Guidelines* refer to interventions when describing any activity or undertaking that should be included in a key population programme. In this guidance, the term 'service' is used to describe any intervention that is directly targeted to an individual from a key population (for instance, condom distribution, information, testing, treatment). When this report uses the term 'intervention', it is following the *Consolidated Guidelines* in referring both to services and to the broader set of actions (such as structural interventions or programme mapping) that are aimed at the programme or environment rather than at individuals.

The science for HIV prevention is constantly evolving, with new interventions being developed, tested and approved. Particularly important in recent years have been the advances in long-acting PrEP, in multiplex testing for HIV and STIs, and in new contraceptive/preventive devices. For instance, in 2024 WHO published an implementation tool on oral and long-acting PrEP,[19] and in July 2025 WHO issued a new recommendation and guidelines in favour of twice-yearly injectable lenacapavir for HIV prevention.[20] Based on this guideline, WHO also recommended rapid HIV testing which will remove barriers to access to long-lasting injectable drugs. It is important for programmes to keep abreast of these developments, act quickly to obtain national registration and financing and deploy them to key populations once they have been approved by WHO.

Box 4

Services versus Interventions

The WHO *Consolidated Guidelines* refer to interventions when describing any activity or undertaking that should be included in a key population programme. In this guidance, the term 'service' is used to describe any intervention that is directly targeted to an individual from a key population (for instance, condom distribution, information, testing, treatment). When this report uses the term 'intervention', it is following the *Consolidated Guidelines* in referring both to services and to the broader set of actions (such as structural interventions or programme mapping) that are aimed at the programme or environment rather than at individuals.

In the 2022 WHO *Consolidated Guidelines*, the interventions are categorized as follows:

- *Essential for impact enabling interventions*. Structural interventions that form the bedrock to removing barriers and establishing trusted access. While some of these interventions reach individuals directly, others are cross-cutting and aimed at improving the overall environment.
- *Essential for impact health interventions*. Services with a direct effect on HIV prevention and treatment outcomes, as well as viral hepatitis and STIs.

- *Essential for broader health interventions*. Services related to health needs beyond HIV, hepatitis and STIs, and that are specific to each key population group.
- *Supportive interventions*. Individually focused services that strengthen the knowledge, skills and self-efficacy of key population members.

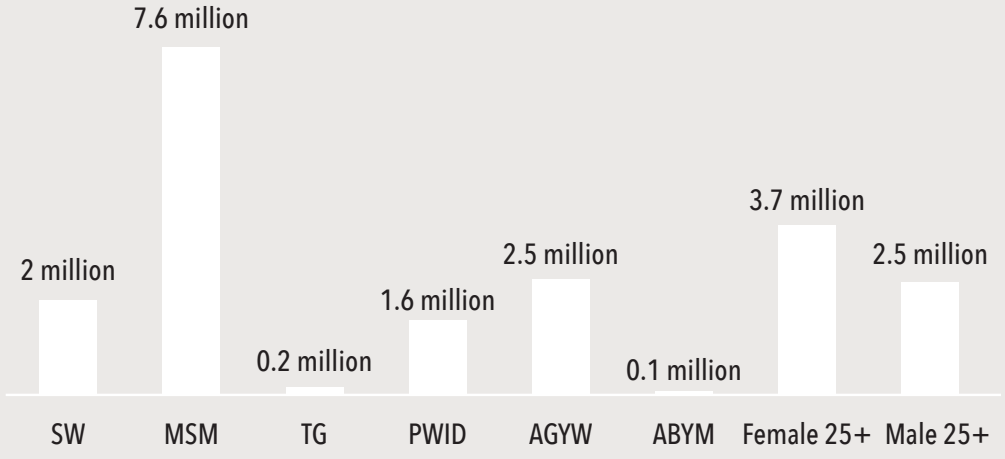
While many interventions are common to all or most of the four key populations, there are some important differences shown in Table 1 which summarizes the WHO *Consolidated Guidelines*, identifying which interventions are relevant for each of the four key populations. WHO has also published Policy Briefs describing recommended interventions for sex workers,[21] people who inject drugs,[22] gay men and other men who have sex with men[23] and trans and gender-diverse people[24] to accompany the *Consolidated Guidelines*. It has also published a good practice report on behavioural counselling interventions for key populations which clarifies the evidence in this area.[25]

Although the *Consolidated Guidelines* recommend that members of key populations have access to all the interventions, the extent to which each is available in every country will depend on the country context, policies and resource availability as outlined in WHO's June 2025 guidance on service prioritization in a changing funding landscape (Box 5).[26]

Box 5

2030 Global PrEP Targets for Key Populations

The Prevention 2030 Global Access Framework aims to have 20 million people using different forms of PrEP by 2030. This includes 2.0 million sex workers (SW), 7.6 million gay men and other men who have sex with men (MSM), 1.6 million people who inject drugs (PWID), 0.2 million transgender people (TG), 2.5 million adolescent girls and young women (AGYW) and 0.1 million adolescents boys and young men (ABYM). Trusted access platforms are essential for key populations to initiate and continue taking PrEP, including newer long-acting options.



Part 1.2 deals with the different types of service provider or entity that can make up a TAP, while Part 1.3 deals with planning, assembling, coordinating and adapting the different parts of a platform at local level as well as cross-cutting structural considerations (see Annex 1 on cost benchmarking for select key populations interventions).

Table 1: Recommended interventions for key populations from the WHO *Consolidated Guidelines 2022*[27]

Intervention	Sex workers	People who inject drugs	Men who have sex with men	Trans and gender diverse people
Essential for impact: enabling interventions				
Removing punitive laws, policies and practices	✓	✓	✓	✓
Reducing stigma and discrimination	✓	✓	✓	✓
Community empowerment	✓	✓	✓	✓
Addressing violence	✓	✓	✓	✓
Essential for impact: health interventions				
Prevention of HIV, viral hepatitis and STIs				
Harm reduction (needle–syringe programmes (NSPs), opioid agonist maintenance treatment (OAMT) and naloxone for overdose management)		✓		
Condoms and lubricant	✓	✓	✓	✓
Pre-exposure prophylaxis for HIV	✓	✓	✓	✓
Post-exposure prophylaxis for HIV and STIs	✓	✓	✓	✓
Prevention of vertical transmission of HIV, syphilis and hepatitis B virus (HBV)	✓	✓	✓	✓
HBV vaccination	✓	✓	✓	✓
Addressing chemsex	✓	✓	✓	✓
Diagnosis				
HIV testing	✓	✓	✓	✓
STI testing	✓	✓	✓	✓
Hepatitis B and C testing	✓	✓	✓	✓
Treatment				
HIV treatment	✓	✓	✓	✓
Screening, diagnosis, treatment and prevention of HIV associated TB	✓	✓	✓	✓
STI treatment	✓	✓	✓	✓
HBV and hepatitis C virus (HCV) treatment	✓	✓	✓	✓
Essential for broader health: health interventions				
Anal health	✓		✓	✓
Conception and pregnancy care	✓	✓		✓
Contraception	✓	✓		✓
Mental health	✓	✓	✓	✓
Prevention, assessment and treatment of cervical cancer	✓	✓		✓
Safe abortion	✓	✓		✓

Intervention	Sex workers	People who inject drugs	Men who have sex with men	Trans and gender diverse people
Screening and treatment for hazardous and harmful alcohol and other substance use	✓	✓	✓	✓
TB prevention, screening, diagnosis and treatment	✓	✓	✓	✓
Gender affirming care				✓
Supportive interventions				
Information and education which help key populations understand their health, health risks, available services and legal rights				
Interventions which aim to increase demand (demand creation) for evidence-based HIV, viral hepatitis and STI services				
Supportive counselling which does not aim to change behaviours				
Counselling for mental health issues				

Suggested reading

Global HIV Prevention Coalition. Program self-assessment tool for key populations. Geneva: UNAIDS; 2020 (https://hivpreventioncoalition.unaids.org/resource/hiv-prevention-self-assessment-tool-psat/; accessed 1 March 2025).

Protocol of HIV services for key populations. Dacca: Government of Bangladesh; 2023 (https://asp.portal.gov.bd/sites/default/files/files/asp.portal.gov.bd/page/2d04f70c_c5e5_4d3d_9a13_e8cc7e5af9c9/2024-08-29-10-29-d54bf09d5f4c84dffdbc65eb32ecc78d.pdf; accessed 1 March 2025).

National implementation guidelines for STI and HIV programming among young key populations. Nairobi: Ministry of Health; 2018 (https://www.iavi.org/phocadownload/userupload/National%20Implementation%20Guidelines%20for%20HIV%20and%20STI%20Programming%20among%20YKPs%202018.pdf; accessed 4 May 2020).

Zimbabwe's national key populations HIV and AIDS implementation plan 2019–2020. Harare: National AIDS Council; 2019 (https://www.nac.org.zw/wp-content/uploads/2021/04/Zimbabwes-National-Key-Populations-HIV-and-AIDS-Implementation-Plan-2019-2020-1.pdf; accessed 1 March 2025).

Implementing comprehensive HIV and STI programmes with transgender people (TRANSIT) (UNDP, IRGT, UNFPA, UCSF, JHSPH, WHO). New York: UNDP; 2016 (https://www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-transgender-people-practical-guidance; accessed 1 March 2025).

Implementing comprehensive HIV and STI programmes with men who have sex with men (MSMIT) (UNFPA, The Global Forum on MSM and HIV, UNDP, UNAIDS, WHO, USAID). Geneva: WHO; 2015 (https://mpactglobal.org/wp-content/uploads/2015/11/MSMIT-for-Web.pdf; accessed 1 March 2025).

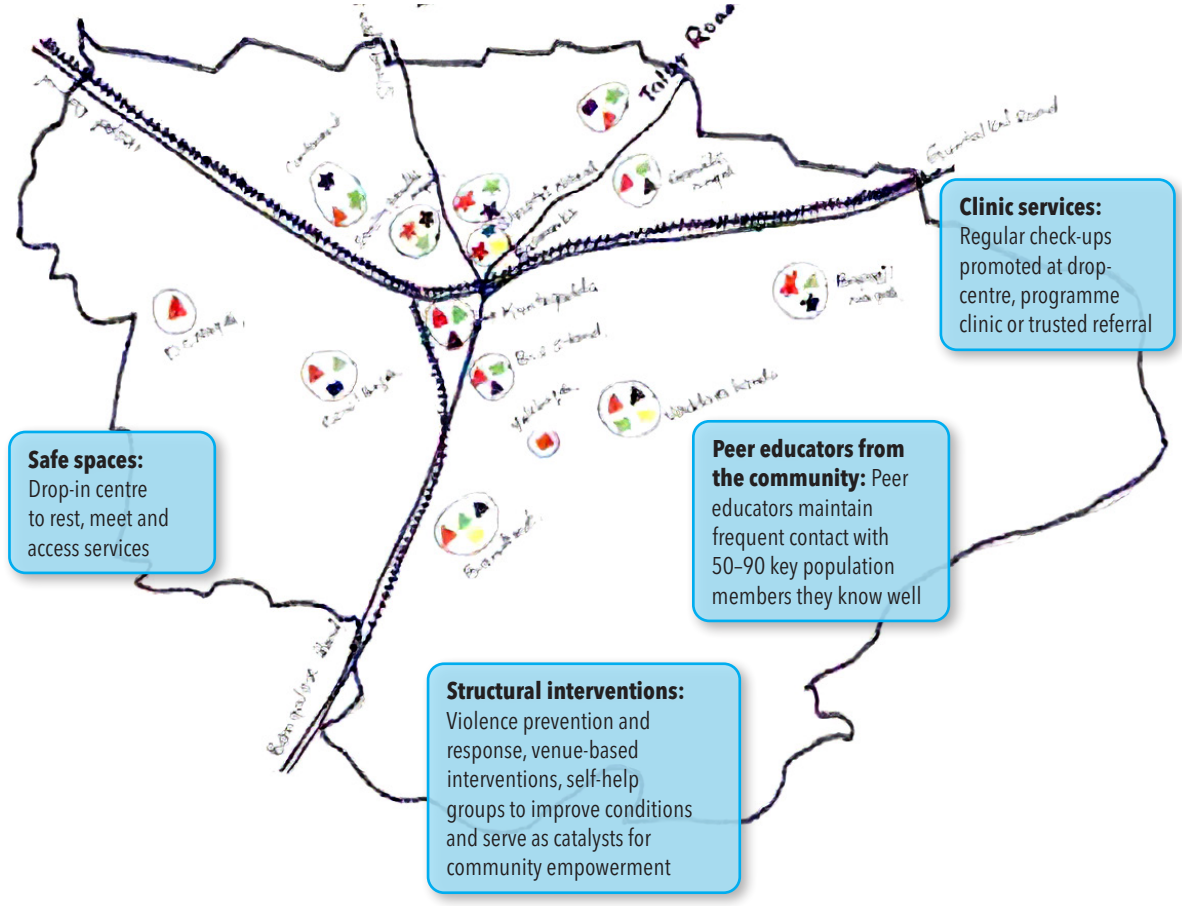
Implementing comprehensive HIV and HCV programmes with people who inject drugs (IDUIT) (UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO). Vienna: United Nations Office on Drugs and Crime; 2017 (https://inpud.net/iduit-implementing-comprehensive-hiv-and-hcv-programmes-with-people-who-inject-drugs/; accessed 1 March 2025).

Implementing comprehensive HIV/STI programmes with sex workers (SWIT) (WHO, UNFPA, UNAIDS, NSWP, The World Bank, UNDP). Geneva: WHO; 2013 (https://www.nswp.org/resource/sex-worker-implementation-tool-swit; accessed 1 March 2025).

1.2. Key elements of a trusted access platform approach

Trusted access to HIV and other health services for key populations can be provided by a range of actors in a given location. What is important is to bring these different actors together to work as a platform. Local maps can be used to identify priority locations where key population members often congregate or where services are being provided, and to identify how they will work together to provide trusted access to these services. This may include using existing service providers and conducting community-level outreach and establishing new service delivery points where access to the existing ones is not satisfactory for key populations. Knowing the characteristics of the location can also help to design the required structural and enabling interventions (Figure 2).

Figure 2. Example of local mapping



This section discusses different types of actors, and the types of services or other interventions from the WHO *Consolidated Guidelines* for key populations that each actor can provide or implement. Each section focuses on a different actor or type of provider: peer outreach; online and virtual programming; community safe spaces; health facilities; mobile clinics; and other actors able to contribute.

1.2.1. Peer outreach

What is it?

Peer outreach is conducted by key population individuals who work directly with their peers at their homes, in health facilities, community or work locations, in venues such as bars, clubs or locations such as where sex work or drug injection take place, and in virtual settings. This section focuses on peer workers conducting physical or face-to-face outreach in communities and venues. The other settings are considered in the following sections.

Depending on the context, peer workers may have different names, such as *peer educators*, *peer workers*, *peer leaders,* or *peer outreach workers*. The different terms used sometimes reflect different functions or emphasis of their work, for instance *peer paralegals*, *peer navigators, PrEP champions*, *adherence support workers,* etc. In all cases they are members of key populations (peers) who provide services where these populations need them—'outreach'. This ensures that advice and services are available in a continuous and trusted way to large numbers of key populations. Peer outreach is also a source of information and advice and provides a bridge to other providers that are trusted by key populations through referrals. Table 2 shows some typical names used for peer workers and their roles and specializations, although it should be noted that these roles often overlap, with some outreach workers able to take on multiple roles.

Because they are themselves members of key population communities, peer outreach workers have the potential to generate high levels of trust, which is the backbone of effective programming. They are the front line for providing trusted access to some of the basic services and interventions identified in the WHO *Consolidated Guidelines*.

Table 2: Different types of peer outreach worker and typical roles

Peer educator	Provide education about HIV prevention, transmission, treatment, other health matters and stigma reduction. Activities include: 1:1 sessions; group discussions; distributing prevention commodities.
PrEP champion	Key population leaders focused on educating, motivating, and supporting others to learn about and access PrEP. They may be current or past PrEP users themselves, which gives them credibility and relatability in their communities.
Peer navigator	Peer workers who are themselves living with HIV and who assist individuals to access HIV testing, care and treatment services, for instance by accompanying them to clinics, assisting with paperwork, following up after diagnosis, and helping overcome barriers to care (e.g. stigma, transport, fear).
Adherence support worker	Peer workers, often also living with HIV, whose role is to support people from key populations living with HIV to remain on treatment and take medication consistently by providing reminders, supporting disclosure, tracking missed appointments and conducting home visits. They work closely with clinicians.
Peer paralegal	Provide basic legal information, support, and advocacy, monitoring human rights violations and providing assistance to those requiring support. They are not lawyers, but they are trained to understand laws, rights, and legal processes relevant to their communities.

What services and interventions are delivered through peer outreach?

Peer outreach is most effective at delivering non-clinical services that key populations require at high frequency or at short notice. While the exact mix of services delivered through peer outreach will depend on national frameworks, resource availability and the profile and specific roles of peer outreach workers, Table 3 lists the services that are almost always delivered through peer outreach (first column) and those that are delivered when required through peer outreach (second column). While all peer outreach workers require training, they may require additional training, supervision and/or accreditation for some of the services in the second column.

Peer workers can potentially also provide services that are not directly related to HIV, but that respond to emergencies faced by key populations through the provision of legal support and first aid as well as promoting and supporting self-care practices. They also support and promote better self-care practices among key populations.

Table 3: Services delivered through peer outreach

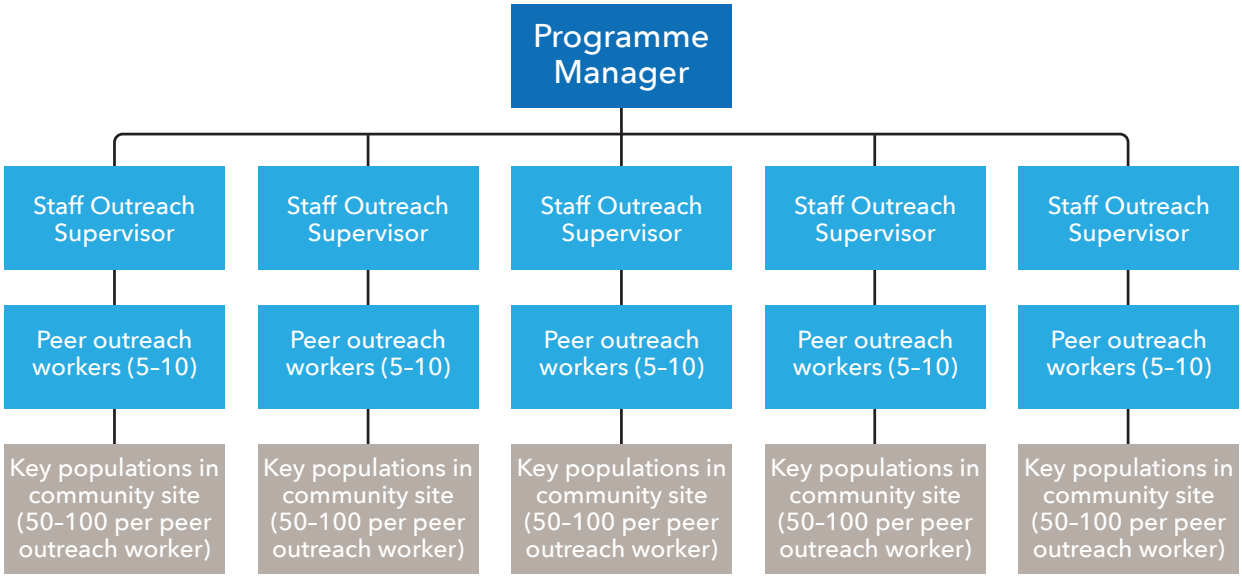
Commonly delivered through peer outreach	Sometimes delivered through peer outreach (depending on need, training, and roles)
Condoms and lubricant	Harm reduction (needles/syringes and naloxone)
Supportive counselling	HIV testing (including supporting self-testing)
Information and education which support key populations to understand their health, health risks, available services and legal rights	HIV treatment (adherence support)
Interventions which aim to increase demand	Contraception
Referral and accompaniment to other services	Counselling for mental health issues
	Addressing violence

How do you do it?

Peer outreach workers systematically visit the places where their community congregates to provide services in a continuous, trusted and safe manner. By maintaining regular contact with the community they are serving, they can identify changes such as arrivals of new individuals, changes in risk factors, security concerns, or repression, and adapt to them. There are well-established, evidence-based norms related to the ratios of peer outreach workers to key population individuals, as well as to training, supervision and management.[28] While peer workers work as a team, a TAP approach connects them to other parts of the platform.

Figure 3 provides a sample organization chart for peer outreach workers and their supervisors under a trusted access platform. Ratios may vary according to the population and resource availability. Annex 2 provides more details on the outreach management and team functions.

Figure 3. Sample organization chart for peer outreach workers under a trusted access platform



There are several elements to establishing and managing effective peer outreach. The key elements are as follows:

- Peer outreach worker selection (and involvement of the broader community in this process).
- Pre-service and in-service training.
- Provision of job aids for peer workers.
- Supervision of peer outreach.
- Microplanning.
- Remuneration.

Peer outreach worker selection

Selection is conducted in a manner that fosters trust. For instance, it can be important for peer workers to be of the same gender (to reach women who use drugs), same HIV status (for peer navigation), same age (to reach older sex workers), or same work environment/lived experience (for instance, brothel-based peer outreach workers for sex workers in brothels). Involving key populations in defining and selecting peer educators helps to ensure that local preferences are followed. The criteria to consider in peer outreach worker selection are as follows (adapted from the implementation tool for gay men and other men who have sex with men[29]):

- Active in the community and available in relevant locations.
- Committed to programme goals.
- Knowledgeable about the local context.
- Accepted by and accountable to the community.
- Tolerant and respectful of different key population profiles.
- Able to maintain confidentiality.
- Listening, communication and interpersonal skills.
- Self-confident and with potential for leadership.
- Strong role model for the behaviour they promote.
- Willing to learn and experiment in the field.
- Available to support peers affected by violence or an emergency.

The appropriate ratios of peer outreach workers to beneficiaries should be applied. Studies have shown that one peer outreach worker to 80–90 sex workers and one to 40–50 gay men and other men who have sex with men are adequate for maintaining the frequent contact required, although the most appropriate ratio will vary at the local level depending on the density of the site, risks, etc.[30] However, ratios should be based on the programme locations and venues—for instance, in locations where key population communities are more cohesive and easier to reach, one peer educator may be able to work with larger numbers.

