AN MSF MANUAL FOR **KEY POPULATIONS PROGRAMMING**

MEDECINS SANS FRONTIERES

ACKNOWLEDGEMENTS

We extend our sincere appreciation to all individuals and organisations whose commitment and collaboration made this manual possible. Your engagement and courage were vital to getting this first edition of the Key Populations Manual done.

We extend our gratitude to all who shared insights and co-designed models and approaches for key population programming, with special recognition to the peers who, with their lived experience, led the way. Your leadership enabled person-centred strategies within safe spaces and broader community contexts, and your efforts to foster understanding and challenge stigma and discrimination have been invaluable.

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To ensure that the manual continues to evolve while remaining adapted to changing realities, please share your comments and suggestions: Key.Populations@joburg.msf.org

PREFACE

Key populations are present in every context where MSF operates. However, they often remain unseen due to the fear of stigma and harassment from government, police, and health workers, and from within their communities.

This marginalisation results in their health needs frequently being unmet. This manual brings together MSF's extensive experience, materials, and tools for interventions with key populations. It presents the steps needed for successful engagement with them and for ensuring their access to necessary healthcare. The manual has been developed in collaboration with programme leads, experts, and crucially with representatives from key populations themselves; ensuring that it reflects their needs and perspectives.

Our goal is to inspire colleagues in projects and headquarters to actively engage and provide healthcare to these neglected and excluded populations.

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General Director MSF OCB

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A sex worker conceals their identity in a doorway at an MSF project in Malawi, reflecting the challenges of accessing healthcare in a context of stigma and criminalisation. © Isabel Corthier/MSF

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ACRONYMS

ART antiretroviral therapy

ARV antiretroviral drugs

CBO community-based organisation

CHW community health worker

CSO civil society organisation

DIC drop-in centre

DSD differentiated service delivery

EC emergency contraception

GBV gender-based violence

HBV hepatitis B virus

HCV hepatitis C virus

HCW healthcare worker

HIV human immunodeficiency virus

HP health promotion

HPV human papillomavirus

HSV herpes simplex virus

HTC HIV testing counselling

IAS international AIDS society

KP key population

M&E monitoring and evaluation

MAT medication-assisted treatment

MoH ministry of health

MHPSS mental health and psychosocial support

MSM men who have sex with men

NGO non-governmental organisation

NSP needle and syringe programme

OI opportunistic infection

OST opioid substitution therapy

PEC patient education and counselling

PEP post-exposure prophylaxis

PFA psychological first aid

PMTCT prevention of mother to child transmission

PNC postnatal care

PPT presumptive periodic treatment

PrEP pre-exposure prophylaxis

PT pregnancy test

PWUD people who use drugs

SAC safe abortion care

SMA self-managed abortion

SoV survivors of violence

SRH sexual reproductive health

SRHR sexual reproductive health and rights

STI sexually transmitted infection

SW sex worker

TB tuberculosis

T&T test and treat

TGP trans and gender-diverse people

TPT tuberculosis preventive treatment

UNAIDS Joint United Nations Program on HIV/AIDS

WHO World Health Organisation

Just after midday in a bustling market, a multidisciplinary team reaches out to bring healthcare to key populations where it's needed most. MSF Corridor Project, Tete, Mozambique. © MSF

A female client waits to be seen at a mobile clinic in Zalewa, Malawi. © Diego Menjibar/MSF

INTRODUCTION

This manual brings together MSF experiences, materials, and tools tailored for MSF Key Populations (KP) interventions. It builds on the experiences of the gradually increasing numbers of MSF projects that are recognising the exclusion and vulnerability of KP and working actively to include them. It has been developed in collaboration with KPs programme leads and experts and KP representatives themselves, to ensure that it reflects the needs, preferences and perspectives of the KPs it is meant to serve. The objective is to inspire and guide fieldworkers in designing and providing appropriate healthcare to individuals who often find it difficult to engage in care.

We encourage reflection on how MSF can evolve into an organisation where the needs of the most excluded and marginalised communities are routinely integrated into all projects, rather than seen as isolated cases. The resources and tools mentioned in this manual are available on the MSF intranet, with many assets also available online.

WHO ARE THE KEY POPULATIONS?

Key populations refers to groups of people who face higher risks for HIV, viral hepatitis, and sexually transmitted infections (STIs). This is due to:

- Social, economic, and legal factors that contribute to their marginalisation and limited access to healthcare services.
- Lifestyle and risk behaviours that increase risk of transmission.

In this manual, KP refers to:

Sex workers (SWs): include female, male, trans, and gender-diverse adults who receive money or goods in exchange for sexual services, whether regularly or occasionally. Sex work involves consensual sexual activity (unlike sex with a victim of trafficking, which is forced and not consensual) and can take many forms. Sex work may be regular and organised – often referred to as commercial sex work – or irregular and informal – referred to as transactional or informal sex work[1].