Similarly, ratios should reflect the specific tasks of the peer outreach worker. For instance, peer navigators, who support key populations living with HIV in treatment access and adherence, often work at ratios of 1:20–30, reflecting the higher workload including the need to work closely with clinical case managers and additional confidentiality requirements associated with their work.

Pre-service and in-service training

Peer outreach workers should be provided with a standard training package that provides all the required skills for the role (noting that different cadres may have different roles). Training should also cover skills such as microplanning, monitoring and safety and security. Ongoing training and job aids should be provided as a refresher or to add further skills/services to the roles of peer outreach workers.

Supervision

Supervision is an essential part of peer outreach worker programmes to ensure their effectiveness as well as to provide the support that workers need if they are involved in difficult environments where they face challenges related to safety, security and mental health. Supervision is often done by more experienced/senior peer leaders who have the necessary literacy and numeracy skills. Supervision is also important for continuous monitoring of outreach activities and for adaptation as new needs or situations emerge. Frequent supportive supervision of peer educators by peer supervisors includes monitoring progress towards targets and planning upcoming work.

Similar to peer worker ratios, peer supervisor ratios will vary by context, but in general peer supervisors can effectively support around five–ten peer outreach workers. Smaller ratios may be appropriate where the outreach worker covers tasks such as adherence support or harm reduction.

Microplanning

Microplanning, or local-level planning, is a pillar of effective peer outreach. It builds on the intimate knowledge of key population communities by mapping the venues where they congregate and interact with peer educators. It empowers key population communities to lead programmes by focusing programme monitoring and decision-making at the local level.

In microplanning, peer supervisors have weekly or fortnightly one-on-one meetings with each peer educator to review the previous one or two weeks of work (collecting forms or entering data for monitoring). They also plan the next week's work.

Several tools have been developed for microplanning[31,32,33,34]:

- Site load map. Aids in planning the number of peer educators needed for the site and prioritizing outreach based on the site's population load.
- Site analysis. Assists in determining the type of peer educator to select and planning the timing of outreach at the site.
- Contact listing. Helps identify the peer educator's social network at the site to confirm if it is the ideal location for the peer worker. Also aids in selecting peer workers for new sites. Often these lists are anonymous/use nicknames to ensure privacy.
- Peer registration form. Facilitates understanding of the risk and vulnerability of each key population and developing an individualized plan. It also aids in creating the peer plan.
- Peer plan. Enables a peer worker to plan outreach activities for the upcoming month based on the individual needs of key populations, prioritizing those who require more attention and support including any new entrants to the community.
- Peer Educator Outreach Calendar. Helps track all key populations within each cohort.
- Violence reporting tool. Documents incidents of violence and provides necessary support. It also assists in ensuring referrals for medical and legal support and conducting evidence-based advocacy against violence.
- Opportunity gap analysis. Identifies the reasons behind gaps and formulates plans to address them while leveraging existing opportunities to improve the programme.

Payment/incentives

Peer workers should be compensated for their work, and ideally there should be standardized terms within a programme or country.

Structural considerations for peer outreach

Although peer outreach programmes help to overcome some of the barriers that key populations face because of stigmatization and criminalization, the programmes themselves can face the same barriers and peer outreach workers, by virtue of being

on the frontlines, face safety and security concerns. It is therefore essential for peer outreach programmes to continually identify and address structural issues that may affect their work. These include:

- Working with local communities and with local leaders, law enforcement and other influential people to build acceptance and legitimacy of the programme and ensure that it is protected; may include sensitization training.
- Establishing a support structure for peer educators affected by violence and other security concerns.
- Embedding safety and security measures into the programme, through assessing risks, training of peer outreach workers, recording of incidents, emergency response procedures, and safe working practices.
- Ensuring data about peer workers and key populations are safely and confidentially stored.[35]
- Means of safe communication to notify of emergencies and security incidents during outreach.
- Obtaining official agreement for the programme activities, including written permission and ID cards. However, this is not always appropriate and approaches should be adapted to the context.
- Ensuring peer outreach workers understand stigma and discrimination and are skilled in addressing these at community level, including addressing internalized stigma among their peers.
- Monitoring of security incidents and human rights violations.
- Providing paralegal support and access to legal services and redress mechanisms.

Budgeting considerations

The key points to consider in budgeting for peer outreach programmes are as follows:

- Sufficient number of peer educators based on the population of the locality and the necessary ratios; and sufficient peer supervisors.
- Remuneration, travel/phone reimbursements, initial training, refresher training and microplanning materials (e.g. forms, pens/pencils, tablets with associated software development/adaptation and connectivity costs), based on the number of peer educators. Additional training may include integrating treatment and human rights and legal literacy, demand creation for viral load testing, new PrEP formulations, safety and security and new or emerging challenges for the community (e.g. Covid-19, Mpox).
- Microplanning and site validation activities, which include forms, data analysis and remuneration and travel support.
- Sufficient quantity of commodities such as condoms, lubricant, test kits, needles and other harm reduction items. Although these are likely to be procured centrally, it is important that the quantities needed are calculated at site level for each location.

See Annex 1 on cost benchmarking for peer outreach to key populations.

Suggested reading

Micro-planning in peer led outreach programs—a handbook. A handbook based on the experience of the Avahan India AIDS initiative. New Delhi: Bill & Melinda Gates Foundation; 2013 (https://docs.gatesfoundation.org/documents/Microplanning%20Handbook%20(Web).pdf; accessed 2 March 2025).

Bhattacharjee P, Musyoki H, Prakash R, Malaba S, Dallabetta G, Wheeler T, et al. Microplanning at scale with key populations in Kenya: optimising peer educator ratios for programme outreach and HIV/STI service utilization. PLoS One. 2018 (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205056; accessed 2 March 2025).

Impact case: developing an effective community outreach system for the key populations programme in Tanzania Global HIV Prevention Coalition, South to South Learning Network; 2024 (https://drive.google.com/file/d/1LZsGu9nRgu2WD9EhIpQYmnr_yt6jVYTd/view; accessed 2 March 2025).

Draft standard operating procedure to implement effective community-led outreach and microplanning strategies in key and vulnerable population programmes in Tanzania. Nairobi: Partners for Health and Development in Africa; 2024 (https://drive.google.com/file/d/1t7gb8lTAJgeNWK3PVyt5ghXGwpk9W8zE/view?usp=sharing; accessed 2 March 2025).

Thompson LH, Bhattacharjee P, Anthony J, Shetye M, Moses S, Blanchard J. A systematic approach to the design and scale-up of targeted interventions for HIV prevention among urban female sex workers. Karnataka Health Promotion Trust. Washington, DC: World Bank; 2012 (https://documents.worldbank.org/pt/publication/documents-reports/documentdetail/336971468151769158/a-systematic-approach-to-the-design-and-scale-up-of-targeted-interventions-for-hiv-prevention-among-urban-female-sex-workers; accessed 2 March 2025).

USAID, PEPFAR, Linkages, Bill & Melinda Gates Foundation, University of Manitoba. Monitoring guide and toolkit for key population HIV prevention, care and treatment programs. Durham, NC: FHI 360; Linkages; 2020; https://www.fhi360.org/wp-content/uploads/drupal/documents/resource-linkages-monitoring-tools.pdf; accessed 2 March 2025).

1.2.2. Virtual service delivery

What is it?

Virtual platforms have transformed how people get information and services. As connectivity has increased, they have also changed how people interact with each other. Like any other group, many members of key populations have access to and use phones or online platforms to obtain information including support for self-care, to find partners and clients, to receive health services and to purchase health-related products. This section discusses how virtual spaces can be developed and used to reach key populations who have access to these with services as part of a TAP. While this section focuses on online and virtual platforms that are leveraged and developed by programme implementers, Section 1.2.6. Access to services through other actors deals with online modalities that are owned or run by third parties and that can also be leveraged as part of TAPs.

Online approaches can be particularly relevant for key populations where in-person encounters with outreach or health care workers carry the risk of stigmatization, harassment, or arrest.

As social networking sites have evolved, they have created an opportunity for more targeted outreach or discussion, including group and 1:1 chats, apps for advice and decision-making and referrals. Certain types of counselling services, including for mental health, can also be provided virtually either by phone or through online chats and video calls for those with online access and smartphones. In addition, artificial intelligence approaches are increasingly changing the ways in which online programmes can be delivered and increasing the range of services that can be provided.

Which services are delivered?

Online services can act as a substitute or complement for in-person contact, and they can therefore be used to provide some of the services that physical peer outreach provides such as health literacy and HIV prevention and harm reduction information. Similar to peer outreach, they can provide a bridge to physical services by being used to advertise where condoms can be obtained or which health facilities are trusted for providing services to key populations.

They can also help reach much larger key population communities than those that are engaged in in-person services. This can include people who do not disclose their status or identity, those who do not associate themselves with key population communities, or those who want quick, anonymous access to HIV services because they fear disclosure among their community or because of community differences. Virtual support can also enable self-care practices. Table 4 shows the services commonly and sometimes delivered through online/virtual platforms.

A 2022 UNAIDS/WHO policy brief explains the potential of these approaches:

"Virtual case management (also known as targeted client communication) is a virtual intervention used to manage people living with HIV or other conditions. This typically involves the use of virtual tools to support clients in their journeys and engagement

with the health system after diagnosis. Virtual case management can support differentiated service delivery models such as community- or home-based services, including antiretroviral therapy and PrEP initiation and refills, virtual consultations and support, automated or provider-led client reminders, and chatbots. Once reached, interested clients can be supported virtually using tailored, client-centred approaches to help them access services. Services may be fully virtual (e.g. distribution of self-testing kits, online ordering and delivery, virtual support), or they may allow virtual referral and navigation to facilities (e.g. for confirmatory testing after HIV self-testing or initiation of PrEP or antiretroviral therapy). These approaches can be particularly useful to link people to services, such as post-exposure prophylaxis (PEP), needle–syringe services, opioid substitution therapy, HIV testing, identification and referral of people with symptoms of sexually transmitted infections or HIV, contraception, mental health services, and support for people experiencing violence, and to support the client's journey from initiation of antiretroviral therapy to achieving viral suppression." [36]

Table 4: Services delivered through online and virtual programming

Commonly delivered through online and virtual programming	Sometimes delivered through online and virtual programming (depending on need, training, and roles)
Supportive counselling	Condoms and lubricant
Information and education which help key populations understand their health, health risks, available services and legal rights	PrEP for HIV
Interventions which aim to increase demand (demand creation) for evidence-based HIV, viral hepatitis and STI services (referral to other services)	PEP for HIV and STIs
	Testing (HIV self-testing)
	HIV treatment (including adherence support)
	Counselling for mental health issues
	Addressing violence

In addition to the services listed in the table, online mechanisms can also be used to facilitate access to physical services, for instance through online booking and referrals, and can also provide an opportunity for gathering service user feedback on provider attitudes and performance.

How do you do it?

Like everyone else, key populations use the online world organically and are likely to find the platforms and services that most meet their needs. It is therefore important to begin with an understanding of which sites and apps are popular among key populations (including people from different sub-categories who often have different preferences), how they are used, and why. In addition, an understanding is needed of any changes in online habits in the communities since usage is dynamic and can change quite quickly. Gaining this understanding is made easier through active engagement with key population members, which is one of the pillars of a

TAP approach. Tools have been developed to conduct social media mapping that programmes can use as a basis for developing online approaches.[37]

Unlike the physical elements of TAPs discussed in this report, online or virtual approaches are not inherently specific to a given location. This provides opportunities in that advice services, hotlines, or counselling can all be provided through a national or even cross-national approach. The UNAIDS–WHO guide on virtual programming provides advice on how programmes can work with key population members to design, plan and deliver virtual services.[38]

If key populations are effectively accessing good quality services that they trust through online approaches, this means that a programme can increase the ratios required for in-person outreach (see the previous section) (Box 6).

Box 6

Virtual Delivery for Key Populations: an Example from FHI 360[39]

"Between 2017 and 2021, FHI 360 implemented an online outreach and online reservation application (ORA) platform in Mali, Nepal and Thailand. A unique set of activities adapted to the local context, needs and resources was implemented to support community HIV outreach by online outreach workers, based on popular social media applications and internet coverage in each country.

The interventions included online demand creation, such as periodic paid advertisements and online influencer promotions through social media. The interventions were effective in reaching people from priority populations. More than two-thirds (69%) of clients who booked appointments through ORA were first-time testers (47% in Mali, 81% in Nepal). HIV positivity was higher compared with traditional outreach (6.3% versus 4.4% in Thailand, 10.1% versus 3.6% in Nepal, and 15.6% versus 11.2% in Mali).

Online outreach through ORA contributed to the overall prevention, testing and case-finding goals in all three countries. In Thailand, between July 2017 and March 2021, online outreach accounted for 10% of all people reached by the programme, 11% of all people tested for HIV and 15% of all people who tested positive for HIV. In Nepal, between October 2018 and March 2021, online outreach accounted for 9% of all people reached, 4% of all people tested for HIV and 11% of all people who tested positive for HIV."

It is therefore worth investing in online programming at a national level. At the same time, it is necessary to establish links between online provision and the physical services that the user can obtain. Well-designed online services can achieve this. For instance, peer outreach workers operating an online national advice service can access information about local level services that they can use to support referrals for service users.

Key population members should always be involved in the design and implementation of online and virtual services, and key population-led organizations can lead in their implementation.

Structural considerations for online and virtual programming

While online and virtual programming can reduce the possibility of key populations facing stigma, discrimination and violence, the approach does come with risks. The anonymity offered by online interactions can protect key populations, but can also make it easier for attackers to target key populations without consequences. Data protection and confidentiality are particularly important when large amounts of information are collected online. Although not addressed in this guide, it should be recognized that online platforms and influencers can be a source of misinformation and disinformation, and programmes need to be able to counter these risks. Possible protections include:

- Embedding safety and security measures into online programmes, through training of online outreach workers and other providers, recording of incidents and threats, emergency response procedures, and implementing safe working practices.
- Considering data security, safety and privacy policies, in consultation with community members, when developing or working with virtual platforms.
- Identifying unequal levels of access to phones/smartphones among key populations.
- Developing and implementing robust anonymity, confidentiality and data protection mechanisms across all online programmes.
- Monitoring private and public online spaces for harassment, abuse, disclosure of personal data, hate speech and misinformation and instituting mechanisms for responding safely.

Budgeting considerations

As noted above, there are many forms of online and virtual programming and these are likely to be planned and costed nationally rather than locally. Associated costs can include:

- Infrastructure/development (if new products are being developed rather than existing platforms being leveraged).
- Content creation.
- Training of those involved in online outreach and other service provision.
- Internet/data connection costs for implementers and costs associated with providing low-data cost access to key populations.
- Equipment.
- Subscriptions to virtual/online platforms.
- Safety and security measures.

Commodities for prevention are unlikely to be budgeted as part of virtual programming since they would be obtained from physical spaces via referral from the virtual space

Suggested reading

FHI 360. Creating virtual safe spaces for people affected by HIV. 2022 (https://shortyawards.com/7th-impact/creating-virtual-safe-spaces-for-people-affected-by-hiv-providing-stigma-free-mental-health-care; accessed 5 March 2025).

Offering mental health services for LGBTQI+ people in Algeria, Morocco, and Tunisia. Durham, NC: FHI 360; 2022. "(https://unitedgmh.org/app/uploads/2025/03/ilovepdf_merged-1.pdf; accessed 24 November 2025).

Going online to accelerate the impact of HIV programs. Durham, NC; FHI 360 Linkages; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vision-going-online.pdf; accessed 4 March 2025).

Quick online surveys—for planning online HIV outreach and service delivery. Durham, NC: FHI 360; Linkages; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-surveys-planning-online-outreach.pdf; accessed 4 March 2025).

Social influencer outreach—for HIV programs reaching at-risk populations online. Durham, NC: FHI 360; Linkages; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-influencer-outreach.pdf; accessed 4 March 2025).

Social media mapping—for planning online HIV outreach and service delivery. Durham, NC: FHI 360; Linkages; 2019; (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-media-mapping.pdf; accessed 4 March 2020).

Social network outreach—for HIV programs reaching at-risk populations online. Durham, NC: FHI 360; Linkages; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-network-outreach.pdf; accessed 4 March 2025).

Safe queers. Empowering LGBTQ+ organizations in at-risk areas to protect themselves digitally. 2020 (https://safequeers.org/; accessed 4 March 2025).

Virtual interventions in response to HIV, sexually transmitted infections and viral hepatitis. Innovate–implement–integrate. UNAIDS, WHO. Policy Brief. Geneva: UNAIDS; 2022 (https://www.unaids.org/sites/default/files/media_asset/policy-brief_virtual-interventions_en.pdf; accessed 14 April 2025).

Budgeting and resource planning guidance for implementing virtual interventions as part of HIV responses. Geneva: WHO; 2025 (https://www.who.int/publications/i/item/9789240105713).

1.2.3. Service provision through community safe spaces

What are they?

Community safe spaces are welcoming and secure places where members of key populations can go for support, shelter, advice and rest, as well as for HIV or other health related services. They vary widely and can include community drop-in centres, space within a key population organization or another civil society organization, a home of a community member, or even a dedicated room in a regular health facility. The critical point is that members of key populations can trust that they are indeed safe spaces. They are most effective when they are easy to access and located in areas where key population members live and congregate.

Community safe spaces always actively involve key population members as staff and volunteers and are often directly implemented by key population-led organizations.

Which services are delivered?

Because community safe spaces are settings that vary considerably in character and capacity there is a wide range of services that can be delivered through them, as shown in Table 5. They are almost always a way of delivering, in a permanent and safe way, some of the same services that are delivered through peer outreach. In addition, they are also generally amenable to doing group/collective based services that contribute to community empowerment. Enhanced community safe spaces can provide clinical services, either by directly hiring practitioners, or by having medics from other facilities drop in to conduct scheduled clinics. However, even without a clinic component they help increase and sustain demand for services and increase the ability of key populations to organize and self-advocate.

Table 5: Services delivered through community safe spaces

Commonly delivered through community safe spaces	Sometimes delivered through community safe spaces (depending on need, training, and roles)
Community empowerment	Addressing violence
Condoms and lubricant	Harm reduction (NSPs, OAMT and naloxone)
Supportive counselling	PrEP and PEP
Information and education which support key populations to understand their health, health risks, available services and legal rights	HIV testing (including self-testing)
	HIV treatment/other treatment (adherence support)
	Broader health interventions
Referral to other services	Counselling for mental health issues

How do you do it?

As always, the starting point for establishing a safe space is the community itself. Members of key populations should identify the location, accessibility, set-up and characteristics of the space (e.g. opening hours, facilities) and to do this effectively they should be kept informed of the resources available. They may also identify existing venues, including places where the community already congregates, a home of a community member, or a health facility that is supportive and welcoming of key populations, that can be adapted for use as a safe space.

Because of the wide range of services that can be provided through a community safe space, they should be regularly reassessed for the potential to add or change what they provide. Close links between safe spaces and outreach programmes should be maintained, and indeed community safe spaces often also function as planning and meeting spaces for peer outreach workers, and can provide storage for condoms, lubricant, etc.

Structural considerations for community safe spaces

Particular care is needed to ensure that safe spaces are kept secure, that they guarantee privacy, and that they are accepted within communities. They can face many of the same challenges that they are tasked to address in the first place. Ensuring that safe spaces and the activities that are conducted in them are lawful and are acknowledged and supported by local authorities and law enforcement officers is critical, in particular in highly stigmatizing and criminalized environments, so as to avoid safe spaces attracting negative attention.

Safe spaces should have security protocols, including safety measures and safe ways of working, and confidentiality. They should be situated in locations that do not make them more vulnerable to criticism or attack from the broader community and local leaders and authorities.

Budgeting considerations

It is necessary to keep safe space costs at a minimum, especially if they are integrated within existing locations or facilities. However, the key considerations to keep in mind for a basic safe space are as follows:

- Rent.
- Refurbishment.
- Furnishings.
- Utilities.
- Storage space.
- Appropriate facilities for the provision of clinical services when these are included.
- Staffing (paid peer outreach workers and other community members can participate in the staffing of the safe space).
- Communication and internet access.
- Physical security measures, as appropriate, including security personnel and CCTV monitoring.
- Although commodities such as condoms, lubricant, test kits, needles and other harm reduction commodities are likely to be procured centrally, it is important that the volumes needed are calculated at site level so that sufficient quantities are available at each location

Additional considerations may include requirements for enhanced capacity, for instance to implement day clinics or for workshops with community members.

When community safe spaces are implemented or managed by community-led organizations, it is critical that investments be made to strengthen the management and governance capacity of those organizations.

Suggested reading

Trust and choice: Increasing access to HIV services for LGBT people in Mozambique & Uganda. Brighton: Frontline AIDS; 2021 (https://frontlineaids.org/wp-content/uploads/2021/04/FLA-LGBT-Platform-Guide-EN-WEB.pdf; accessed 4 March 2025).

ICAP in DRC provides HIV health services, and supportive, safe spaces to key populations. New York: ICAP Columbia University; 2024 (https://icap.columbia.edu/news-events/icap-in-drc-provides-hiv-health-services-and-supportive-safe-spaces-to-key-populations/; accessed 4 March 2025).

Mathews C, Duby Z, Bunce B, van Blydenstein N, Bergh K, Ambrose A, Safe spaces for beneficiaries of a combination HIV prevention intervention for adolescent girls and young women in South Africa: access, feasibility, and acceptability. BMC Publ Health. 2022;21:22(1):1026 (https://pmc.ncbi.nlm.nih.gov/articles/PMC9123612/; accessed 4 March 2025).

Serving the needs of key populations: case examples of innovation and good practice in HIV prevention, diagnosis, treatment and care. Geneva: WHO; 2017 (https://iris.who.int/bitstream/handle/10665/255610/9789241512534-eng.pdf?sequence=1 accessed 4 March 2025).

1.2.4. Providing services through health facilities

What are they?

Health facilities include primary care centres, or specialized clinics within hospitals (e.g. infectious diseases or HIV departments, STI, family planning, harm reduction or dependence treatment clinics). They are an essential part of a trusted access platform for key populations, in particular where clinical services are either provided in a limited way or not provided at all through community safe spaces or mobile clinical services. To be part of a trusted access platform a health facility has to be competent for key populations. Box 7 describes the characteristics of such a health facility.

Box 7

What is a Key Population-Competent Health Facility?