Men who have sex with men (MSM): refers to all men who engage in sexual relations with other men. The words “men” and “sex” are interpreted differently across different cultures, societies, and personal perspectives. Consequently, this term encompasses the wide range of settings and contexts in which male-to-male sex occurs, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, or various identifications with any particular community or social group[1].

Trans and gender-diverse people (TGP): refers to individuals whose gender identities and expressions do not conform to the traditional expectations associated with the sex assigned at birth. This includes transsexuals, transgender individuals, and those who are gender nonconforming. They may identify as transgender, female, male, trans woman, trans man, or other nonconforming identities and may express their genders in masculine, feminine, or androgynous ways. Their high vulnerability and specific health needs require distinct recognition in the global HIV response[2].

People who use drugs (PWUD): include people who use psychoactive substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal. People who inject drugs (PWID) are at high risk of HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) transmission due to the sharing of blood-contaminated injection equipment[1].

People in prisons or other closed settings: refers to imprisoned people in all places of detention within a country where people may be held during the investigation of a crime, or while awaiting trial, after conviction, before sentencing and after sentencing. Unfortunately, during a life course, KPs have disproportionately higher rates of detention, in part because aspects of their identities or some of their practices are criminalised in many countries[1].

Adolescents of Key Populations: are individuals aged between 10 and 19. Young and adolescent KPs are particularly vulnerable due to their youth and face unique challenges. These may include limited access to healthcare due to socio-economic and cultural barriers. They also have higher rates of mental health issues, and increased vulnerability to substance abuse and violence[2,3].

Transactional sex

Individuals involved in informal transactional sex are often overlooked in formal counts of sex workers, yet they remain highly vulnerable. This toolkit includes strategies for engaging both key populations. Transactional sex is typically informal, rooted in relationships that may include love and trust, with sexual favours exchanged for essentials like food or clothing. Partners are often called "blessers," "sugar daddies," or lovers. It occurs globally across all genders and ages, but demands special attention when involving adolescent girls and young women in sub-Saharan Africa due to its link to increased HIV risk[4,5].

People who use drugs and people who inject drugs

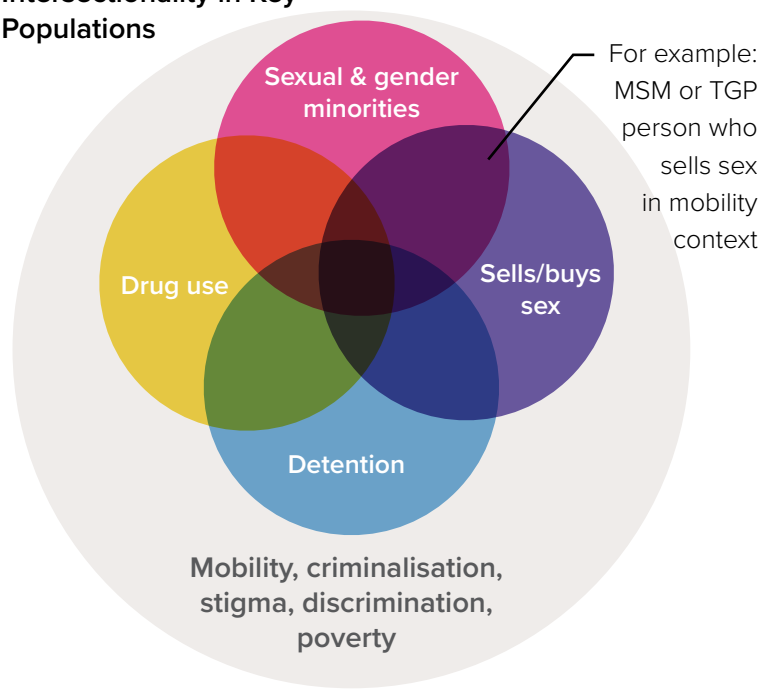
This manual includes PWUD rather than focusing solely on PWID. Although those PWUD who never inject are not as at high risk for contracting HIV, HBV or HCV, they still experience similar vulnerabilities due to stigma and discrimination. Moreover, they may transition to injecting drugs, and they may also intersect with other KP groups. For these reasons, they are crucial targets for harm reduction programmes.

LGBTQI+ and Key Populations

Although being part of LGBTQI+ communities is not the same as belonging to key population groups, there is considerable overlap in health concerns due to shared experiences of stigma, discrimination, and criminalisation based on actual or perceived identity. Historically, the definition of KPs has focused more on behaviours than on identities. Both KPs and LGBTQI+ communities are heterogeneous. Moreover, while an individual may identify as LGBTQI+, they may or may not be considered part of a KP, and vice versa. The current rollback of LGBTQI+ rights and escalating anti-LGBTQI+ sentiment across various continents risks driving these communities further into hiding and discouraging them from seeking healthcare. MSF must remain especially attentive and sensitive to these issues, as failing to do so risks overlooking people at high risk for poor health outcomes.