A health facility competent for key populations:

- Is trusted by key population users who can access the clinic without fear of being treated badly.
- Involves key population leaders/peers in the design, delivery and monitoring of services.
- Provides quality HIV and sexual and reproductive health services that meet the needs of key populations.
- Respects service users' confidentiality and privacy (e.g. private consultation rooms/waiting areas, no signs/labels/materials that may cause stigma, etc.).
- Provides services without judgment, coercion or discrimination and without requiring service users to stop behaviours considered 'risky'.
- Provides opening times that are adjusted around the needs of key populations.
- Has security measures in place to protect the premises, staff and service users.
- Collects and stores service users' confidential data in safe and secure ways that support confidentiality and anonymity.
- Has a system to react and respond to stigma, discrimination and violence that occur within the premises.
- Regularly monitors access to services to assess availability, appropriateness, acceptability and quality of service provision.
- Can exist as standalone health facilities (either public or private) or run as nongovernmental organizations/community-based organizations (i.e. not for profits).

Key population programmes often include dedicated clinics that are established and run almost entirely for the benefit of these groups. This approach can be very effective,

but is only viable if the programme is well-resourced, if there are large numbers of key populations requiring this type of service, and if such a facility can operate safely and within the law. Dedicated facilities can be vulnerable to funding fluctuations and to security problems at the community level, particularly if they become associated with serving highly stigmatized populations.

Existing public or private health facilities can be part of a TAP for key populations provided they are key population-competent, are adapted to provide the services that key populations need, at appropriate times and in a confidential and non-stigmatising way (Figure 7). Members of different key populations sometimes choose public facilities that they trust to offer safe, non-discriminatory care, but often it is necessary to provide training and inputs to ensure that these facilities are competent for key populations.

The characteristics of public and private facilities differ considerably from one location or jurisdiction to another. Most private facilities are independent, but some may be part of a broader network or health insurance mechanism. Members of key population communities sometimes prefer private facilities, in particular when they can offer more discreet services and confidentiality. At the same time, private facilities may not always offer a full range of services and there are often considerable financial barriers to using them. Programmes can work with private facilities to enable them to provide subsidized or free services to key populations, for instance by covering insurance premiums or reimbursing service users who fulfil certain criteria.

Similarly, primary health-care centres and specialized public facilities (e.g. those focused on infectious diseases, HIV or drug dependence) have different capacities and potential to serve key populations.

Which services are delivered?

Table 6: Services delivered through health facilities

Commonly delivered through health facilities	Sometimes delivered through health facilities (depending on need, training, and roles)
Condoms and lubricant	Harm reduction (NSPs, OAMT and naloxone)
Testing (HIV, STI, hepatitis)	Addressing violence
Treatment (including adherence support)	Supportive counselling
Emergency post-violence/trauma care	Information and education which support key populations to understand their health, health risks, available services and legal rights
PEP and PrEP	Demand creation for services
Broader health interventions	Counselling for mental health issues
Referral to other services	

Dedicated key population clinics often provide a specific set of services related to HIV and sexual health, in particular if they are wholly funded by HIV programmes and if the resources do not permit a broader approach. This will also depend on the capacities and clinical specialties of the personnel working in the facility. However, any health facility can potentially provide a broader set of interventions and services, including support for self-care (Table 6).

Public or private facilities that are not dedicated solely to key populations often offer a broader range of services, or as in the case of a public integrated sexual health and family planning clinic, will arrange referrals to other specialties within the same overall facility even if they are not directly covered by key population programme funding. This provides the opportunity to respond to the service user's broader health needs.

Because key populations are advised to monitor their health regularly, programmes can opt for a quarterly or six-monthly check-up system. Regular sexual health check-ups provide clinicians with the opportunity to screen, treat and follow up HIV and STIs; ideally other common health conditions are also covered.

For key populations on PrEP or antiretroviral therapy, regular visits are necessary for clinical management, counselling and refills—the frequency of visits depends on the products and regimens being used, and can also be reduced for stable patients.

People who inject drugs using harm reduction services and people on TB treatment may require far more frequent attendance. There are examples of regular clinic attendance helping to reduce stigma, although the exact approach adopted should be informed by what key populations themselves prefer. The WHO regularly updates recommendations on the need for clinic attendance for different types of service, based on the most recent research. In addition, national guidelines often determine the requirements.

How do you do it?

As with all of the components described above, the fundamental principles for working with health facilities are trust and access. The starting point for working with existing facilities to achieve trusted access for key populations is involvement of the intended service users in the process. Members of key populations will provide insights on their preferences, the services they need, locations and opening hours, as well as concerns that need to be addressed related to the behaviour and attitudes of health-care workers, non-discrimination, safety and confidentiality. This engagement with the intended service users should be continuous, with procedures for ongoing feedback such as community monitoring, observatories, or community feedback meetings and online feedback mechanisms.

Developing community trust in a health facility requires investment in sensitization and training of facility personnel, including clinical, administrative and security staff and enacting policies against discrimination. It can also involve investment in making the facility more accessible, for instance through extended or dedicated opening hours, or creation of separate key population entrances/exits or waiting areas. Special clinic days for different key population groups or family health days can help build trust.

Where resources permit, investing in the capacity of health facilities (whether dedicated for key populations or aimed at the public in general) to provide a broader range of health services can enhance their key population competence or friendliness. Additional services can include gender affirming care, harm reduction, anal health, counselling on risk reduction related to chemsex and keeping up to date on new formulations and regimens for HIV prevention and treatment. Facilities need to be provided with a reliable supply of all of the commodities and equipment needed to provide these services.

Involving members of key populations in service delivery in a health facility is also part of key population competence. Trained key population members can provide a range of services in the facility, including all of the roles described for peer outreach workers, and they can also ensure strong referrals, follow up and coordination between health facilities and community-based and online services included in the platform.

In a given location (town or neighbourhood), multiple health facilities can be part of a TAP. Including both a dedicated clinic and a public clinic expands choice for key populations and can also increase the range of services they can access.

Structural considerations for health facilities

Stigma and discrimination against key populations can be particularly pronounced in clinical settings. In highly stigmatizing or criminalizing environments, key population members have very little trust that they will be treated correctly and confidentially. This is why dedicated facilities have often been adopted as part of key population programmes. When working with established public or private facilities, particular care is needed to ensure barriers are addressed. Otherwise they will not be trusted or used by key populations. As well as active participation of key population members, the following aspects need to be considered in working with any type of health facility:

- Addressing legal barriers such as duty to report any illegal activity.
- Addressing the stigmatizing and discriminatory attitudes of all personnel (clinical, administrative and others) towards key populations through sensitization and training and relevant health facility policies and accountability mechanisms.
- Monitoring and regularly reviewing incidents and threats.
- Safety and security, including physical security measures, to protect the facilities.
- Ensuring licences to operate through agreements with health officials and local authorities.
- Ensuring that all activities conducted are lawful, particularly in environments where legislation may criminalize activities that are supportive of key populations.
- Understanding and acceptance from the broader community; in the case of dedicated clinics this can include open days and ensuring that services are not perceived as being exclusive to key populations.
- Receiving and responding to feedback from service users (e.g. via community monitoring, observatories, consultations, etc.).

Budgeting considerations

Budgeting considerations vary widely depending on whether the facility is owned/established by a programme (for instance a dedicated key population clinic), or is an existing public or private facility. Key elements to consider are as follows:

- Space for providing clinical services (stand-alone clinic or shared with safe space/drop-in centre) if service referral is not utilized.
- Equipment (e.g. examination table, light, diagnostic equipment and reagents, specula or anoscope, sterilization and disposal facilities, data recording equipment and materials).

- Medicines (for STIs and HIV; preferably also for family planning and common general ailments).
- Condoms, lubricant, needles and syringes for clinic-based distribution.
- Training and resources required for ensuring and maintaining discriminatory and stigma free services.
- For trusted referrals: training of health-care providers, monitoring quality and acceptability of service provision, and monitoring and supporting linkage to trusted providers and retention in care.
- Establishment of electronic booking system and creation of referral networks for virtual/online engagement.
- Depending on the service delivery option: clinician salaries or honoraria, clinic space, basic diagnostic equipment, and reagents, medicines, quality controls and supplies.
- Programmes relying solely on trusted referrals to existing health facilities will likely have lower infrastructure/supply costs, but they will need to invest more in mechanisms to ensure that referrals take place, are tracked and are of good quality and in establishing and ensuring key population trust of the service.
- Capacities for other health, harm reduction (e.g. OAMT) or gender-affirming services that key populations want and need, that won't necessarily be covered by HIV specific funding. In addition, some facilities may be able to generate income that contributes towards sustainability by providing elective procedures on a fee-for-service basis that generates income (e.g. wart removal, laser hair removal, etc.).

Suggested reading

FHI (India Country Office). STI clinic supervisory handbook. Comprehensive STI services for sex workers in Avahan-supported clinics in India. Durham, NC: FHI 360; Linkages; 2008 (https://www.aidsdatahub.org/sites/default/files/documents/ STI_Clinic_ Supervisory_Handbook.pdf; accessed 4 March 2025).

Kidd R, Clay S, Stockton M, Nyblade L. Facilitator's training guide for a stigma-free health facility: training menus, facilitation tips, and participatory training modules. Washington, DC: Health Policy Project; 2015 (https://www.healthpolicyproject.com/pubs/281_SDTrainingGuide.pdf; accessed 4 March 2025).

Linkages. Health4All. Training health workers for the provision of quality, stigma-free HIV services for key populations. Durham, NC: FHI 360; Linkages; 2018 (https://www.fhi360.org/sites/default/ files/media/documents/resource-linkages-h4all-2018.pdf; accessed 4 March 2025).

Key populations manual for healthcare providers. Harare: Ministry of Health and Child Care; 2018 (https://www.prepwatch.org/wp-content/uploads/2022/07/KP-Manual-Health-Providers-2018.pdf, accessed 4 March 2025).

Dayton R, Morales GJ, Dixon KS. Health care worker training: preventing and responding to violence against key populations. Durham, NC: FHI 360; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-hcw-training-manual.pdf; accessed 4 March 2025).

1.2.5. Service delivery through mobile health clinics/outreach clinics

What are they?

Mobile clinics are a way of providing clinical services that is convenient to key populations. Based in an adapted vehicle, they are able to travel to sites where members of key populations congregate, at convenient times. Outreach clinics are temporary clinics in venues where key populations congregate. They are set up for a short period in a physical location (for instance, a bar or a club) at times that are convenient for reaching key populations. These two models are particularly helpful in situations where there are no other facilities in close proximity or where existing facilities are not providing trusted access to services to key populations.

Which services are delivered?

Mobile or outreach clinics can deliver a similar package of services to fixed health facilities, although the exact content depends on resources, time available. etc. They can sometimes deliver simple surgical procedures as well. Table 7 describes the services commonly and sometimes delivered by these facilities.

Table 7: Services delivered through mobile or outreach clinics

Commonly delivered through mobile or outreach clinics	Sometimes delivered through mobile or outreach clinics depending on need, training and roles
Condoms and lubricant	Harm reduction (NSPs, OAMT and naloxone)
Testing (incl. support for self-testing)	Broader health interventions
Treatment (including adherence support)	Supportive counselling
PrEP	Information and education which help key populations understand their health, health risks, available services and legal rights
Demand creation for services	
Referral to other services	

How do you do it?

Mobile clinics or outreach/'pop-up' clinics are used in many different contexts, in particular to serve remote areas. Where these resources are available, they can also provide an option for reaching key populations. Less often, these facilities are fully supported in a key population programme budget, although this is only likely where programmes have considerable resources.

Key population engagement is required to ascertain whether mobile clinics are acceptable and will be trusted by the key population, as well as modalities such as timing and location and safe access to avoid stigma and support uptake. Continuous

monitoring is important to ensure that venues/locations used for mobile services continue to be safe and trusted, and to identify new potential locations as they emerge.

Mobile clinics should work closely with other elements of the platform, in particular the outreach components so that population needs are accurately understood and met. Indeed, outreach workers often facilitate and support outreach clinic visits, for instance mobilizing community members in the area where the mobile clinic is being delivered. Where mobile clinics are being used, they should be included in referral pathways and in programme data and monitoring systems.

Mobile clinics can be included in a TAP alongside health facilities to increase the options for key populations and to ensure that high frequency services are more readily available.

Structural considerations for mobile clinics

Mobile clinics can help avoid the structural barriers associated with relying on health facilities. However, they can themselves be the target of stigma, discrimination and violence. The structural considerations are similar to those for health facilities:

- Addressing legal barriers, such as the duty to report any illegal activity.
- Addressing stigmatizing and discriminatory attitudes of all personnel (clinical, administrative and others) towards key populations through sensitization and training and relevant health facility policies and accountability mechanisms.
- Selecting times for mobile/outreach clinic visits that minimize security risks.
- Monitoring and regularly reviewing incidents and threats.
- Safety and security, including physical security measures and emergency protocols.
- Ensuring licensing to operate through agreements with health officials and local authorities, including preparing a schedule of clinic visits.
- Ensuring that all activities conducted are lawful, particularly in environments where legislation may criminalize activities that are supportive of key populations.
- Understanding and acceptance from the broader community.
- Receiving and responding to feedback from service users (e.g. via community monitoring, observatories, consultations etc.).

Budgeting considerations

Since mobile clinics are generally established within a key population programme, they need to be fully costed, including many of the same elements that should be costed for health facilities, as well as the mobile equipment itself:

- Mobile facility. Adapted vehicle, furniture, shelters/tents, fuel and maintenance, and safe storage.
- Equipment (e.g. examination table, light, diagnostic equipment and reagents, specula, or anuscope).
- Medicines (for STIs and HIV; preferably also for family planning and common general ailments).
- Training and resources required for ensuring and maintaining discriminatory and stigma-free services.
- Condoms, lubricant, needles and syringes for clinic-based distribution.
- For trusted referrals, training of health-care providers, monitoring the quality and acceptability of service provision, and monitoring and supporting linkage to trusted providers and retention in care.
- Depending on the service delivery option, clinician salaries or honoraria, clinic space (can be part of safe space), basic diagnostic equipment, and reagents, medicines and supplies.
- Drivers.
- Security personnel.

Suggested reading

Rousseau E, Julies RF, Madubela N, Kassim S. Novel platforms for biomedical HIV prevention delivery to key populations—community mobile clinics, peer-supported, pharmacy-led PrEP Delivery, and the use of telemedicine. Curr HIV/AIDS Rep. 2021;18:6 (https://pmc.ncbi.nlm.nih.gov/articles/PMC8549812/).

Differentiated service delivery for key populations - men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other people living in closed settings: A background review. 2016 (https://www.differentiatedservicedelivery.org/wp-content/uploads/2022/05/DSD-Key-populations-review.pdf).

Rousseau E, Bekker L, Julies R, Celum C, Morton J, Johnson R, Baeten JM, O'Malley G. A community-based mobile clinic model delivering PrEP for HIV prevention to adolescent girls and young women in Cape Town, South Africa. BMC Health Serv Res 2021;21:888 (https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06920-4).

1.2.6. Access to services through other actors

What are they?

Since a TAP approach is about maximizing the use of existing assets in the community, there are many other entities or actors that can be included, such as:

- Pharmacies.
- Bars and clubs.
- Vending machines.
- Online shops.

What these have in common is that they can be private businesses or establishments, and so they are not necessarily planned by or under the direct control of a key population programme or reliant on programme financing, although it is also possible for vending machines or online shops to be planned as part of a programme approach or a public–private partnership.

Since they are independent of key population programmes, extra effort is needed to ensure that key populations wishing to use services in or from these entities can do so safely (see the section on structural aspects).

Which services are available?

Because these other providers are third parties, there are many services that they can potentially deliver as shown in Table 8. However, as they are third parties rather than planned parts of a programme what they provide will be largely up to each entity.

Table 8: Services available through other actors

Potentially available through other actors
■ Information and education which help key populations understand their health, health risks, available services and legal rights.
■ Demand creation for services.
■ Referral to services.
■ Condoms and lubricant.
■ PrEP/PEP.
■ HIV testing (including self-testing support).
■ Treatment (refills, adherence support).
■ Contraception.

As with the range of service providers described above, some of these, in particular pharmacies, may also be able to support self-care practices.

How do you do it?

Working with other providers within the context of a TAP approach is about partnering with the broader range of actors in a programme location. Key populations themselves are good at identifying organizations or entities that can meet their needs in a non-stigmatizing, safe way. Programmes should therefore follow the lead of key populations and use this as a basis for bringing these entities into the platform and broadening the services they can provide. Peer outreach workers are often well placed to act as brokers with these venues to negotiate collaboration.

This implies working with the owners of entertainment establishments to ensure a constant supply of condoms, or working with pharmacies to improve referrals by training pharmacy workers in basic screening and working with key populations in a non-stigmatizing way. It could also mean placing subsidized commodities in these locations.

There is no correct approach to working with this category of provider; rather, it is about identifying the potential to broaden the range of safe, trusted services and options for key populations.

Collaborations with these actors can be established and formalized, for instance through a memorandum of understanding or public–private partnership. In some countries regulatory considerations need to be complied with, in particular if these non-programme actors are being engaged in conducting regulated activities (e.g., use/placement of vending machines generally needs to ensure safe and appropriate storage of commodities and may need to guarantee compliance with age restrictions for those accessing products) (Box 8).

Box 8

Pharmacies: An Underutilized Community Resource for Trusted Access[40]

Pharmacies are an under-utilized asset in communities that can be a valuable component of a TAP. People from key populations often trust a local pharmacist to provide discreet advice in relation to HIV and sexual health and broader health services, and to be a source of condoms and lubricant. In addition, the footprint of community pharmacies is very broad as they are more numerous and accessible than health facilities. In locations where key population programmes are not established, pharmacy staff often have a very good insight into the health needs and risks of the local population.

In Mozambique, the EpiC programme scaled up work with private pharmacies to expand access to a range of services for key populations, including STI screening, condoms, lubricants, HIV self-testing, PEP, PrEP, violence/GBV screening and care, and family planning, as well as the essential services and monitoring related to antiretroviral treatment. Key population members participated in the selection and sensitivity training of the private pharmacists.

Structural considerations for working with other providers

Because other providers are often selected by key population members themselves, there already exists by definition a degree of trust and access. However, environments are dynamic and new political and legal directions can influence the ability and willingness of these independent actors to continue meeting the needs of key populations. Ways to mitigate these risks include:

- Dialogue with the providers on the importance for public health of key population programmes, and the environment for key populations.
- Provision of correct and up to date information on legal changes, especially in environments where legislation may be perceived as placing restrictions on working with or providing services to key populations.
- Provision of subsidies, materials and training to encourage providers to remain engaged with the overall effort.
- Ensuring compliance with local regulations and conditions.
- Developing formal agreements/memorandums of understanding in order to strengthen and sustain collaboration.
- Receiving and responding to feedback from service users (e.g. via community monitoring, observatories, consultations, etc.).

Budgeting considerations

As noted above, this category of provider is independent and probably established outside of the context of a programme. Many of the services are likely to be provided on a commercial basis. Nonetheless, if resources are available some investments can help make public–private collaboration with these providers more effective, for instance:

- Supplies of prevention products and materials; subsidies to enable the provider to provide these products to key populations at low or no cost; or collaboration with national health insurance providers to enable reimbursement.
- Training on public health and on new interventions.
- Reward schemes for providers that are highly rated by key populations.

Suggested reading

Bateganya M. Experiences and lessons in optimizing decentralized drug distribution for key populations. Differentiated service delivery for key populations–virtual meeting. Durham, NC: FHI 360; 2021 (https://cquin.icap.columbia.edu/wp-content/uploads/2021/08/Bateganya-_CQUIN-Key-Pops-Meeting_Final-8_25.pdf; accessed 6 March 2025).

Crawford ND, Harrington KRV, Chandra C, Alohan DI, Quamina A, Beck O. et al. Feasibility of reaching populations at high risk for HIV in community pharmacies. JAPhA. 2024:64;6;102239 (https://www.sciencedirect.com/science/article/abs/pii/S154431912400267X; accessed 6 March 2025).

Lalla-Edward S; Venter W. Feasibility and impact of community pharmacy and novel pick-up points for antiretroviral therapy pre-exposure prophylaxis initiation and continuation in low and middle-income countries. Curr HIV/AIDS Rep. 2024;16:22:1:2 (https://pmc.ncbi.nlm.nih.gov/articles/PMC11568023/#:~:text=Likewise%2C%20novel%20pick%2Dup%20points,injecting%20drug%20users%20%5B33%5D; accessed 6 March 2025).

Rousseau E, Julies RF, Madubela N, Kassim S. Biomedical HIV prevention delivery to key populations—community mobile clinics, peer-supported, pharmacy-led PrEP delivery, and the use of telemedicine. Current HIV/AIDS Rep. 2021;18:500–507 (https://link.springer.com/article/10.1007/s11904-021-00578-7; accessed 6 March 2025).

Protecting key populations from abrupt disruptions to essential HIV services. Geneva: WHO; 2025 (https://www.who.int/news/item/27-02-2025-protecting-key-populations-from-abrupt-disruptions-to-essential-hiv-services; accessed 6 March 2025).

1.3. Planning and adapting trusted access platforms and addressing cross-cutting structural considerations

1.3.1. Planning trusted access platforms

As described above, a TAP comprises all of the providers that key populations trust and can access. No two platforms are the same as each will be made up of different combinations of the different types of actor or provider described in the previous section, ideally working in a coordinated way. Establishing coordination and referrals between different actors is an important element of a TAP approach.

Building an effective platform therefore requires strong engagement with key populations at the outset and throughout design and implementation. A key tool for this is participatory programme mapping (PPM), a process which puts key populations in the lead and identifies the assets and challenges in a community, as well as any changes and new priorities and challenges as they emerge.

Communities and contexts are dynamic—they change over time. This is why processes such as microplanning need to be continuous rather than one-off. In addition, a continuous process acknowledges that at any given point in time there are always improvements that can be made, and places more emphasis on continuous adaptation of what is already in place rather than on a lengthy planning process that requires programme interruptions.

How do you plan a trusted access platform?

Periodic PPM involves key population communities in the process of identifying high risk venues and locations and estimating population sizes. It is often the first step in launching key population programming, and it is a critical opportunity for engaging communities. It is also useful for identifying members of key populations who are influential in their communities and committed to working with them. PPM thus provides information, sparks community interest and helps the programme identify members of key populations who can be effective peer outreach workers.

Repeat mapping (site validation every 6–12 months) as part of microplanning is important in order to update outreach planning, population size estimates (PSEs) and targets with information about new high risk venues and new key populations, as well as any venues that have become inactive or key populations that have moved away. It also helps to identify new issues as they emerge and can help build preparedness for the introduction of new interventions or the adaptation of existing interventions.

PPM involves meeting with key populations from different sites and guiding them to draw maps of their sites which identify high risk venues, key roads and landmarks, providers of HIV, health and other services that are trusted by key populations. Also identified are services that are not trusted and risky locations, as well as estimates of the number of key populations found at each spot.

The second stage, venue validation, involves the outreach team and key population members in walk-around visits to venues for observation and informal discussions with members and stakeholders. This helps to validate estimated numbers, peak times and other details. The same method is often used as part of microplanning. Enhanced

mapping can include focus group discussions with key populations to assess their views on how services should be configured and on the challenges they face.

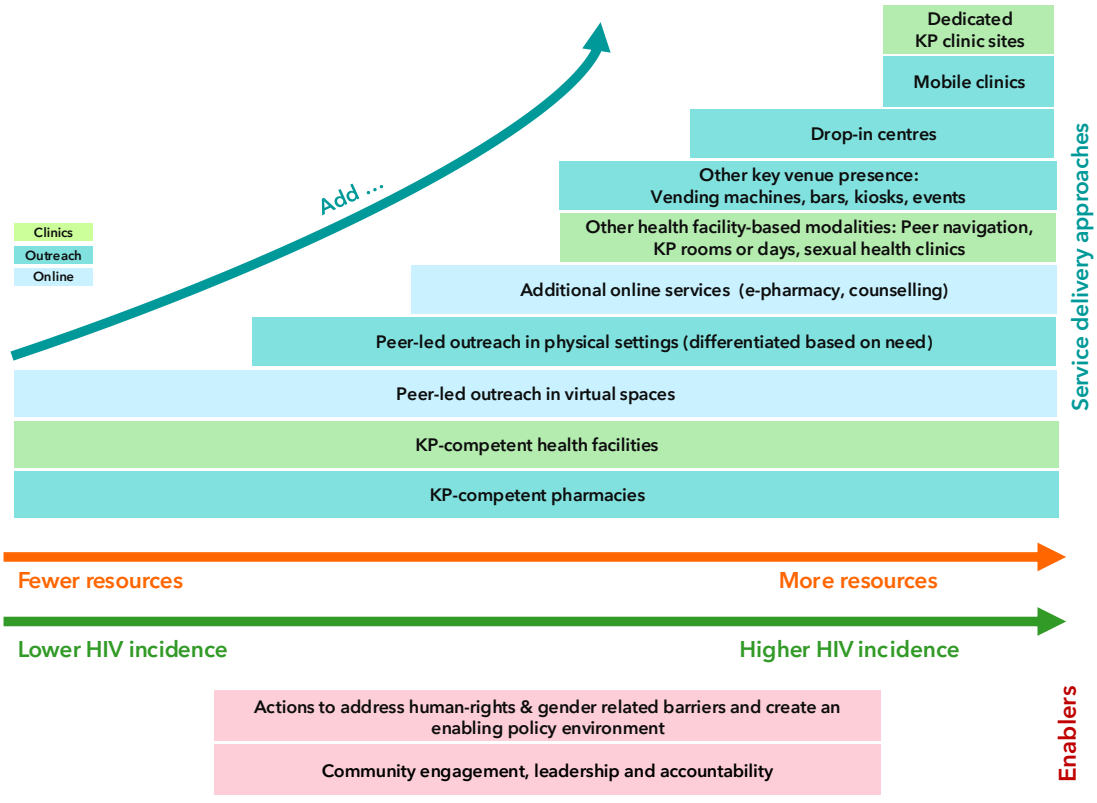
Context and resource availability considerations for a trusted access platform approach

As the sections above make clear, the TAP approach emphasizes a strong understanding of the local context: where key populations have high levels of trust in public health facilities and do not face significant legal barriers and discrimination. Where they have high self-efficacy, which allows for strong self-care practices, there will be less need for tailored, key population services. On the other hand, where public health facilities are not acceptable or accessible, and legal barriers exist, the likelihood is that there will need to be significant investment in reducing those barriers in the long term *and* providing specialized, safe services in the immediate term.

Another major factor for TAP design is availability of resources for dedicated programmes. Where dedicated funding is limited, managers need to maintain results with fewer resources, often by pivoting away from key population specific approaches towards working with mainstream public health services, or new types of partners such as pharmacies, kiosks, etc. Planners must evaluate when population specific approaches need to be preserved—for instance, where other types of providers are not sufficiently capable or trusted by key populations.

Figure 4 illustrates the ways in which different resource scenarios can lead to different programme designs, showing how additional service delivery options can be considered in contexts where more resources are available and where the environment is such that dedicated services are necessary.

Figure 4. Different programme scenarios based on resource availability



No country or programme will fit neatly into any of these scenarios. However, they illustrate the choices that decision-makers face. Where funding permits, additional programme components help address barriers and bring more services to more members of key populations.

In addition, factors such as resource availability, the enabling environment and needs often differ for different key populations and different sub-groups (e.g. young or migrant key populations), as well as for different locations in a country (urban/rural or different social/cultural attitudes and laws within a country). So, a TAP for gay men and other men who have sex with men in a given country may look very different to a TAP for sex workers or injecting drug users in the same country. Box 9 summarizes the considerations that should be taken into account for each key population group and sub-group when planning programmes.

Box 9

Considerations When Building a TAP for Different Key Populations

There are a range of factors that determine what a TAP will look like. In any given country, these factors may differ for each key population category. They include:

- Epidemiological considerations, such as HIV prevalence, testing and treatment access, and key population sizes.
- The interventions and services needed by each key population as outlined in the WHO *Consolidated Guidelines* (see Table 1), as well as legal barriers related to these interventions (for instance, whether needle substitution is permitted, or age-related restrictions on access to some services).
- Legal and other barriers that affect access to services for different key populations, including fear of stigma, discrimination or arrest; and legal barriers affecting programme delivery (e.g. laws requiring reporting of sexual orientation or laws on 'promotion' of certain behaviours).
- Trust and accessibility in regular/mainstream services.
- Resources available for specialized programming and services, which may be different for each key population category.
- Variations within a given key population category such as age, language, migration status and preferences for online or in-person services.

Crucially, as Figure 4 shows, there is no scenario in which investment in human rights and gender investments and key population engagement are not required. Continued effectiveness and trusted access for key populations under any funding scenario, and regardless of the barriers that exist, require continued community led monitoring and accountability.

To complement Figure 4, another way to conceptualize various 'stages' of maturity for a TAP is presented in Annex 3.

Suggested reading

Emmanuel F, Persaud N, Weir SS, Bhattacharjee P, Isac S. Programmatic mapping: providing evidence for high impact HIV prevention programs for female sex workers. JMIR Public Health Surveill. 2019;5(2):e12636 (https://publichealth.jmir.org/2019/2/e12636/pdf; accessed 4 March 2025).

Standard operating guidance on programmatic mapping and validation. Learning site partners in Sri Lanka. Durham, NC: FHI 360; Linkages; 2019 (https://www.aidscontrol.gov.lk/images/publications/UNAIDS_FHI360/Hotspot-Mapping-and-Validation-SOP-English.pdf; accessed 6 March 2025).

Standard operating procedure to implement effective community-led outreach and micro planning strategies in key and vulnerable population programmes in Tanzania. Dar-es-Salaam: National AIDS Control Programme Tanzania, Ministry of Health; 2024 (https://www.hivinterchange.com/member-countries/tanzania; accessed 6 March 2025).

The Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO, UNDP, PEPFAR, University of Manitoba, UNAIDS. Using programmatic mapping to improve program access and coverage for key populations: guidelines for countries. Geneva: UNAIDS; 2016 (https://hivpreventioncoalition.unaids.org/resource/using-programmatic-mapping-to-improve-program-access-and- coverage-for-key-populations-guidelines-for-countries/; accessed 6 March 2025).

Mann Global Health, UNAIDS, UNFPA. Micro-planning for more effective and efficient HIV programs: Sex-worker led condom programming in Malawi. Case study. Geneva: UNAIDS; 2024 (https://hivpreventioncoalition.unaids.org/en/resources/micro-planning-more-effective-and-efficient-hiv-programs-sex-worker-led-condom; accessed 6 March 2025).

South to South Learning Network. Designing outreach and microplanning for key population programmes. Johannesburg: SSLN; 2021 https://cdn.prod.website-files.com/63ff2c1bed17e622bce9c2ea/64f6d301d1986ad990d3f8fb_Kenya-Malawi-Zim-outreach-and-microplanning-case-study_FINAL.pdf; accessed 3 March 2025).

Cowan F, Reza-Paul S, Ramaiah M, Kerrigan DL. Strategies to promote meaningful involvement of sex workers in HIV prevention and care. Curr Opin HIV AIDS. 2019;14(5):401-8 (https://pubmed.ncbi.nlm.nih.gov/31219886/; accessed 1 March 2025).

1.3.2. Adaptability and differentiation

What is it?

Members of a key population may have different preferences regarding how to access services and which providers they trust, or their needs may change over time. Also, new challenges can arise in key population environments. Human rights-related and security emergencies may occur which require a programme to be adapted to ensure safe continuity of services. The profiles of key populations may change, meaning new skills and profiles of peer outreach workers need to be brought into the platform. Changes in personnel in health facilities or other entities may provide new challenges or opportunities for the platform. New prevention and treatment approaches and tools may come on stream and need to be rapidly deployed to those who need them. A TAP needs to be able to identify and respond to all of these opportunities and challenges as they emerge.

If a TAP approach is adopted, it should incorporate continuous monitoring through PPM, microplanning (in particular, routine monitoring data and opportunity gap analysis) and community monitoring or observatories. It should also be well linked with national level insights and decision-making. This approach will then be well placed to identify and respond to these changes in the environment.

Differentiation, which is enabled through the TAP approach, is also critically important for ensuring that the needs of different profiles of key populations are met since services can be available in more than one setting or from more than one provider, allowing users to choose the most appropriate. Furthermore, individuals can belong to more than one key population, meaning that they have intersecting needs—for instance, a sex worker who injects drugs may be enrolled in a sex work programme which does not provide advice and access to a full range of harm reduction services. Connecting programmes for different populations and/or understanding and addressing these intersectionalities is therefore also an important part of a person-centred approach.

Age is a specific factor for key populations, with both older and younger key populations having specific needs, which may include additional legal constraints on service access and consent for young key populations. Continuous monitoring and engagement with communities helps ensure that programs are sensitive and responsive to key populations with intersecting or specific needs, and to changes in those needs over time, is essential to adaptive programming. Providers including health facilities, peer outreach workers and others require training and advice on recognizing and addressing these specific needs.

Suggested reading

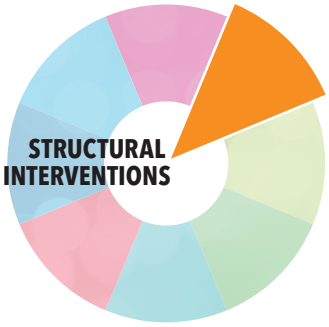
Differentiated Service Delivery. A decision framework for differentiated antiretroviral therapy delivery for key populations. (https://differentiatedservicedelivery.org/wp-content/uploads/decision-framework-key-population-web3.pdf; accessed 4 March 2025).

Innovations to overcome vaccine hesitancy and increase COVID-19 vaccination among key populations and people living with HIV in Telangana, India. Durham, NC: FHI 360; 2022 (https://www.fhi360.org/wp-content/uploads/drupal/documents/resource-epic-increasing-vaccination-india-success-story.pdf accessed 6 March 2025).

Reaching men who purchase sex with differentiated service delivery in the Democratic Republic of Congo. Durham, NC: FHI 360; 2023 (https://www.fhi360.org/wp-content/uploads/2024/02/resource-epic-success-story-drc-dsd-mwps.pdf accessed 6 March 2025).

Serving the needs of key populations: case examples of innovation and good practice in HIV prevention, diagnosis, treatment and care. Geneva: WHO; 2017 (https://iris.who.int/bitstream/handle/10665/255610/9789241512534-eng.pdf?sequence=1 accessed 4 March 2025).

1.3.3. Cross-cutting structural interventions for trusted access platforms



What are they?

As the previous sections illustrate, there are specific structural considerations for each different type of service delivery that is included in a TAP. There are also a number of structural interventions that are cross-cutting in that they can help support a TAP as a whole. These interventions can be implemented at a programme location, for instance through engagement with local authorities and law enforcement. Others target the national level and address constraints related to legislation, policy and practices, or resource availability and sustainability for key population programmes. They are essential for achieving a TAP and for programme impact.

Key population programmes have increasingly been confronted with deteriorating environments in many countries with the introduction of laws and polices challenging global human rights and gender equality standards. Increasing incidents of online misinformation, disinformation and hate speech, and mob violence are being recorded. Addressing structural considerations and programme security to ensure effective public health programming for key populations is more important than ever.

Which interventions are included?

The WHO *Consolidated Guidelines* provide detailed explanations of the types of structural interventions that are necessary for effective key population programmes.[41] They address the conditions at national or sub-national level that affect how key population programmes are delivered. As Table 9 shows, they include ongoing activities working directly with key populations and the broader local community, and longer-term efforts that address the overall environment.

Local and national level efforts in this domain can and should be linked, with community empowerment initiatives and information gathering at the local level providing a platform for both local level change and national level advocacy and policy change.

Table 9: Cross-cutting structural interventions

Common structural interventions
■ Removing punitive laws, policies and practices
■ Reducing stigma and discrimination
■ Community empowerment
■ Addressing violence

Some of the most important local-level activities under this category are as follows:

- Violence prevention/response, training, making connections with police, lawyers and health facilities, form printing, travel support, safety and security, and advocacy with local gatekeepers, decision-makers, health-care facility managers and law enforcement officers.
- Legal literacy, rights training ('Know Your Rights') and community paralegal training: understanding laws through collaboration with the legal community and developing appropriate training materials for key population members, monitoring of security incidents and human rights violations, provision or referral to legal services and redress.
- Legal services and other support to access justice and redress.
- Advocacy with religious, traditional and community leaders, and with venue owners.
- Child protection/welfare, access to educational assistance for both young and older key populations, access to housing, access to government entitlements, savings/credit plans, childcare, and other structural interventions to address priorities identified by the community or self-help groups.
- Health-care provider training for stigma-free, respectful services, confidentiality, informed consent and other patient's rights, as well as responses to violence, with community input in training.
- Addressing stigma and discrimination in all settings.
- Addressing venues and undertaking advocacy with owners/managers.
- Economic empowerment, e.g. for people who inject drugs as well as family and social protection interventions for young people

In many cases it will be necessary to link with other service providers since HIV programmes may not be adequately funded to cover them.

Common national level activities include:

- Strengthening the capacities of representative key population networks, including for advocacy.
- Compiling evidence of structural challenges at the local level.
- Establishing a national rapid response mechanism to respond to violence and other human rights violations, including provision for health care, legal support, etc.
- Advocacy, learning and sensitization aimed at policy and legal reform to improve the environment for key population programming, and at institutionalizing human rights capacity building for duty bearers.

- Key population participation in national level HIV prevention bodies, such as technical working groups.
- Advocacy for governmental buy-in and acknowledgement and recognition of the key population groups

How do you do it?

Although there are many commonalities in the structural barriers across countries, there are significant differences in particular in relation to legal contexts. And even in countries there are likely to be differences between programme locations, not only in terms of the barriers but also in terms of the strategies that are most effective for reducing them. As a result, the approach to addressing barriers needs to be tailored and contextual. Similar to all of the components described above, understanding the context requires the active participation of people from the key populations concerned.

Barriers and potential strategies can be identified as part of programme design, and through ongoing observation or community monitoring mechanisms.

As the interventions recommended by WHO suggest, addressing structural barriers requires particular coordination and constant feedback between local and national levels since conditions at the local level may well be determined by conditions at the national level. Strong linkages between community groups and representation at the local level with those acting at the national level are therefore also critical, and investment is required to ensure key population organizations have the capacity and the resources to do this work effectively.

Budgeting considerations

Key considerations beyond those outlined under other subsections above include:

- Training and organizational capacity-building for key population organizations involved in addressing structural barriers at local and national levels.
- Training of duty bearers, in particular health-care providers and law enforcement officials.
- Transport and communication costs.
- Funds for emergency response measures.
- Monitoring of security incidents and human rights violations.
- Funds for paralegals and for engaging legal assistance and ancillary costs, court fees etc.

Suggested reading

Avahan, Bill & Melinda Gates Foundation. Community led crisis response systems. New Delhi: Bill & Melinda Gates Foundation; 2013 (https://docs.gatesfoundation.org/documents/Community%20Led%20Crisis%20Response%20(Web).pdf; accessed 4 March 2025).

Dayton R. Law enforcement training: preventing and responding to violence against key populations to increase access to justice and strengthen the HIV response. Durham, NC: FHI 360; Linkages; 2019 (https://www.fhi360.org/sites/default/ files/media/documents/resource-linkages-le-training-manual.pdf; accessed 4 March 2025).

Dayton R, Morales GJ, Dixon KS. A guide to comprehensive violence prevention and response in key population programs. Durham, NC: FHI 360; Linkages; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-vpr-guide.pdf; accessed 4 March 2025).

Safety and security toolkit: strengthening the implementation of HIV programs for and with key populations. Durham, NC: FHI 360; Linkages; 2018 (https://www.fhi360.org/wp-content/uploads/drupal/documents/resource-linkages-safety-security-toolkit.pdf, accessed 4 March 2025).

Removing barriers to HIV services. Technical briefing note. Geneva: Global Fund to fight AIDS, Tuberculosis and Malaria; 2023 (https://resources.theglobalfund.org/media/14366/cr_removing-barriers-to-hiv-services_technical-briefing-note_en.pdf; accessed 2 April 2025).

Spectrum: a tool for key population-led law and policy reform. New York: UNDP; 2024 (https://www.undp.org/publications/spectrum-tool-key-population-led-law-and-policy-reform;, accessed 4 March 2025).

Ensuring quality health care by reducing HIV-related stigma and discrimination. Technical brief. Geneva: WHO; 2024 (https://www.who.int/publications/i/item/9789240097414; accessed 2 April 2025).

UNDP, UNFPA, ILO, UNODC, UNICEF, UNHCR. Preventing and responding to HIV related human rights crises: guidance for UN agencies and programmes. New York: UNDP; 2024 (https://www.undp.org/publications/preventing-and-responding-hiv-related-human-rights-crisis-guidance-united-nations-agencies-and-programmes; accessed 4 March 2024).

PART 2

MANAGEMENT FOR SCALE AND IMPACT

Part 2 MANAGEMENT FOR SCALE AND IMPACT

Key population programmes and services rely on programmatic data for continuous planning and monitoring progress

To operate at scale and reach as many people as possible, key population programmes and services rely on programmatic data for continuous planning and monitoring progress. This information starts with the most current available estimates of key population locations and population sizes. Regularly updated programmatic mappings are also critical to optimize scale and coverage (Section 2.1).

Effective oversight of TAPs begins with priority programme indicators (Section 2.2). These measure the extent to which key populations are being reached in the community and are using clinical services. Targets for these programmatic indicators are population-based, using population size estimates as denominators. These basic performance indicators enable reliable monitoring uptake, utilization and retention, using routine programme data.

Basic programme data can also be used to monitor selected outcome and impact indicators for the TAP, such as HIV incidence, condom use, or experiences of violence (Section 2.3). This can complement and triangulate data from larger-scale bio-behavioural surveys. Analysis of programme data can also inform necessary adjustments to the service package, especially where there are intersectional risk factors (i.e. sex workers who inject drugs).

Community-led monitoring of TAPs provides an important accountability mechanism for service quality while simultaneously empowering key populations with their own data for advocacy (Section 2.4). Different models are used in key population programmes around the world. The CLM mechanism has been shown to have a direct effect on improvements to HIV service provision.

Capacity strengthening and leadership of key populations is essential for the sustainability of the TAP (Section 2.5). At the organizational level, there should be clear plans and opportunities for advancement provided to communities and programme staff. At the national level, countries should develop rigorous training and certification processes so that key population-led services can be part of the formal health system.

The sustainability of key population programmes and services is a vital consideration, especially as funding decreases and global goals demand significant systems-level transformations (Section 2.6). Countries will need to be flexible and adapt recommended approaches based on resource availability. Sustainable financing mechanisms such as social contracting should be explored, along with partnership models that embed key populations programmes and services within primary care.

2.1. Updating Mapping and Population Size Estimates

Regular and repeated mapping is important to update outreach planning, population size estimates, and targets with information about new high risk venues and new key populations

What is it?

For a scaled key population response, it is essential to review what is already known about key populations across the country and to answer these questions:

1. How many key populations exist?
2. Where can most key populations be found and when?
3. Where are existing key population programmes providing services?
4. What subpopulations of key population communities are not being reached by the programmes?
5. What are the gaps to be filled (in terms of geographical coverage or range of services offered)?

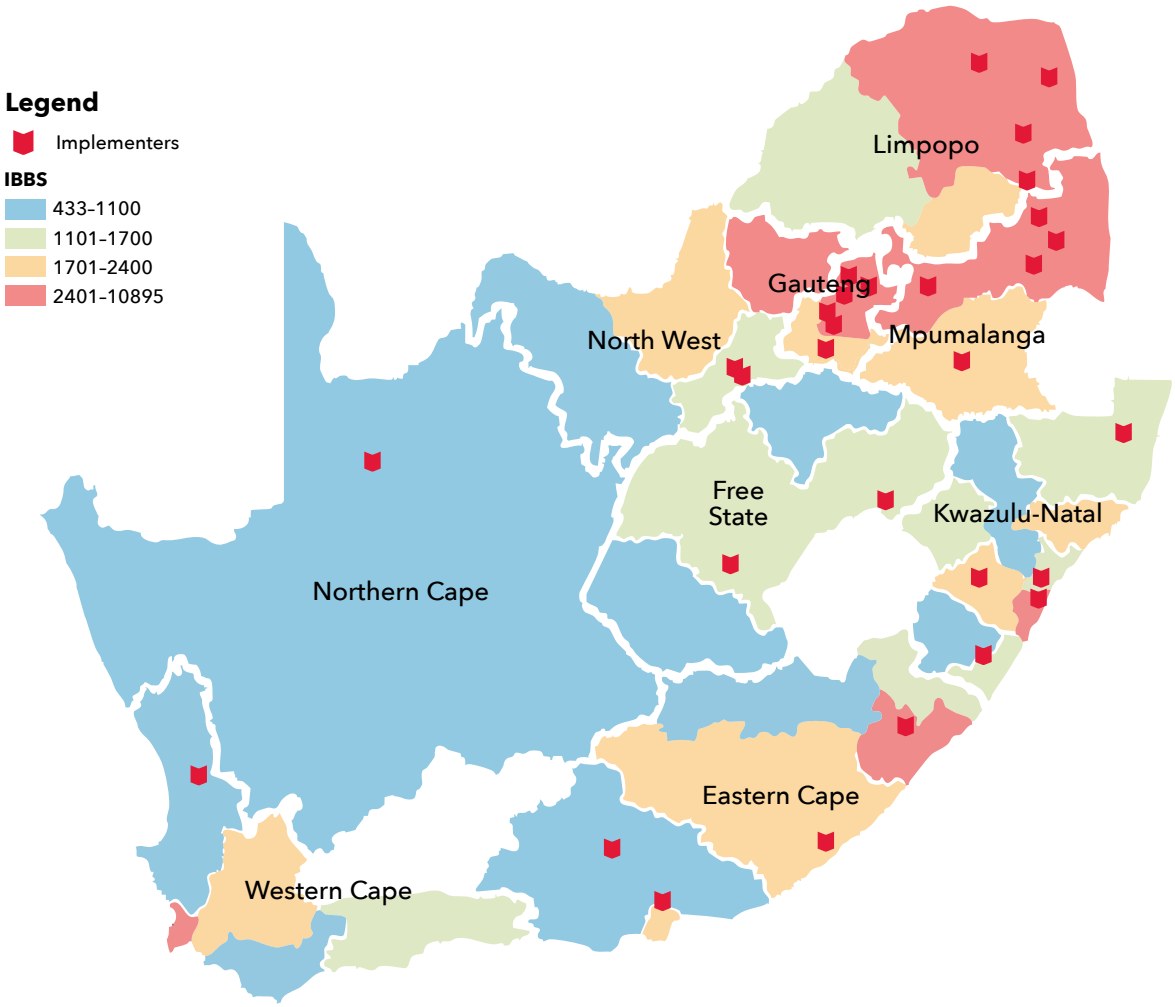
There are many different methods for estimating population sizes and mapping key population communities. These include census, capture–recapture, multiplier method, network scale-up, programmatic mapping and others.[42] Mapping must be done in a way that respects the needs and safety of key populations, mitigating any risk of police or mob violence aimed at specific locations. Local key populations must be involved in—and ideally leading—the mapping.[43]

Additional size estimate methodologies are needed, especially those which can be undertaken with fewer resources than large scale surveys. One such alternative is to generate small area estimations using programme data.[44] Better still, periodic PPM involves key populations in the process of identifying high risk venues and estimating population sizes, including any changes over time.

Programmatic mappings are distinct from more formal, mathematical size estimations. Both are useful in different ways. The former is necessary for practical programme planning, while the latter often informs national targets, quantification and resource mobilization efforts.

Data from any formal size estimation studies can be triangulated with data collected through PPM and can be linked to microplanning tool site analysis. It may be useful to overlay population size estimate data with other data such as HIV incidence, treatment coverage, or implementation sites (Figure 5). This can help visualize if the programme is scaled in the most efficient manner, or if there are geographical equity gaps.

Figure 5. Mapping of sex worker sites overlayed with population size estimates, South Africa (adapted from the original)[45]



Countries should consider whether the entire key population is at risk, and whether the entire size estimate should therefore be used as the denominator for outreach targets. In a recent think tank series, experts suggested programmes use population size estimates of gay men and other men who have sex with men with a non-regular partner, rather than all such men.[46]

Why is it worth investing in?

Countries should choose the size estimation and mapping method(s) that are most appropriate for their context, including available financial and technical resources. Participatory programme mapping should be prioritized in all settings, given that: (a) the data are reliable, (b) the cost is lower than more formal surveys, (c) the exercise can be regularly repeated, (d) communities are engaged throughout the process, and (e) potential peer educators are identified for recruitment and training. Resources permitting, more formal size estimation studies provide a useful complement.

Repeat mapping (site validation every 6–12 months) is important to update population size estimates, and revise outreach planning and targets with information about new high risk venues and new key populations, as well as any venues that have become inactive or key populations that have moved away.

What is needed?

- Nationally adopted unique identifier codes are critical for accurate key population size estimates.
- Research protocols with ethical considerations (including safety and security) approved by an IRB, ideally with multi-year renewal for repeat mapping.
- For formal population size estimates, survey protocols and standard operating procedures.[47,48]
- For programmatic mappings, team meetings with key populations from different sites to guide them to draw simple maps of their sites, including high risk venues, key roads and landmarks. Participants should provide rough estimates of the number of key populations found at each spot.
- High risk venue validation involving the outreach team and key population members in walk-around visits to high risk venues for observation and informal discussions with key population members and stakeholders. This helps to validate estimated numbers, peak times and other details.
- A rapid mapping to be repeated every 6–12 months to update information.

Is it in the budget?

- The cost of participatory programmatic mapping varies by country. The main drivers are interviewer and travel costs. Countries should plan for several days per site for participatory mapping, and then several hours per high risk venue for a walk-around validation. Cost estimates for an in-depth programmatic mapping are contained in Annex 4. Modifications may be needed in resource constrained environments.
- A lighter-touch repeat site validation and PSE update should be done every 6–12 months. This can be done by existing outreach teams, remunerated peers and supervisors, with support from data managers.

Suggested reading

UNAIDS, WHO. The BBS-lite implementation tool. Geneva: UNAIDS; 2024 (https://www.unaids.org/en/resources/documents/2024/BBS-lite-tool).

Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO, UNAIDS. Using programmatic mapping to improve program access and coverage for key populations: guidelines for countries. Geneva: UNAIDS; 2016 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/Programmatic-mapping-to-improve-program-access-and-coverage-of-KPs.pdf).

Review and revise: a tool for reviewing and revising key population size estimates. Chapel Hill, NC: MEASURE Evaluation; 2018 (https://www.measureevaluation.org/resources/publications/tr-18-274.html).

Priorities for local AIDS control efforts (PLACE) Toolkit. Chapel Hills, NC: MEASURE Evaluation; 2020 (https://www. measureevaluation.org/resources/tools/hiv-aids/place).

Social media mapping—for planning online HIV outreach and service delivery. Durham, NC: FHI 360 Linkages; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-media-mapping.pdf).

Xu C, Jing F, Lu Y, Ni Y, Tucker J, Wu D. Summarizing methods for estimating population size for key populations: a global scoping review for human immunodeficiency virus research. AIDS Res Ther. 2022:19(1);9 (https://link.springer.com/content/pdf/10.1186/s12981-022-00434-7.pdf).

2.2. Conducting Effective Programme Oversight

Priority programme indicators show how well the different parts of the key population platform are working to reach key populations

What is it?

Monitoring progress of a TAP begins with four questions[49] related to a given population:

1. Have all key population members been reached at least once by a peer educator (outreach uptake)?
2. Are key populations being reached regularly (outreach frequency)?
3. Have all key populations visited the clinic at least once (clinic uptake and registration)?
4. Are key populations using clinic services regularly (clinic frequency)?

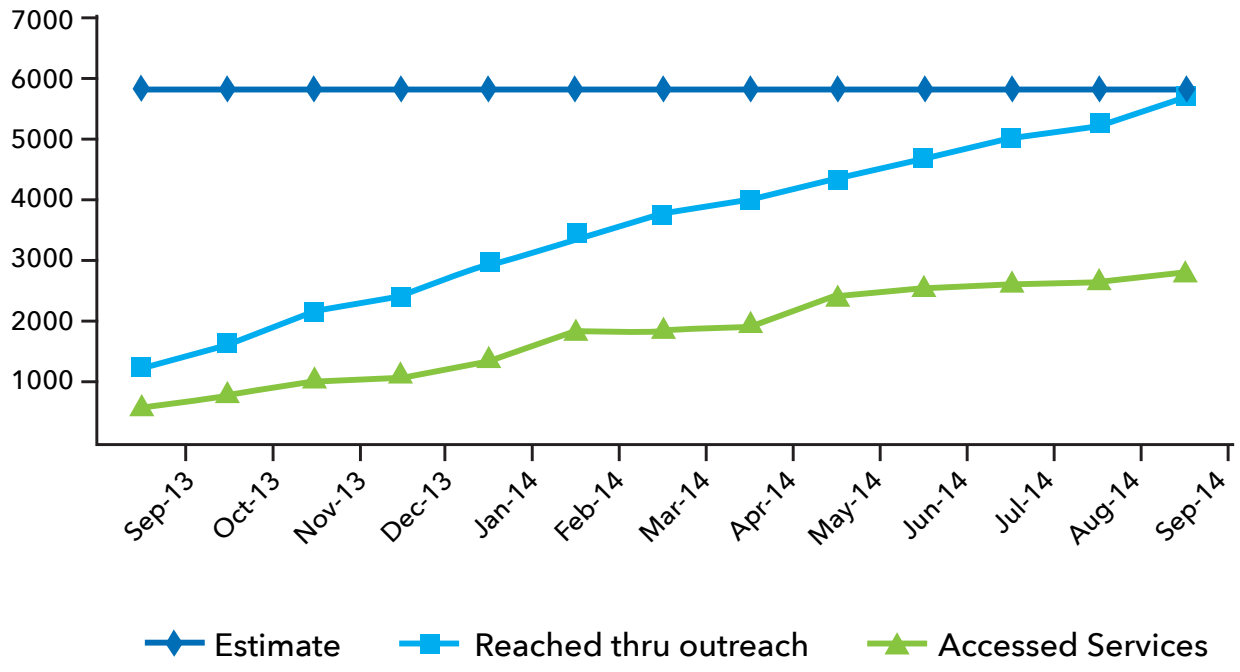
These questions show how well the platform is working to reach key populations and link them to clinical services.[b] Progress should be monitored monthly (or as needed) by relevant stakeholders according to local mapping and size estimates (as the denominator).[50] Targets for outreach and clinic frequency are set by the programme, but are usually one–four times monthly for outreach contacts (depending on risk) and quarterly for clinic visits.[c] If HIV self-testing is available, or six-month dispensing of ART/PrEP, clinic visits may be less frequent (bi-annually).[51] Targets for virtual outreach may vary.

For physical outreach and services, microplanning tools like peer calendar and opportunity gap analysis can help in monitoring the peer cohort.[52] Virtual outreach may be measured through the number of clicks or interactions with public content (likes, comments, shares, video views), or the number of chats or one-on-one engagements with clients on the topic of HIV (Box 10).[53] Other virtual services can be monitored in similar ways to physical services.[54] For key populations using self-care, pharmacies, or the private sector, a light touch survey may be useful as complementary programme data on service uptake (Figure 6).

b. The next two monitoring sections address outcomes and impact (Section 2.3) and service quality through CLM (Section 2.4). Other indicators (not covered here) measure the use of specific services like HIV testing or STI screening, distribution of prevention commodities, HIV testing, and linkage to care and adherence.

c. Specific services should also be monitored in the context of the population and priority indicators. For instance, if only two thirds of the estimated members of key populations have been reached, and only half of them have used the clinic, HIV testing uptake will be low. Improving platform performance for outreach and clinic attendance will yield higher testing rates.

Figure 6. Example of programme monitoring for female sex workers in Mombasa, Kenya[55]



Box 10

Monitoring Use of Online Mental through Health services in the Middle East And North Africa Region

From 2021 to 2022, FHI 360 and Pragma Corporation delivered a programme of mental health services for LGBTQI+ people in Algeria, Morocco and Tunisia.[56] Sessions with mental health professionals were offered both in-person and online. The programme monitored uptake of both modalities. In total, 3549 sessions were delivered to 1494 unique users. In Algeria, only 1% of sessions were conducted this way. In Morocco, 27% of sessions were delivered virtually; in Tunisia, 37% were virtual. The programme had a very low rate of no-shows–2% in Algeria and 10% in both Morocco and Tunisia. This programme monitoring provides key insights into the acceptability of virtual services for key populations as part of TAPs.

Harmonized unique identifier codes (UICs) remain crucial for programme oversight, especially across public, private and non-governmental service providers (Box 11).[57] Key populations' preferences, as well as their safety and security, must be considered

when rolling out different kinds of UICs.[58] A global review of 32 countries found that just 11 had a key population UIC system in place, allowing for de-duplication of results and provision of accurate numbers of clients receiving various services.[59]

Box 11

Africa Case Example: Use of Unique Identifier Codes

In Africa, nine countries—Burundi, Burkina Faso, Ghana, Kenya, Liberia, Malawi, Mali, Togo and Uganda—have integrated key population UICs into their routine health management information systems.[60] A pilot project for the same is ongoing in South Africa, with results expected at the end of 2025.[61]

Why is it worth investing in?

Monitoring platform performance is only the first step in monitoring key population programmes. But these data are essential for understanding how well the programme is performing on other indicators and targets, such as: condoms; lubricant; needle and syringe distribution; HIV testing; PrEP uptake; OAMT uptake; and successful linkage to care. Without reliable data on key population sizes and the proportions using clinic services and being reached through outreach, it is difficult to make sense of data on specific service usage or to identify gaps.

Most importantly, platform indicators are used to monitor overall progress, identify problems and manage programmes for continuous improvement. They are also indicative of community trust and participation. Partial outreach uptake or declining clinic visits can suggest that key populations are avoiding peer educators or are dissatisfied with services for some reason, inspiring further investigation (also see Section 2.4 on embedding CLM).

The platform aims to identify key populations systematically, followed by frequent outreach and regular clinic check- ups, including progress made towards reaching identified targets and gaps. Targets for specific services like HIV testing and ART linkage are then set according to other indicators and eligibility criteria.

What is needed?

- Robust, routine programming monitoring system with UICs, with core indicators standardized across key population programmes and reported upward for a country-wide view of progress and gaps. Where possible, consensus should be reached on the UICs to be used across public, private and community-led service providers for key populations.

- The management plan should reflect the planned scale and standards of the programme, often summarized as a common minimum programme, with clear targets. Management starts at the local level with frequent (weekly) review of peer educator work with the peer supervisor. The peer supervisor reviews the previous week's work, discusses problems, collects/enters data and then assists with planning the work for the next week. Similarly, the peer navigator discusses work and problems with case management supervisors, reviews data and assists with planning subsequent work.
- Dashboard reviews of priority indicators for basic coverage and engagement, HIV testing and ART linkage and retention take place monthly by site (and at the intermediate district and central programme levels) with active problem-solving. Higher level reviews involving other interested partners or stakeholders may be organized quarterly or annually, with additional areas of focus (such as updating high-level mapping for scale). Light touch surveys are suggested to capture self-care (see Section 2.3).

Is it in the budget?

- Mapping and size estimation for the PSE (see Section 2.1).
- Meeting/process to plan the UICs (if not already operational) for key population programmes in the area (related training, implementation and IT support).
- Under local implementation, weekly supportive supervision visits of peer educators by peer supervisors and peer navigators with case managers.
- Data entry, cleaning and analysis to produce priority programme indicator dashboards and prevention/care cascades.
- Regular dashboard reviews with outreach and clinic teams, government and programme managers (local level: monthly; intermediate district: quarterly; and central programme level: semi-annually).

Suggested reading

Monitoring HIV programmes with key populations. Geneva: UNAIDS; 2024 (https://jointsiwg.unaids.org/wp-content/uploads/2025/03/Monitoring-HIV-Programs_English.pdf).

Monitoring guide and toolkit for HIV prevention, diagnosis, treatment, and care programs with key populations. Durham, NC: FHI 360; 2020 (https://www.fhi360.org/wp-content/uploads/drupal/documents/resource-linkages-monitoring-tools.pdf).

Simple methods of monitoring and evaluating for LGBTQI advocates everywhere. Oakland, CA: MPact Global Action for Men's Health and Rights; 2021 (https://mpactglobal.org/wp-content/uploads/2021/02/MPact-Evaluation_Toolkit_6_spreads.pdf).

Rampilo M, Phalane E, Phaswana-Mafuya RN. Tracking HIV outcomes among key populations in the routine health information management system: a systematic review. Sexes. 2025;6(3):32 (https://www.mdpi.com/2411-5118/6/3/32).

2.3. Monitoring Selected Outcomes and Impact

It is important to know whether programmes are moving towards key outcome targets

What is it?

The methods for measuring outcomes and impact of key populations programmes (Section 2.3) are different from those used to measure coverage (Section 2.2). There are several ways of doing this, including large-scale Integrated Bio-Behavioural Surveys (IBBS), which should be done every five years. The new 'BBS-lite' may be used to supplement results from a full IBBS and programme data.[62] To some extent, outcomes and impact can also be measured using programme data coming from TAPs. This is especially useful in low-resource settings.

Routine programme data on outcomes and impact from TAP clinics can include:

1. Trends of new syphilis infections diagnosed (from systematic screening with high uptake).
2. Trends in seroconversion (from regular HIV testing among previously HIV-negative individuals).[d]
3. Rates of viral load suppression among key populations on ART

Routine programme-based light touch survey methodologies can be used to collect more in-depth information on other HIV prevention outcomes, including BBS-Lite, Rapid Coverage Surveys, Polling Booth Surveys (Table 10), or computer-assisted methods conducted either in clinics or the community.[63] These are commonly used to assess condom use, use of sterile injecting equipment, experience with violence and/or discrimination, knowledge about HIV status and viral suppression, and others. These can be validated with less frequent, more rigorous population-based surveys (i.e. IBBS).

d. Monitoring new STIs and HIV infections in this way requires confidentiality safeguards, which is more feasible in programme-linked clinics and more challenging with outside referrals. Monitoring antiretroviral therapy use, adherence and viral load outcomes currently requires working closely with clinical services, which is the role of the peer navigator.

Table 10: Recommended Polling Booth Survey study team structure and scope of duties

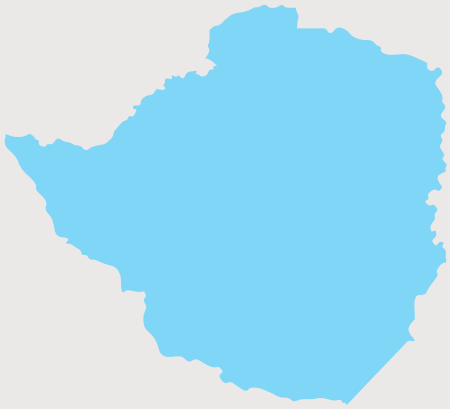
Study coordinator (one per two–three field teams)
■ Coordinates and oversees overall operations of data collection teams.
■ Troubleshoots logistical issues during study implementation.
■ Maintains regular communication and provides updates to study investigators and other stakeholders, like government, other networks, etc.
■ Conducts community consultations before and after the data collection.
■ Disseminates the findings of the study in appropriate forums, including community forums.
Researcher/polling booth survey data collector (one per team)
■ Leads group informed consent procedure with potential Polling Booth Survey participants, using consent form.
■ Facilitates Polling Booth Survey sessions.
■ Tallies Polling Booth Survey responses and fills the reporting form and tallying form.
■ Submits eligibility screening form and Polling Booth Survey tallying form via the data entry platform on tablet or another data entry system.
Community researcher (two per field team)
■ Identifies a random sample of 10–12 potential participants and conducts eligibility screening at locations.
■ Mobilizes selected members at the assigned time of the Polling Booth Survey.
■ Fills the eligibility screening form.
■ Fills the time-location sampling monitoring tool.
■ Oversees and supports the Polling Booth Survey session.
■ Tallies the Polling Booth Survey responses.

Why is it worth investing in?

Measuring outcomes using routine programmatic data from robust access platforms or light touch surveys linked to the programme offers several important advantages over infrequent large-scale surveys: (1) data reflect what is happening across all intervention communities rather than a few sample sites; (2) trends can be followed with regular updates (rather than several years passing between survey rounds); and (3) it is much more cost-effective than large-scale surveys. When triangulated with platform indicators of outreach and service uptake, programmes can continuously assess progress toward outcome and impact targets and adjust as needed. Such analysis of programme data is also useful to inform necessary adjustments to the service package, especially for intersectional risks (i.e. sex workers who inject drugs) (Box 12). Ideally, and if resources permit, both large formal surveys (i.e. IBBS) and programmatic surveys (i.e. BBS-Lite, Rapid Coverage Surveys, Polling Booth Surveys) should be done to capture those reached and not reached by the programme.

Box 12

Changes in HIV Incidence Among Sex Workers in Zimbabwe



In Zimbabwe, programme data from 'Sisters with A Voice' was used to estimate changes in HIV incidence among sex workers. Implementers routinely collected HIV testing data from Sisters' clinic visits between 2013 and 2023. HIV prevalence was stable from 2013 to 2016-17 but declined significantly between 2016-17 (54.6%) and 2021-23 (38.9%). As neither mortality, sampling bias or turnover in the sex worker population explained the recent changes, they can likely be attributed to programmatic changes, such as increasing treatment coverage among male clients and prevention options including expanding PrEP coverage. This is an innovative use of programme data that helps measure impact in the context of TAPs.[64]

What is needed?

- Routine voluntary STI screening, HIV testing and/or viral load monitoring (if these metrics are prioritized).
- UICs, and methods to filter duplication, including multiple HIV tests per individual, and tracking information on individuals as they move outside of nongovernmental and community-based service catchment areas.
- Community organization staff/peer outreach workers to conduct interviewer-led surveys.
- Polling booth equipment or computer-assisted survey software.

Is it in the budget?

- Robust monitoring system with peer–beneficiary interaction data, coupled with clinical data that are aggregated upwards (after being used and acted upon locally).
- Training of peers, peer supervisors, peer navigators, project-supported case managers and project-supported clinical staff in data forms, data entry, data management and security.
- Project staff responsible for aggregated data.
- Design, training and procurement of necessary supplies and implementation of mini surveys with the community.
- Related information technology and analysis support.

See Annex 5 for a budget template for conducting a BBS-Lite survey.

Suggested reading

Global Prevention Coalition. New directions in measuring combination HIV prevention: a think tank series to align measurement of HIV prevention to the Global AIDS Strategy 2021–2026. Geneva: UNAIDS; 2022 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/New-Directions-in-HIV-Prevention-Measurement-Series-Report-Final.pdf).

Expanded polling booth surveys (ePBS) for assessing HIV outcomes among key and prioritised populations: Implementation guide and manual. Nairobi: Partners for Health and Development in Africa; 2023 (https://cdn.prod.website-files.com/63ff2c1bed17e622bce9c2ea/65c47b23b8b21c7e5803ac09_expanded%20Polling%20Booth%20Survey%20Manual_full%20document.pdf).

HIV prevention outcome monitoring workshop. Johannesburg: South–South Learning Network; 2024 (https://www.hivinterchange.com/events/ssln-hiv-prevention-outcome-monitoring-workshop

HIV Prevention Outcome Monitoring Toolkit (POMT). Annex 2. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2024 (https://resources.theglobalfund.org/media/13909/cr_me-measurement-hiv-prevention-programs_guidance_en.pdf).

The BBS-lite. A methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations. Implementation tool. Geneva: UNAIDS; 2023 (https://jointsiwg.unaids.org/wp-content/uploads/2024/05/UNAIDS_BBS-liteTool_EN_WEB.pdf).

EpiC. Guideline for conducting a rapid coverage survey of HIV services among key populations. Durham, NC: FHI 360; 2023 (https://www.fhi360.org/resources/guideline-conducting-rapid-coverage-survey-hiv-services-among-key-populations).

2.4. Embedding Community-led Monitoring

Community-led monitoring is essential to assess the quality and accessibility of services and ensure that the data generated are used to tailor responses to the needs of people living with HIV and key populations, including young key populations.

What is it?

Community-led monitoring (CLM) uses a structured platform and rigorously trained peer monitors to collect and analyse qualitative and quantitative data on HIV service delivery and to establish rapid feedback loops with decision-makers to implement reforms.[65] It can also be used to monitor funding, policy, human rights, community engagement and other elements of a key populations programme.[66,67,68,69] Key population-led CLM is increasingly recognized as important, for example by the USA through PEPFAR.[70] When embedded in TAPs, this mechanism can help to identify issues and co-create solutions to remove barriers and optimize the accessibility, availability, acceptability and quality of HIV services. Some common CLM methods used in key population TAPs include:

- Mystery shoppers.
- Feedback hotlines.
- Community scorecards.
- Clinic records surveys.
- Facility exit interviews.
- Focus group discussions and key informant interviews with service users and health-care workers.

Community-led monitoring should be supported by the programme and the data it generates routinely incorporated into programme reviews and problem-solving meetings. It should be embedded in the TAP and led by peers and service users who access services from it. For objectivity, the CLM component should be conducted by a community organization that is not involved in direct service delivery. Reporting links from the community to national key population groups should use CLM data to inform national advocacy, or solutions to challenges faced at the local level. As programmes evolve for greater ownership, CLM should be integrated into community decision-making and engagement processes (Table 11).

Table 11: Calculating service availability as part of CLM for key populations[71]

		Service availability tally sheet						
Service visits during Q2		HIV Testing		PrEP		STI Treatment		All services available (Y/N)
Client	Key population	Sought	Received	Sought	Received	Sought	Received	
101	**Gay men and other men who have sex with men**	Y	Y					Y
107	**Female sex workers**	Y	Y	Y	N			N
85	**Transgender women**					Y	N	N
143	**Male sex workers**					Y	Y	Y
122	**People who use drugs**	Y	Y					Y
98	**Transgender women**			Y	Y	Y	Y	Y
114	**Gay men and other men who have sex with men**	Y	N					N
151	**Gay men and other men who have sex with men**	Y	Y					Y
89	**Gay men and other men who have sex with men**					Y	Y	Y
134	**Transgender women**			Y	Y			Y
Total Client Visits: **10**					Total visits where ALL services were available: **7**			
Availability score (7/10)								**70%**

Note: There must be a rigorous system in place to protect peer educators, peer navigators, other health service providers and clients against retaliation for reporting negative aspects of service delivery. Safety and security protocols should consider this aspect and ensure anonymity of all CLM participants.

Why is it worth investing in?

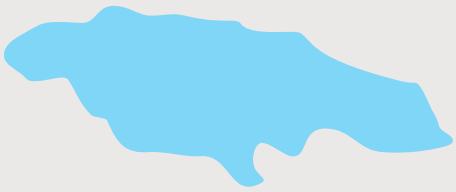
The Global AIDS Strategy prioritizes CLM, aiming to ensure that community-generated data is used to tailor responses to the needs of people living with HIV and key populations, including young key populations. CLM is associated with reduced stigma and discrimination, improved uptake of HIV services, decreased frequency of medicine stockouts, and increased likelihood of viral load suppression.[72]

It is critical for TAPs to be designed to respond to community needs and issues. Early investment in key population-led CLM with an action plan for resolution builds trust and participation in the programme and improves the quality of services (Box 13).

Community-led monitoring is associated with reduced stigma and discrimination, improved uptake of HIV services, decreased frequency of medicine stockouts and increased likelihood of viral load suppression.

Box 13

Quality of HIV Services for Key Populations in Jamaica



In 2019, ten LGBTQ individuals and allies were selected and trained by JFLAG to undertake a 'mystery shopping' assessment to evaluate the quality of HIV services for key populations at five clinics in Jamaica. The mystery shoppers were selected through community networks. An assessment tool was developed and shared with participants during training. Twenty-three assessments were conducted. Most shoppers (70%) felt it was easy to access HIV services, while 28% thought it was difficult. Some 16% of shoppers critiqued certain facilities for lack of professionalism and or lack of privacy for HIV testing. The shoppers recommended scaling up gender sensitivity training to improve access to services for transgender people.[73]

What is needed?

- A plan for CLM of service quality using peer networks, community feedback meetings, systematic community data collection, qualitative research, or similar methods.
- Negotiation with clinical services and government offices regarding community data and identifying platforms for routine engagement and bidirectional feedback in regular meetings.
- Support for data collection (if it is not part of routine outreach).
- Robust data analysis methods and frameworks to ensure credibility of data generated through CLM.
- Reporting links with national key population advocacy groups, national Key Population Technical Working Groups, or other relevant structures.
- Where possible, integration of CLM data into national monitoring and evaluation systems, including routine monitoring such as DHIS2.

Is it in the budget?

- Training (and refreshers) for data collectors and data supervisors.
- Data collector's stipends/salaries and transport.
- Support for community feedback meetings.
- Support for community involvement in problem-solving meetings with referral services and government.
- Community-led monitoring of programme/referral services:
  - Technical and financial support for communities for routine monitoring.
  - Education of community monitors on the elements of international standards for care and services, data collection methods and information gathering.
  - Tools tested, database established and interpretation support/training provided.
  - Linkage to national key population network.
- Support for other qualitative methods with technical assistance (e.g. focus groups, key informant interviews, exit interviews and mystery client).
- Electronic devices and software subscriptions for electronic client feedback systems (if needed).
- Financial and technical support for outside community members to monitor quality.
- Production of advocacy materials using CLM data
- Advocacy meetings with key decision-makers to present CLM data and co-create solutions.

See Annex 4 for a sample budget for peer-led mystery shopping CLM.

Suggested reading

Community-led monitoring of HIV services toolkit: a guide for key populations. Selangor: SKPA2; 2024 (https://assets.healthequitymatters.org.au/wp-content/uploads/2024/10/04034619/DIGITAL_SKPA-2_CLM_Toolkit_FINAL.pdf).

Makoni T, Kadziyanhike G, Mademutsa C, Mlambo M, Malama K. Community-led monitoring: a voice for key populations in Zimbabwe. J Int AIDS Soc. 2022;25(Suppl 1):e25925 (https://pmc.ncbi.nlm.nih.gov/articles/PMC9274208/pdf/JIA2-25-e25925.pdf).

State of healthcare for key populations. Johannesburg: Ritshidze; 2022 (https://ritshidze.org.za/wp-content/uploads/2022/01/Ritshidze-State-of-Healthcare-for-Key-Populations-2022.pdf).

Mystery shopper assessment report. Kingston: JFLAG Equality for All Jamaica; 2019 (https://www.equalityjamaica.org/wp-content/uploads/2021/08/Mystery-Shopper-Assessment-Report.pdf).

Manual on the "secret client" methodology for assessing the quality of the services related to HIV treatment and prevention among MSM and trans people. Tallinn: ECOM; 2018 (https://ecom.NGO/library/secret_client_en).

LINK—electronic client feedback systems for HIV programs. Durham, NC: FHI 360 Linkages; 2019 (https://www.fhi360.org/wp-content/uploads/drupal/documents/resource-linkages-electronic-client-feedback-systems.pdf).

2.5. Strengthening Community Capacity and Leadership

Capacity-building and community empowerment is a progressive process arising from well-implemented key population programmes that can be facilitated by a range of community systems strengthening activities.

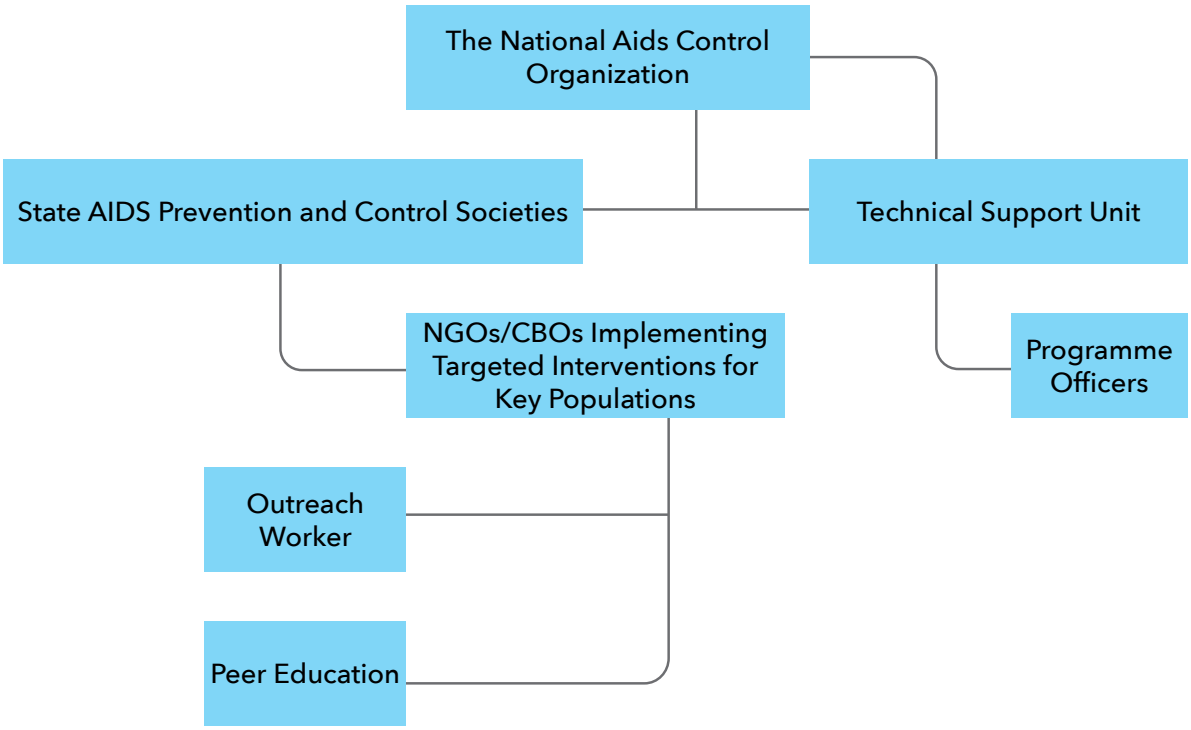
What is it?

Community empowerment is a progressive process arising from well-implemented key population programmes that can be facilitated by a range of activities to strengthen community systems. Evidence suggests that community ownership of key populations programmes is associated with positive behavioural and clinical outcomes.[74]

Key population-led organizations actively engaged in service delivery and engagement processes should be supported to strengthen their own institutional, financial and technical capacity. Key population programmes should have capacity strengthening and community engagement plans for peers and staff. Staff development requires a capacity building mechanism or technical capacity unit that includes training and supportive supervision based on standards closely linked to programme monitoring. Programmes should provide opportunities for professional advancement within organizations, particularly for peers to move up into oversight or managerial positions.

Many key populations organizations possess advanced knowledge and experience. These can be engaged as technical assistance providers to strengthen TAPs. Key population-led technical support is most effective for this kind of capacity strengthening. Key population technical support units have been established in India, Kenya, Mozambique, South Africa and Zimbabwe to strengthen programme and implementer capacity (Figure 7). These units provide flexible, roving support to programme implementers, ranging from strategic planning to community outreach, clinical support, capacity building, communications and advocacy guidance.[75]

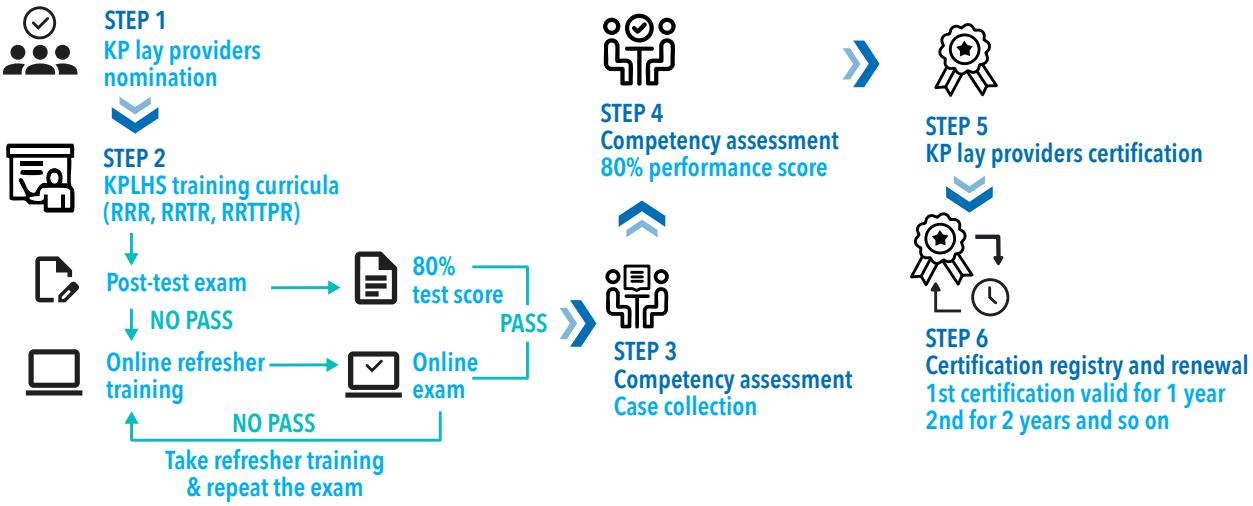
Figure 7. Structure of India's key population programme with built-in technical support unit[76]



Why is it worth investing in?

Building capacity of community and staff facilitates and strengthens programme implementation while building trust and empowering communities to play a leading role. Strengthening the capacity of key population-led and focused organizations is an important component of sustainability. Key population-led HIV prevention models are more cost-effective than public services in some contexts.[77,78] (Box 14). Further, formal accreditation of key population organizations is an important step for social contracting and universal health coverage (Figure 15).

Figure 8. Process for training and accrediting key population-led health service providers in Thailand[79]



Box 14

Addressing Low Uptake of HIV Services By Key Populations in Thailand

In 2015, the key population-led health services (KPLHS) model was established to address low uptake of HIV services by key populations. A rigorous training curriculum and certification process was developed. To date, 625 KP lay providers have been trained. Thirty KPLHS sites are certified and 22 are receiving direct reimbursements for service provision from the government through the National Health Security Office. KPLHS contributed 55% of HIV tests in 2018, and 82% of current PrEP users in 2021.[80]

What is needed?

- (Self) assessments to identify capacity development needs.
- Organizational and institutional capacity-building plan(s), including staff and outreach workers for planned services.
- Provision of regular support through a technical support unit or similar mechanism.
- Peer learning and mentorship among key population-led organizations and leaders.
- Articulated and planned progression pathways for key populations to assume increasing responsibilities in the planning, implementation and review of programmes with associated training plans.
- Community systems strengthening at the local level to promote critical enablers, address conditions identified by key populations and support community empowerment.
- Where possible, nationally approved training curriculum and accreditation process.

Is it in the budget?

- Capacity-building needs assessment and planning process.
- Organizational and institutional capacity-strengthening plan and activities.
- Technical support unit or similar capacity building mechanism, ideally peer-to-peer.
- Community systems strengthening plan and activities—leadership development, mentoring, advocacy and research.
- Adaptation of existing capacity-building materials or development of new ones.
- Support for key population engagement in decision-making spaces at all levels.
- Support for communities to link to national, regional and/or global key populations advocacy groups.

Suggested reading

UNAIDS, UNDP, UNFPA. Increasing support and partnerships with key HIV populations. In-reach online training. Geneva: UNAIDS; 2023 (https://hivpreventioncoalition.unaids.org/en/resources/increasing-support-and-partnerships-key-hiv-populations-reach-online-training).

Global Fund to Fight AIDS, Tuberculosis and Malaria, Enda Sante, Civil Society Institute for West and Central Africa. Community pulse: assessing strengths, empowering change—a tool for community-led organizations. Accra: Civil Society Institute for Health; 2024 (https://www.civilsocietyhealth.org/website/wp-content/uploads/2024/08/2024-Community-Pulse-Facilitators_v7-2.pdf).

Mehrotra A, Davis DA, Evens E, White B, Wilcher R. The importance of key population community engagement and empowerment in HIV programming: insights from a global survey with local implementing partners. J Glob Health Rep. 2020;4:e2020044 (https://www.joghr.org/article/12926-the-importance-of-key-population-community-engagement-and-empowerment-in-hiv-programming-insights-from-a-global-survey-with-local-implementing-partner).

Training courses for health workers providing key population-led health services. USAID Community Partnership Project. Bangkok: Institute of HIV Research and Innovation; 2024 (https://www.prepwatch.org/wp-content/uploads/2024/03/Course-syllabus_English.docx)

Matambanadzo P, Otiso L, Kavhaza S, Bhattacharjee P, Cowan FM. Community leadership is key to effective HIV service engagement for female sex workers in Africa. J Int AIDS Soc. 2025;28:e26425 (https://doi.org/10.1002/jia2.26425).

2.6. Sustaining Programmes for Lasting Impact

Integration of trusted access platforms into primary health care is essential for long-term sustainability. Service delivery and financing models should be tailored to local contexts.

What is it?

As the deadline for the 2030 Global Goals approaches, there is a need to transform the HIV responses for greater sustainability. The achievement of targets is uneven, international assistance is declining, progress towards universal health coverage has stalled and a different response is required to reach the most marginalized populations at the tail of the epidemic.[81]

To sustain key population programmes and services, a change in approach is required. Depending on resource availability—and where those resources come from (domestic versus external)— there are different key population programme models.[82]

Strategies to integrate TAPs into primary health-care systems should be explored, as outlined in Section 1.3.1, Figure 4 and Table 12. Integration models must consider the legal and policy environment and never compromise on safety and security. The preferences of key populations should be at the centre when considering sustainability options.[83] Sustained progress will require inclusion of key populations in primary health-care policies and planning.[84]

Expansion of social contracting and other sustainable financing mechanisms for key population programmes and services is critical. National social contracting policies and guidelines should include key populations and HIV prevention programmes (Box 15). In some countries, approaches that blend government, corporate and individual giving have shown success.[85]

Ongoing stigma and discrimination reduction and social norm change is important to ensure that progress towards sustainable TAPs does not face setbacks.

Box 15

State Social Contracts for Key Population Programmes in Kazakhstan

Kazakhstan has been implementing state social contracting for HIV prevention since 2009. Yet, in 2018, just 4 of 20 state social contracts for HIV and TB prevention were benefitting key populations.[86] From 2020–2024, ICAP provided technical support to Almaty City to boost domestic funding in key populations. Support included: defining technical specifications for key population-specific social contracting; training KP organizations; and assisting with applications. As a result, in 2022 and 2023, $355 000 was allocated in state social contracts for key population programmes. The number of people living with HIV diagnosed by NGOs increased from 5% in 2021 to 10% in 2022 and 2023.[87]

Why is it worth investing in?

HIV financing challenges are particularly acute for key populations. In 2023, $487.5 million was available for all programmes targeting key populations, of which $261.5 million was focused on comprehensive prevention programmes—representing just 4.5% of the need. Further, it is estimated that only 14.2% of funding for key populations comes from domestic public sources.[88] In 2024, only 2.6% of total HIV funding was spent on programmes for key populations, despite accounting for an estimated 80% of new HIV infections outside sub-Saharan Africa and about 25% in sub-Saharan Africa.[89] The 'Prevention 2030' Global Access Framework emphasizes that spending on HIV prevention services for key populations (excluding PrEP) must reach 13% of total funding by 2030.[90] The Framework contains a new top-line target to see 20% of domestic funding for HIV go towards prevention, noting that domestic funding for key population is especially critical.

In 2025, abrupt policy changes from the United States Government paused and then cancelled billions in HIV funding, with key population programmes disproportionately affected.[91,92] One survey found that 88% of key populations organizations have been forced to lay off staff, 77% are grappling with supply chain disruptions, and 76% have had to close offices or service delivery points.[93] Solutions that increase financing—especially domestic financing—are critical to sustaining TAPs.

Table 12: Integration of key population TAPs through NGO–clinic partnerships in Malaysia ('KK Model')[94]

NGO-based key population TAP in collaboration with the ministry of health (MOH)	Clinic-based key population TAP with NGO assistance	Clinic-based key population programme with no NGO involvement
■ Distance between NGO office, clinics, and outreach area is nearby. ■ Government absorbs NGO space and utility cost. ■ Outreach workers (peers) are based in NGO offices. ■ Daily activities are supervised by NGO management. ■ Peers navigate clients to nearby government clinic where partnership is established (OAMT and PrEP are provided there).	■ A strong partnership between the MoH and NGO. ■ Government will absorb the administration cost of managing peers. ■ The model is implemented in small towns. ■ Daily activities of peers are supervised by clinic staff (site supervisor) ■ NGO will recruit and train peers. ■ NGO will do reporting (Programme Manager/ Programme Coordinator).	■ Only pursued if there are no suitable NGOs in the state/district. ■ Technical supervision is conducted directly by the State Health Department. ■ Recruitment, training and support: State AIDS Officer. ■ Temporary model (longer time sustainability and local NGO ownership is desired).
As of 2021, there were 45 such NGO–clinic partnerships in Malaysia, and another seven supported by the Global Fund.		

What is needed?

- Define the suite of key population interventions to be included and costed in the national benefits package.
- Mapping of civil society and community organizations working with key populations who can partner with clinics for integrated models of care, or who can be encouraged to apply for social contracting opportunities.
- Established costing norms for TAPs to facilitate standardized government payments and/or absorption of programme elements.
- Legal and policy reforms to enable community-led service delivery of key programme elements (PrEP, OAMT) and to enable funding to flow from government to community-led organizations for key population service delivery.
- Develop or update national social contracting guidelines to include key population interventions, including HIV prevention.
- Setting up clinic/community partnerships whereby TAPs may be integrated into primary health care through a collaborative approach that maintains key population leadership and ownership of service delivery.

Is it in the budget?

Time for legal experts to draft policy change proposals and sample legislation to expand community-led service delivery and domestic funding mechanisms for key population programmes.

Technical support for mapping exercises to inform NGO–clinic integration efforts and expand access to social contracting.

Consultations with key population service providers to establish evidence-based costing norms.

Sensitization and training for public clinics to be able to provide key population-friendly and key population-competent services.

Joint review meetings between government, clinics and community organizations on the performance of the TAP.

Suggested reading

HIV response sustainability primer. Geneva: UNAIDS; 2024 (https://sustainability.unaids.org/wp-content/uploads/2024/06/HIV-response-sustainability-response-primer_web.pdf).

EpiC, Global black gay men connect. Sustaining the HIV response: a report on consultations with key population communities. Version 1. Durham, NC: FHI 360; 2024 (https://www.fhi360.org/wp-content/uploads/2022/02/resource-epic-report-kp-consultation.pdf).

Towards domestic public financing and social contracting for harm reduction. London: Harm Reduction International; 2024 (https://hri.global/wp-content/uploads/2023/04/SOCIAL-CONTRACTING_FINAL.pdf).

HIV Leadership forum implementing social contracting for HIV prevention: policy brief. Geneva: UNAIDS; 2024 (https://hivpreventioncoalition.unaids.org/en/resources/implementing-social-contracting-hiv-prevention).

Differentiated service delivery: a decision framework for differentiated antiretroviral therapy for key populations. Amsterdam: International AIDS Society; 2018 (https://differentiatedservicedelivery.org/wp-content/uploads/decision-framework-key-population-web3.pdf).

Ncube, G. Lessons learnt implementing integrated KP-focused HIV/SRHR programs in the public sector, Zimbabwe. New York: ICAP-Columbia University; 2023 (https://cquin.icap.columbia.edu/wp-content/uploads/2023/11/Ncube_Session-11c_DSD-for-Key-Populations_Final-for-posting.pdf).

ANNEXES

Annex 1: Benchmarking Unit Costs for Trusted Access Platforms

When costing key population TAPs, it is useful to benchmark the estimated resource needs against established unit costs. These costs can vary significantly by country (and indeed by district, and by implementer). Benchmarking can be used as a check to ensure that unit costs are reasonable. If they are too low, this could indicate that critical package elements are missing. If they are too high, the TAP may not be sustainable (Table 13).

Table 13: Regional unit costs for key population outreach, UNAIDS resource estimation (fast-track modelling)[95]

Region	Population	Average unit cost	Median unit cost
Africa–East and Southern	Gay men and other men who have sex with men	$128.00	$100.80
	Sex workers	$80.40	$94.00
	People who inject drugs	$94.90	$135.00
Africa–West and Central	Gay men and other men who have sex with men	$53.60	$51.20
	Sex workers	$53.30	$52.70
	People who inject drugs	$89.40	$90.30
Asia and the Pacific	Men who have sex with men	$45.40	$44.50
	Sex workers	$66.30	$77.40
	People who inject drugs	$144.80	$161.90
Caribbean	Gay men and other men who have sex with men	$44.50	$44.50
	Sex workers	$29.90	$29.90
	People who inject drugs	$48.90	$48.90
Eastern Europe and Central Asia	Gay men and other men who have sex with men	$47.20	$44.60
	Sex workers	$122.90	$108.10
	People who inject drugs	$117.00	$122.50
Latin America	Gay men and other men who have sex with men	$44.50	$44.50
	Sex workers	$29.90	$29.90
	People who inject drugs	$48.90	$48.90
Middle East and North Africa	Gay men and other men who have sex with men	$105.00	$105.00
	Sex workers	$15.40	$15.40
	People who inject drugs	$68.50	$68.50

A 2024 UNAIDS review contains more than 350 unit costs for community-led and community-based key populations interventions in 26 countries (Table 14). These data are more granular and may assist with further cost benchmarking or resource needs estimates. The Systematic Review Database is accessible via the UNAIDS HIV Financial Dashboard.[96]

Table 14: Unit costs for select key populations interventions, 2024 UNAIDS review (various studies)[97]

Country	Population	Intervention	Unit cost
Burkina Faso	Female sex workers	Cost per HIV-negative client	$56.70
Côte d'Ivoire	Female sex workers	Cost per HIV self-test kit distributed	$13.00
Kenya	Female sex workers	Cost per person tested	$9.56
India	Male sex workers	Cost per person reached	$90.00
	Transgender people	Cost per person reached	$116.00
Indonesia	People who inject drugs	Cost per HIV test	$65.00
Mexico	Gay men and other men who have sex with men	Cost per person reached	$14.00
Mali	Gay men and other men who have sex with men	Cost per HIV self-test kit distributed	$28.00
Senegal	Gay men and other men who have sex with men	Cost per HIV self-test kit distributed	$27.00
South Africa	Female sex workers	Cost per PrEP per person-year	$146.60
Thailand	Male sex workers (Phuket)	Cost per person served	$74.90
	People who inject drugs (Yala)	Cost per person served	$144.20
Uganda	Gay men and other men who have sex with men	Cost per person tested	$15.90
Vietnam	People who inject drugs	Cost per person on OST per year	$378.00
Zimbabwe	Key populations (not disaggregated)	cost per client initiated on PrEP	$86.00

Annex 2: Outreach and Management Team Functions

Peer educators/outreach workers	Peer navigators
Peer educators/outreach workers function as part of the case management team by: ■ Reaching key populations. ■ Ensuring they are engaged in prevention and clinical services, and that they are re-engaged in services if needed. ■ Assisting the team in tracking individuals who may be inactive/lost to follow-up. Depending on the programme, peer educators and workers can often become peer navigators or peer supervisors with the appropriate training and experience.	Peer navigation is an approach used by programmes across countries to ensure that key populations are linked to and guided through the process of accessing (and remaining in) needed services and participate in the clinical case management team (with case manager and possibly clinical staff). Peer navigators are usually HIV-positive (or HIV-affected), medication-adherent role models who understand how to access and use key services, and who can communicate that information clearly and accurately. The goal for peer navigation is that newly diagnosed individuals are supported: ■ To enrol in treatment and remain within the service network to achieve viral suppression. ■ To enrol in medically based prevention (e.g. antiretroviral therapy) within the service network. ■ To remain adherent. Peer navigation picks up where peer outreach traditionally leaves off. Peer navigators work full-time as part of a case management team to assist HIV-positive service beneficiaries with enrolling in and accessing care and treatment services. They support them to identify and overcome barriers that interfere with achieving personal health-related goals. They also assist HIV-negative service beneficiaries to obtain medically based prevention and support them. Peer navigators can be drawn from the pool of peer outreach workers, but they should receive additional training to ensure they have expert knowledge about all of the relevant facility and community-based services available for their beneficiaries. It should also be possible for them to be trained to provide case management services and understand their responsibility in maintaining confidentiality.

Peer supervisors	Case manager
Peer supervisors strengthen outreach efforts by supporting and overseeing peer educators in their work to reach key populations and keep them engaged in prevention and clinical services. They work closely with peer educators in reviewing their work and data, helping them plan the subsequent work and engaging in shared problem-solving. Their role is also to consolidate outreach data from the peer educators and ensure it is reported upwards, and they participate in relevant management and data review meetings.	Case managers strengthen patient outcomes throughout the HIV prevention and care continuum, including: ■ Linkage to antiretroviral therapy-based prevention. ■ Early linkage to care and treatment. ■ Retention in care and treatment. ■ Sustained antiretroviral therapy adherence through assessing client needs. ■ Development, monitoring and evaluation of treatment plans and progress. ■ Liaison between the client and other service providers to ensure comprehensive client care. Depending on the setting (community or facility based), the case manager's role might vary. Various cadres (including peer navigators) can provide case management services and be designated as a case manager, depending on the context and programme. A case manager can also play a role in coordinating with facilities and personnel that are not in the catchment area to ensure that key populations are being supported and linked to appropriate services.

Annex 3: Progression Matrix for Trusted Access Platforms

Table 15: Maturity model for a TAP

	Poor practice	Start-up	Consolidating	High quality
Planning/ replanning	■ Random visits to hotpots by mobile teams chasing one-off targets. ■ No continuous high-risk venue presence or community engagement. ■ Peer educators unsupervised. ■ No remapping to update PSEs and locations.	■ High-level mapping to identify national priority areas and programme gaps. ■ Programmatic mapping and PSEs to guide local outreach/service referral. ■ Peer outreach designed for continuous hotspot presence.	■ Microplanning to empower community outreach workers to assess and improve work. ■ Targets with regular dashboard review of priority programme indicators (PPIs), HIV testing and counselling, and linkage to care to assess progress. ■ Periodic high risk venue validation to refine PSE denominators and targets, and to look for individuals not covered.	■ Scale achieved through coverage of main national sex work areas. ■ Outreach uptake ■ >90% PSE at the majority of sites. ■ Outreach frequency at least monthly. ■ Regular HIV testing and counselling of HIV- negative individuals per standard operating procedures of the country. ■ Strong linkage to care and adherence. ■ Special efforts to find the unserved.
Target-setting	■ Narrow reach, testing and yield targets. ■ Lack of unique identifiers does not permit relating performance to PSEs.	■ Clear targets set for at least four PPIs for outreach: outreach uptake and frequency, clinic uptake and frequency. ■ Clear targets for linkage to treatment and retention.	■ Documented progress towards >90% outreach uptake, frequent outreach contacts, >80% clinic uptake and regular check-ups. ■ Documented progress on linkage to treatment and retention.	■ Outreach targets stratified by risk, with more frequent contacts (weekly) for those assessed to be at highest risk. ■ Approaches developed for differentiated approaches to linkage to treatment and retention.

	Poor practice	Start-up	Consolidating	High quality
Monitoring/ supervision	■ No monitoring/ supervision of progress (outreach uptake/frequency). ■ No population denominators.	■ Monitoring and supervision framework in place to track progress and support outreach and clinic staff.	■ Microplanning systems with weekly supervision and planning of outreach work, focus on PPIs. ■ Peer navigators plan the follow-up of key population members.	■ Monthly and quarterly meetings at higher levels to review data, solve persistent problems and support local teams.
Outreach	■ Uptake and frequency not monitored.	■ Peer outreach organized to cover high risk venues with appropriate ratios (approximately 1:50 peer educators to key populations). ■ Peer navigators organized to support key population members with treatment or medical prevention (a ratio of 1:20 to 1:30 of peer navigators to key population members needing services).	■ Approaching 90% outreach uptake and monthly outreach contacts.	■ High level of coverage (90% or 'saturation') coverage, full uptake with frequent contact.
Prevention commodity interventions (condoms/ lubricants, needles and syringes)	■ Intermittent, no planning, systems or targets based on need, intermittent supply with stock-outs.	■ Regular condom/ lubricant (and needle and syringe) distribution through outreach, supported by functioning logistics, with messages reinforced at clinic visits.	■ Condom promotion and distribution reflect assessed need (i.e. it is in relation to the number of reported clients).	■ Strong condom promotion and distribution system, with no stock-outs or interruptions. ■ Condom use assessed by Polling Booth Surveys. ■ Or related survey method.

	Poor practice	Start-up	Consolidating	High quality
Clinical/ medical services	■ Uptake and frequency not monitored. ■ No assistance or follow-up to referrals.	■ Promotion of clinic visits for regular check-ups. ■ Referral system for additional medical services established.	■ >80% clinic uptake, followed by regular check-ups. ■ Referred individuals assisted with making it to clinics and efforts made to support adherence.	■ Regular quarterly check-ups. ■ Evidence of STI declines. ■ Robust case management in place with documented high adherence to medical treatment and prevention.
Structural interventions	■ No attention.	■ Assessment and dialogue about main problems.	■ Violence reporting and response mechanism. ■ Linkages established with national key population networks.	■ Self-help groups/ community committees set priorities, implement responses and monitor impact.
Community ownership	■ No attention.	■ Assessment and early engagement of programme with key population community.	■ Programme working with key population community in implementation of interventions. ■ Community has role in decision-making.	■ Key population community members capacitated with increasing leadership roles in the nongovernmental and community-based organizations. ■ A clear progression plan for increasing community responsibility and leadership.

Annex 4: Sample Budget for Programmatic Mapping

Table 16 shows a sample budget for PPM for key populations.[e] The figures are illustrative and should be adapted to the country and the size of the areas that will be mapped. Table 17 shows the estimated costs for conducting PPM and size estimation of key populations.

Table 16: Sample budget for conducting participatory programmatic mapping and size estimation of key populations[98]

Phase	#	Unit cost	# of weeks	% Loe	Total
1. Preparation phase budget					
Legal environment assessment	1	-	-	-	$1000
Mapping readiness assessment	1	-	-	-	$500
Formative research on typology of sites and sub-groups	1	-	-	-	$1500
Community engagement	1	-	-	-	$500
Ethical review	1	-	-	-	$500
Community advisory board	1	-	-	-	$300
Formative work to develop protocol and instruments	1	-	-	-	$200
Work to develop emergency plan and legal assistance	1	-	-	-	$500
2. Field work budget					
A. National level					
In country manager	1	$500	22	100%	$11 000
Mapping specialist	1	$300	13	50%	$1950
Budget and admin person	1	$300	22	100%	$6600
Data manager	2	$300	16	100%	$9600
Four day training workshop--Participants: national stakeholders	10	$100	-	-	$1000
Four day training workshop--Participants: national team	5	$100	-	-	$500
Participants: Two people from each area (ten areas)	20	$500	-	-	$10 000
Transportation and travel costs to districts for field work	1	$400	20	-	$8000
National feedback workshop and action plans	1	$300	-	-	$1000
B. Selected geographical area level (may be comprised of several zones): 1 of these per geographical area					

e. This example assumes ten geographical areas, with a total of 49 zones: one city of 1 000 000; one city of 250 000; one district of 200 000; five cities with 150 000 and two areas with 100 000.

Local field supervisor	1	$300	2	100%	$600
Assistant supervisor	2	$200	2	100%	$800
Training–two days each	3	$800	1	1	$2400
Interviewer training	10	$150	1	100%	$1500
Social mobilizer training	10	$150	1	100%	$1500
Supplies	1	$400	1	1	$400
Local stakeholder meeting to introduce study before field work	1	$500	1	1	$500
Feedback workshop and action plans	1	$500	1	1	$500
Local total for one selected geographic area	–	–	–	–	$8200
C. Zone level (zone population : 50 000)					
Local field supervisor	1	$300	0.5	100%	$150
Assistant supervisor	2	$200	0.5	100%	$200
Interviewers	10	$150	0.5	100%	$750
Social mobilizers	10	$150	0.5	100%	$750
Photocopies of questionnaires and fact sheets	800	$0.25	1	1	$200
Transportation	1	$1000	0.5	1	$500
Data entry technicians	2	$150	0.5	50%	$75
Local total for one zone	–	–	–	–	$2625
				GRAND TOTAL	**$244,650**

Table 17: Estimated costs for conducting PPM and size estimation of key populations

Size of area to be mapped	Estimated cost (us $)
City of two million	$113 000
City of one million	$61 000
City of 500 000	$34 500
City of 250 000	$21 500
City of 100 000 or less	$13 500 or less
District with urban and rural areas/population of district 100 000 or less	$15 000

Annex 5: Budget Template for a BBS-Lite Survey

The estimated cost of a BBS-lite survey is $80 000 (Table 18), compared to about $200 000 for a full IBBS.[99]

Table 18: Budget template for BBS-lite survey

	Units	Number/frequency	Unit cost	Total cost
Staffing costs				
Chief investigator				
Co-investigators				
Study coordinator				
Data collectors (health service/NGO staff)				
Database manager				
Statistician				
Administrative support				
Subtotal				
Total staffing costs				
Meeting costs				
Venue hire				
Refreshments				
Subtotal				
Research costs				
Ethics review				
Subtotal				
Database				
Database and survey instrument development				
Server to host database (monthly charge)				
Subtotal				
Recruitment and data collection				
Printing (consent and information forms, coupons)				
Tablets (purchase, lease, existing)				
Participant reimbursement				
Subtotal				
Reporting and publication				
Design				

	Units	Number/frequency	Unit cost	Total cost
Printing				
Subtotal				
Support costs				
Office supplies				
Transport				
Subtotal				
Total non-staffing costs				
Total costs				

Annex 6: Sample Budget For Peer-Led Mystery Shopping

Table 19 illustrates a budget for conducting CLM using a mystery shopper model and peers from the TAP. Based on this example, from three major metros, recruitment and training of peer mystery shoppers were the most expensive tasks. Average start-up costs were $10 001. Four-month average implementation costs per visit were $228. Average annual implementation costs per visit were 33% lower at $151. Note, however, that this example is from the United States of America. Costs may be significantly less in low and middle-income countries.

Costing guidance for organizations implementing and operating facility-based CLM can range between $100 000 and 150 000 annually.[100] This includes costs for data collection, data management and analysis, project operations and personnel, training/capacity-building, advocacy interventions, hosting stakeholder meetings, and monitoring visits/data quality audits. This cost range varies by country, based on general cost of living, number of data collection sites, use of paper-based versus digital data collection, number of personnel, distance between sites, and location of data collection sites (urban/peri-urban/rural).

Table 19: Activities and costs of peer-led mystery shopping for a key population programme in the United States of America[101]

Activities and costs	Major city 1	Major city 2	Major city 3	% of total
Start-up activities				
Project initiation management	$5779	$5873	$5804	58%
Shopper protocol development1	$3284	$3284	$3284	33%
Training research site staff training in shopping protocol	$898	$898	$898	9%
Subtotal: start-up costs	$9961	$10,055	$9986	100%
Implementation activities				
Clinic identification1	$466	$466	$466	5%
Recruitment of mystery shoppers	$2529	$2824	$3862	31%
Training of mystery shoppers	$843	$811	$1216	10%
Incentives for mystery shopper training	$600	$900	$900	8%
Miscellaneous costs for training (food, parking)	$101	$134	$44	< 1%
Coordinating mystery shopper visits to sites	$1111	$1048	$1816	13%
Mystery shopping visit incentives	$1600	$2000	$4500	27%
Staff debriefing with mystery shoppers on site visit findings	$578	$441	$728	6%
Subtotal: implementation costs	$7828	$8623	$13 533	100%
Total cost	$17 789	$18 678	$23 519	100%
Sites				

Activities and costs	Major city 1	Major city 2	Major city 3	% of total
Number of sites (n)	17	19	30	
Number of visits (n)	34	38	60	
Costs per four month trial duration				
Implementation cost per visit	$230	$227	$226	
Total cost by visit	$523	$492	$392	
Cost per year				
Implementation cost per visit2	$145	$150	$159	
Total cost per visit	$248	$233	$214	

REFERENCES

1 HIV Prevention Coalition. Key population trusted access platforms. Considerations in planning and budgeting for a key population platform to deliver scaled, quality HIV prevention and treatment services and for addressing critical enablers. Geneva: UNAIDS; 2020 (https://hivpreventioncoalition.unaids.org/en/resources/considerations-planning-and-budgeting-key-population-trusted-access-platform-july-2020; accessed 6 March 2025).

2 Godbole R. Analyzing USAID program disruptions: Implications for PEPFAR programming and beneficiaries. Washington, DC: Center for Global Development; 2025 (https://www.cgdev.org/publication/analyzing-usaid-program-disruptions-implications-pepfar-programming-and-beneficiaries).

3 Congressional Budget Justification, FY 2026. Washington, DC: U.S. Department of State; 2025; p.126 (https://www.state.gov/wp-content/uploads/2025/05/FY-2026-State-CBJ-.pdf).

4 Nolen S. Trump budget office is withholding H.I.V. funds that Congress appropriated. New York: The New York Times; 21 August 2025 (https://www.nytimes.com/2025/08/21/health/hiv-aids-pepfar-funding-trump.html).

5 GC7 reprioritization and revision of grant activities. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2025 (https://resources.theglobalfund.org/en/gc7-reprioritization/).

6 Alcorn K. US funding cuts cause immediate drops in numbers testing and on HIV treatment. Aidsmap. 21 July 2025 (https://www.aidsmap.com/news/jul-2025/us-funding-cuts-cause-immediate-drops-numbers-testing-and-hiv-treatment).

7 PrEP delivery imperiled. New York: AVAC; 2025 (https://avac.org/resource/infographic/prep-delivery-imperiled/).

8 Ten Brink D, Martin-Hughes R, Bowring AL, Wulan N, Burke K, Tidhar T. Impact of an international HIV funding crisis on HIV infections and mortality in low-income and middle-income countries: a modelling study. The Lancet HIV. 2025;12(5):e346-e354 (https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(25)00074-8/fulltext#fig3).

9 Godbole, R. Analyzing USAID program disruptions: Implications for PEPFAR programming and beneficiaries. Washington, DC: Center for Global Development; 2025 (https://www.cgdev.org/publication/analyzing-usaid-program-disruptions-implications-pepfar-programming-and-beneficiaries).

10 GC7 programmatic reprioritization approach: protecting and enabling access to lifesaving services. Global Fund to Fight AIDS, Tuberculosis and Malaria; 2025 (https://resources.theglobalfund.org/media/sveowiic/cr_gc7-programmatic-reprioritization-approach_summary_en.pdf).

11 Rapid operational guidance on maintaining essential HIV, Hepatitis and STI services during the US Government Funding Pause. Geneva: WHO, to be published.

12 INPUD, NSWP, GATE, MPact, GBGMC WE INSIST! Non-negotiables for and by key populations in the reprioritisation and revision of Global Fund programmes in Grant Cycle 7. Edinburgh: Global Network of Sex Work Projects; 2025.

13 Global HIV Prevention Coalition. Prevention 2030: A global access framework for country-led HIV responses. To be published.

14 Ncube G. Lessons learnt implementing Integrated KP-focused HIV/SRHR programs in the public sector, Zimbabwe. CQUIN 7th Annual Meeting. 13-17 November 2023. Johannesburg.

15 Global HIV Prevention Coalition, South to South Learning Network. Impact case: developing an effective community outreach system for the key populations programme in Tanzania. Johannesburg: SSLN; 2024 (https://drive.google.com/file/d/1LZsGu9nRgu2WD9EhIpQYmnr_yt6jVYTd/view; accessed: 2 March 2025).

16 Cowan FM, Musemburi S, Matambanadzo P, Chida P, Steen R, Makandwa R. Using a programme science approach to substantially reduce the risk of HIV transmission and acquisition in sex transactions among female sex workers in Zimbabwe. J Int AIDS Soc. 2024;27:e26262 (https://pmc.ncbi.nlm.nih.gov/articles/PMC11236902/; accessed 1 March 2025).

17 Smart ladies mobilizes the community to promote the rights and well-being of sex workers in Nakuru, Kenya. EpiC success story. Durham, NC: FHI 360; 2021 (https://www.fhi360.org/wp-content/uploads/2024/02/resource-epic-kenya-success-story-kpif.pdf; accessed 10 February 2025).

18 *Consolidated guidelines* on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2022 (https://www.who.int/publications/i/item/9789240052390; accessed 10 February 2025).

19 WHO implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection: provider module for oral and long-acting PrEP. Geneva: WHO; 2024) (https://iris.who.int/bitstream/handle/10665/378164/9789240097230-eng.pdf?sequence=1; accessed 10 April 2025).

20 Guidelines on lenacapavir for HIV prevention and testing strategies for long-acting injectable pre-exposure prophylaxis. Geneva: WHO; 2025 (https://www.who.int/publications/i/item/9789240111608; accessed 30 July 2025).

21 Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for sex workers. Policy Brief. Geneva: WHO; 2024. (https://www.who.int/publications/i/item/9789240076198 accessed 10 February 2025).

22 Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people who inject drugs. Policy Brief. (Geneva 2023). https://www.who.int/publications/i/item/9789240071858 accessed 10 February 2025).

23 Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for men who have sex with men. Policy Brief. Geneva: WHO; 2024 (https://www.who.int/publications/i/item/9789240076174; accessed 10 February 2025).

24 Recommended package of enabling and health interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for trans and gender diverse people. Policy Brief. Geneva: WHO; 2024 (https://www.who.int/publications/i/item/9789240076211; accessed 10 February 2025).

25 New good practice statement on counselling behavioural interventions for key populations to prevent HIV, viral hepatitis and STIs. Policy Brief. Geneva: WHO; 2023 (https://www.who.int/publications/i/item/9789240072275; accessed 10 February 2025).

26 Sustaining HIV, viral hepatitis and STI priority services in a changing funding landscape: operational guidance. Geneva: WHO; 2025. (https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/sustaining-hiv--viral-hepatitis-and-sti-priority-services-in-a-changing-funding-landscape_pre-launch.pdf?sfvrsn=a7d3ea3f_6&download=true; accessed 30 July 2025).

27 *Consolidated guidelines* on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations Geneva: WHO; 2022 (https://www.who.int/publications/i/item/9789240052390; accessed 10 February 2025).

28 USAID, PEPFAR, Linkages, Bill & Melinda Gates Foundation, University of Manitoba. Monitoring guide and toolkit for key population JHIV prevention, care and treatment programs. Durham, NC: FHI 360 Linkages; 2016 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/resource-linkages-monitoring-tools.pdf; accessed 2 March 2025).

29 UNFPA, Global Forum on MSM and HIV, UNDP, UNAIDS, WHO, USAID. Implementing comprehensive HIV and STI programmes with men who have sex with men (MSMIT). Geneva: WHO; 2015 (https://mpactglobal.org/wp-content/uploads/2015/11/MSMIT-for-Web.pdf; accessed 1 March 2025).

30 Bhattacharjee P, Musyoki H, Prakash R, Malaba S, Dallabetta G, Wheeler T, et al. Microplanning at scale with key populations in Kenya: Optimising peer educator ratios for programme outreach and HIV/STI service utilization. PLoS One. 2018;13(11):e0205056 (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205056; accessed 4 March 2025).

31 Global HIV Prevention Coalition, South to South Learning Network. Impact Case: Developing an effective community outreach system for the key populations programme in Tanzania. Johannesburg: SSLN; 2024 (https://drive.google.com/file/d/1LZsGu9nRgu2WD9EhIpQYmnr_yt6jVYTd/view; accessed 2 March 2025).

32 Designing outreach and microplanning for key population programmes. Johannesburg: South to South Learning Network (https://cdn.prod.website-files.com/63ff2c1bed17e622bce9c2ea/64f6d301d1986ad990d3f8fb_Kenya-Malawi-Zim-outreach-and-microplanning-case-study_FINAL.pdf; accessed 2 March 2025).

33 Avahan, Bill & Melinda Gates Foundation. Micro-planning in peer led outreach programs—a handbook. New Delhi: Bill & Melinda Gates Foundation; 2013 (https://docs.gatesfoundation.org/documents/Microplanning%20Handbook%20(Web).pdf; accessed 2 March 2025).

34 Linkages. Programmatic mapping and microplanning. Standard operating procedure, Sri Lanka. Durham, NC: FHI 360 Linkages; 2020 (https://www.aidscontrol.gov.lk/images/publications/UNAIDS_FHI360/Hotspot-Mapping-and-Validation-SOP-English.pdf; accessed 2 March 2025).

35 Linkages. Ensuring compliance with LINKAGES data safety and security checklists. Durham, NC: FHI 360 Linkages; 2020 (https://www.fhi360.org/sites/default/files/media/documents/data-safety-guidance.pdf; accessed 4 March 2025).

36 UNAIDS, WHO. Virtual interventions in response to HIV, sexually transmitted infections and viral hepatitis. Innovate-implement-integrate. Policy brief. Geneva: UNAIDS; 2022 (https://www.unaids.org/sites/default/files/media_asset/policy-brief_virtual-interventions_en.pdf; accessed 14 April 2025).

37 Linkages. Social media mapping for planning online HIV outreach and service delivery. Durham, NC: FHI 360, Linkages; 2019 (https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-social-media-mapping.pdf; accessed 4 March 2020).

38 UNAIDS, WHO. Virtual interventions in response to HIV, sexually transmitted infections and viral hepatitis. Innovate-implement-integrate. Policy Brief. Geneva: UNAIDS; 2022 (https://www.unaids.org/sites/default/files/media_asset/policy-brief_virtual-interventions_en.pdf; accessed 14 April 2025).

39 Ibid.

40 Bateganya M. Experiences and lessons in optimizing decentralized drug distribution for key populations. Differentiated service delivery for key populations—Virtual meeting. New York: ICAP-Columbia University; 2021 (https://cquin.icap.columbia.edu/wp-content/uploads/2021/08/Bateganya-CQUIN-Key-Pops-Meeting_Final-8_25.pdf; accessed 6 March 2025).

41 *Consolidated guidelines* on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2022 (https://www.who.int/publications/i/item/9789240052390; accessed 10 February 2025).

42 Abdul-Quader AS, Baughman AL, Hladik W. Estimating the size of key populations: current status and future possibilities. Curr Opin HIV AIDS. 2014;9(2);107–114 (https://pmc.ncbi.nlm.nih.gov/articles/PMC6787402/pdf/nihms-1053821.pdf).

43 Mapping and population size estimates of sex workers. Edinburgh: Global Network of Sex Work Projects; 2015, p.3 (https://www.nswp.org/sites/default/files/Mapping%26Population%20Size%20Estimates%20Policy%20Brief%2C%20NSWP%20-%20November%202015_0.pdf).

44 Loeb T, Willis K, Velishavo F, Lee D, Rao A, Baral S.. Leveraging routinely collected program data to inform extrapolated size estimates for key populations in Namibia: small area estimation study. JMIR Public Health Surveill. 2024;10(1):e48963 (https://publichealth.jmir.org/2024/1/e48963/).

45 SANAC, NDOH. South Africa's national sex worker HIV, TB and STI plan: 2019–2022. Pretoria: South African National AIDS Council; 2021, p.32 (https://sanac.org.za/wp-content/uploads/2021/07/NATIONAL-SEX-WORKER-PLAN-WEB-FINAL.pdf).

46 Global Prevention Coalition. New directions in measuring combination HIV prevention: a think tank series to align measurement of HIV prevention to the Global AIDS Strategy 2021–2026. Geneva: UNAIDS; 2022, p.8 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/New-Directions-in-HIV-Prevention-Measurement-Series-Report-Final.pdf).

47 The BBS-lite implementation tool. Geneva: UNAIDS; 2024, pp.56–64 (https://www.unaids.org/en/resources/documents/2024/BBS-lite-tool).

48 Biobehavioural survey guidelines for populations at risk for HIV. Appendix I–4: survey design checklist. Geneva: WHO; 2017 (https://www.who.int/publications/i/item/978-92-4-151301-2).

49 Monitoring HIV programmes with key populations. Geneva: UNAIDS; 2024, p.51 (https://jointsiwg.unaids.org/wp-content/uploads/2025/03/Monitoring-HIV-Programs_English.pdf;accessed 10 February 2025).

50 Ibid, p.10 (https://jointsiwg.unaids.org/wp-content/uploads/2025/03/Monitoring-HIV-Programs_English.pdf).

51 Ngure K, Ortblad KF, Mogere P, Bardon AR, Thomas K, Mangale D. Six-month PrEP dispensing with HIV self-testing to improve the efficiency of delivery in Kenya: a randomized non-inferiority implementation trial. The Lancet HIV. 2022;9(7);e464.

52 Avahan, Bill and Melinda Gates Foundation. Micro-planning in peer led outreach programs: a handbook based on the experience of the Avahan India AIDS initiative. Detailed guidelines, best practices and implementation tools. New Delhi: Bills and Melinda Gates Foundation; 2013; Tools 4 and 8 (https://docs.gatesfoundation.org/documents/Microplanning%20Handbook%20(Web).pdf).

53 Global Prevention Coalition. New directions in measuring combination HIV prevention. A think tank series to align measurement of HIV prevention to the Global AIDS Strategy 2021–2026. Geneva: UNAIDS; 2022, p.11 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/New-Directions-in-HIV-Prevention-Measurement-Series-Report-Final.pdf).

54 Innovate–implement–integrate: policy brief on virtual interventions in response to HIV, sexually transmitted infections and viral hepatitis. Geneva: UNAIDS; 2022 (https://www.unaids.org/sites/default/files/media_asset/policy-brief_virtual-interventions_en.pdf).

55 Linkages. Monitoring guide and toolkit for key population HIV prevention, care, and treatment programs. Geneva: UNAIDS; 2016, p.40 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/resource-linkages-monitoring-tools.pdf).

56 Offering mental health services for LGBTQI+ people in Algeria, Morocco, and Tunisia. Durham, NC: FHI 360; 2022. (https://unitedgmh.org/app/uploads/2025/03/ilovepdf_merged-1.pdf; accessed 24 November 2025).

57 Linkages. Unique identifier codes: guidelines for use with key populations. Durham, NC: FHI 360, Linkages; 2016 (https://www.fhi360.org/wp-content/uploads/drupal/documents/resource-linkages-uic-guidance.pdf).

58 KELIN, Kenya Key Populations Consortium. "Everyone said no" Biometrics, HIV and human rights: a Kenya case study. Nairobi: KELIN; 2018 (https://www.kelinkenya.org/wp-content/uploads/2022/12/Everyone-said-no.pdf).

59 Global summary of findings of an assessment of HIV services packages for key populations in six regions. Washington, DC: AMPG Health; 2019; p.15 (https://www.globalfundadvocatesnetwork.org/wp-content/uploads/2019/04/ASSESSMENT-OF-HIV-SERVICES-PACKAGES-FOR-KEY-POPULATIONS-IN-SIX-REGIONS.pdf).

60 Rampilo M, Phalane E, Phaswana-Mafuya RN. Tracking HIV outcomes among key populations in the routine health information management system: a systematic review. Sexes. 2025;6(3):32 (https://www.mdpi.com/2411-5118/6/3/32).

61 Rampilo M, Phalane E, Phaswana-Mafuya RN. Piloting the inclusion of the key populations unique identifier code in the South African routine health information management system: protocol for a multiphased study. JMIR Res Protocols. 2024;13(1):e55092 (https://www.researchprotocols.org/2024/1/e55092/).

62 UNAIDS, WHO. The bio-behavioural survey "lite": a methodology for monitoring programmes providing HIV, viral hepatitis and sexual health services to people from key populations. Implementation tool. Geneva: UNAIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/BBS-lite-tool_en.pdf).

63 HIV prevention outcome monitoring toolkit (POMT). Geneva: Global Fund for Fighting AIDS, Tuberculosis and Malaria; 2024; Annex 2. (https://resources.theglobalfund.org/media/13909/cr_me-measurement-hiv-prevention-programs_guidance_en.pdf).

64 Chabata S, Jones HS, Hove T, Ali S, Bansi-Matharu L, Machingura F, Takaruza A, Matambanadzo P, Dirawo J, Steen R, Busza J, Yekeye R, Mugurungi O, Phillips A, Cowan FM, Hargreaves JR. Decline in HIV prevalence among female sex workers in Zimbabwe between 2013 and 2023 (in press).

65 Establishing community-led monitoring of HIV services. Geneva: UNAIDS; 2021 (https://www.unaids.orgsites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf).

66 Resource tracking for HIV prevention research and development. Working Group annual publication. New York: (AIDS Vaccine Advocacy Coalition (AVAC) (https://www.hivresourcetracking.org/).

67 Global HIV policy watch. Washington, DC: International Association of Providers of AIDS Care (https://www.hivpolicywatch.org/).

68 Community engagement monitoring tool manual 2023. Bryanston, South Africa: International Treatment Preparedness Coalition; 2023 (https://itpcglobal.org/wp-content/uploads/2023/09/Community-Engagement-Monitoring-Tool-Manual-Version-1.0_English.pdf).

69 The rights–evidence–ACTion (REAct) tool. Brighton: Frontline AIDS; 2021(https://frontlineaids.org/our-programmes/react/).

70 PEPFAR 2023 country and regional operational plan (COP/ROP). Guidance for all PEPFAR-supported countries. Washington, DC: U.S. Department of State, PEPFAR; 2023; p.109 (https://www.state.gov/wp-content/uploads/2023/02/PEPFAR-2023-Country-and-Regional-Operational-Plan.pdf).

71 SKPA2. Community-led monitoring of HIV services toolkit: a guide for key populations. Surry, New South Wales: Health Equity Matters; 2024 (https://assets.healthequitymatters.org.au/wp-content/uploads/2024/10/04034619/DIGITAL_SKPA-2_CLM_Toolkit_FINAL.pdf).

72 Oberth G, Lauer K, Bozinovski J, Mwebe S, Tshuma N, Soboyisi M, et al. Strengthening the use of community-led monitoring data in the HIV response: findings from an operational research initiative in Malawi and South Africa. Gates Open Res Preprint. VeriXiv. 2025;2(12):12.

73 Mystery shopper assessment report. Kingston: JFLAG Equality for All Jamaica; 2019 (https://www.equalityjamaica.org/wp-content/uploads/2021/08/Mystery-Shopper-Assessment-Report.pdf).

74 Moore L, Chersich MF, Steen R, Reza-Paul S, Dhana A, Vuylsteke B. Community empowerment and involvement of female sex workers in targeted sexual and reproductive health interventions in Africa: a systematic review. Globalization Health. 2014;10(1):47 (https://link.springer.com/article/10.1186/1744-8603-10-47).

75 Kenya Ministry of Health. The successful chase: TSU initiatives reduce HIV risk among key populations in Kenya. Nairobi: Ministry of Health; p.6 (https://cdn.prod.website-files.com/63ff2c1bed17e622bce9c2ea/64f6cf65675d8b902cad104b_Kenya-KP-TSU-Case-Study_FINAL.pdf).

76 World Bank. Targeted interventions. India's pathbreaking approach to address the HIV/AIDS epidemic: key successes, lessons and the future. Washington, DC: World Bank; 2012; p.10 (https://documents1.worldbank.org/curated/en/818261616735177221/pdf/Targeted-Interventions-India-s-Pathbreaking-Approach-to-Address-the-HIV-AIDS-Pandemic-Key-Successes-Lessons-and-the-Future.pdf).

77 Versteegh L, Amatavete S, Chinbunchorn T, Thammasiha N, Mukherjee S, Popping S. The epidemiological impact and cost-effectiveness of key population-led PrEP delivery to prevent HIV among men who have sex with men in Thailand: A modelling study. The Lancet Regional Health-Southeast Asia. 2022;7 (https://www.thelancet.com/journals/lansea/article/PIIS2772-3682(22)00113-5/fulltext).

78 Ibid.

79 KPLHS: Key population-led health services. Birkirkara, Malta: International Health Research Institute;. 2021 (https://ihri.org/wp-content/uploads/2022/10/KPLHS-factsheet.pdf).

80 Pengnonyang S, Ramautarsing RA, Janyam S, Chaisalee T, Chanlearn P, Vannakit R. Certification of lay providers to deliver key population-led HIV services in Thailand's National Healthcare System: lessons learned. J Int AIDS Soc. 2022;25(7):e25965 (https://onlinelibrary.wiley.com/doi/10.1002/jia2.25965).

81 HIV response sustainability primer. Geneva: UNAIDS; 2024 (https://www.unaids.org/sites/default/files/media_asset/HIV%20response%20sustainability%20response%20primer_web.pdf).

82 Global HIV Prevention Coalition. Scalable and sustainable HIV primary prevention models for people from key populations; to be published.

83 EpiC. Global black gay men connect. Sustaining the HIV response: a report on consultations with key population communities. Version 1. Durham, NC: FHI 360 ; (2024) (https://www.fhi360.org/wp-content/uploads/2022/02/resource-epic-report-kp-consultation.pdf).

84 Coleman M, Akolo C, Mbanusi A, Sithole B, Siberry GK, Schowen R, et al. Integrating HIV and primary healthcare for key populations: community-led models from Vietnam, Nigeria and Eswatini. J Int AIDS Soc. 2025;28(9):e70027 (https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.70027).

85 Malaysian AIDS foundation annual report 2023. Kuala Lumpur: Malaysia AIDS Foundation; 2024 (https://maf.org.my/V2/wp-content/uploads/2024/08/Annual-Report-2023_MAF_A4_A_07082024-s.pdf).

86 Taking stock of budget advocacy efforts in Eastern Europe, South-Eastern Europe and Central Asia: Kazakhstan country case. Vilnius: Eurasian Harm Reduction Association; 2021 (https://old.harmreductioneurasia.org/wp-content/uploads/2022/02/Казахстан-англ.pdf).

87 Sauranbayeva M. Kazakhstan: How advocacy with the Almaty City Deputies led to the allocation of US$355,000 in 2023 and 2024 for social contracting of HIV prevention interventions among key populations, including community-led harm reduction interventions. Presentation at virtual learning event on 3 September 2024. Influencing the Allocation of Sub-National Public Financing for Community-led HIV Responses in Asia and the Pacific: Strategies and Approaches for Effective Budget Advocacy, convened by UNAIDS and Seven Alliance; 2024.

88 Aidsfonds, Love Alliance. Dangerously off track: how funding for the HIV response is leaving key populations behind. Amsterdam: Aidsfonds; 2025; p.5 (https://aidsfonds.org/wp-content/uploads/2024/11/Dangerously_off_track_EN_web.pdf).

89 AIDS, crisis and the power to transform: UNAIDS Global AIDS Update 2025. Geneva: UNAIDS; 2025; pp.8 and 55 (https://www.unaids.org/en/resources/documents/2025/2025-global-aids-update).

90 Stover JG, Mattur D, Siapka M, Pliakas T, Valladares-Cardona R. The impact and cost of reaching the UNAIDS global HIV targets. medRxiv, 2025-07; p.13 (https://www.medrxiv.org/content/10.1101/2025.07.01.25330647v1.full.pdf).

91 Impact of the PEPFAR funding freeze on programs for key populations. New York: Global Black Gay Men Connect; 2025; p.12 (https://gbgmc.org/wp-content/uploads/2025/03/Frozen-Out.pdf).

92 Oberth G, Bozinovski J, Lauer K, Rafif N, Sithole S, Mwanza H, et al. Service-level effects of HIV funding cuts in Southern Africa. Findings from a community-led early warning system. Gates Open Research Pre-print. 2025 (https://verixiv.org/articles/2-94/v1).

93 Impact of the PEPFAR funding freeze on programs for key populations. New York: Global Black Gay Men Connect; 2025; p.13 (https://gbgmc.org/wp-content/uploads/2025/03/Frozen-Out.pdf).

94 Malaysian AIDS Foundation Annual Report 2021. Kuala Lumpur: Malaysia AIDS Foundation; 2022 (https://mac.org.my/v4/wp-content/uploads/2023/05/Annual-Report-2021_MAC_A4_.pdf); Suleiman A. Seamless care: integrating HIV services into primary health care model; 2024 (https://www.iasociety.org/sites/default/files/EduFund/meeting-material/pakistan/SeamlessCare-IntegrationOfHIVServicesIntoPHC-MalaysiaModel_AnitaSuleiman.pdf).

95 Financial dashboard. Geneva: UNAIDS (https://hivfinancial.unaids.org/hivfinancialdashboards.html).

96 https://hivfinancial.unaids.org/CLR_Systematic_Review_2024-06-06.xlsx

97 Ibid.

98 Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO, UNDP, PEPFAR, University of Manitoba, UNAIDS, et al. Using programmatic mapping to improve program access and coverage for key populations: guidelines for countries. Geneva: UNAIDS; 2016 (https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/Programmatic-mapping-to-improve-program-access-and-coverage-of-KPs.pdf).

99 UNAIDS, WHO The BBS-lite implementation tool. Geneva: UNAIDS; 2024; p.10 (https://www.unaids.org/en/resources/documents/2024/BBS-lite-tool).

100 The community treatment observatory (CTO) model explained: how communities can collect and analyze health data to ensure accountability and drive change. Bryanston, South Africa: International Treatment Preparedness Coalition; 2019 (https://itpcglobal.org/wp-content/uploads/2019/02/ITPC-CTO-Model-Full-Eng.pdf).

101 Phillips VL, Xue A, Castillo M, Santiago D, Wimbly T, Hightow-Weidman LB. Cost of peer mystery shopping to increase cultural competency in community clinics offering HIV/STI testing to young men who have sex with men: results from the get connected trial. Health Econ Rev. 2023;13(1):34 (https://link.springer.com/content/pdf/10.1186/s13561-023-00447-6.pdf).