Individuals can belong to multiple KP groups and engage in various risk behaviours and may not identify with a specific group. For example, MSM may not see themselves as gay, PWUD might stop using drugs, women who engage in transactional sex might only sell sex occasionally or for a period of their lives and often will not identify as SWs, and individuals may transition in and out of prison. Therefore, it is important to acknowledge the complexities and transitions in people's lives, including high risk-taking during adolescence for some. Recognising that KP individuals can belong to multiple overlapping groups is crucial for providing comprehensive, inclusive services that address their diverse needs.

Intersectionality in Key Populations



WHY FOCUS ON KEY POPULATIONS?

While the world has made significant progress towards the UNAIDS 95-95-95 targets for HIV testing, treatment, and viral suppression, the figures mask substantial disparities among regions, demographics, and particularly KPs[2]. In 2022, more than half (55%) of all new HIV infections worldwide occurred among people from KPs and their sexual partners. Stigma and discrimination, criminalisation or hostile legal and social environments, and violence directed at KPs threatens their access to healthcare.

Relative risk of acquiring HIV infection

compared to the rest of the population, 2019

Transgender people
13 times higher

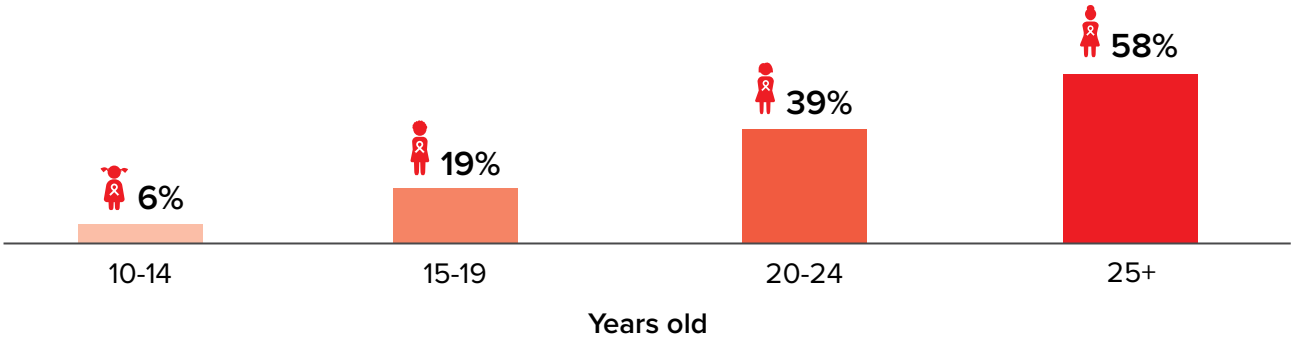
Men who have sex with men
26 times higher

People who inject drugs
29 times higher

Female sex workers
30 times higher

Source: UNAIDS, 2020 [6]

HIV prevalence among female adolescents who sell sex and adult sex workers in Nsanje, Malawi



Source: MSF OCB Malawi Project, 2014-2020

The epidemic varies across regions. While the HIV epidemic is generalised in many African countries, HIV prevalence is highly concentrated among KPs in other regions, such as eastern Europe, the Middle East and North Africa, and Latin America[7].

Hepatitis virus infections are also significant global health issues, with high HCV rates among PWUD, individuals in prisons, MSM, and particularly among those living with HIV. HBV rates have also risen among KPs[2]. Moreover, SWs, their clients, MSM, and TGP are typically at high risk for STIs, and these co-infections exacerbate their morbidity and mortality.

Individuals from KPs often face systemic barriers, which results in higher exposure to risk factors and greater difficulties in meeting their sexual and reproductive health (SRH) needs. These include contraception to prevent unintended pregnancies, condoms for STI protection, safe abortion care (SAC) access, and support for gender-based violence (GBV) – including mental health services. Integrated HIV and SRH services can improve access to comprehensive care, including mental health and psychosocial support (MHPSS), and enhance health outcomes. These services address STIs (including HIV), AIDS-related deaths, unintended pregnancies, maternal mortality, cervical cancer, and GBV, while also supporting survivors of violence (SOV) with tailored, trauma-informed care.

Mpox outbreak

The recent mpox outbreak in Africa has raised serious public health concerns. While historically affecting children, two emerging variants appear to spread not only through droplets and skin contact but also through sexual transmission. These strains have disproportionately impacted MSM, SWs, and their partners, leading to heightened stigma and discrimination. Addressing the outbreak requires sensitivity to ensure public health messaging does not reinforce existing prejudices. Stigma can deter individuals from seeking care, undermining efforts to control the virus. An inclusive, non-discriminatory response is essential to protect those most at risk and effectively manage the outbreak[8,9].

A male peer educator stands in front of his barber shop where he often gives health talks to at-risk men. © Mariana Abdalla/MSF

HOW DOES MSF INCLUDE KEY POPULATIONS IN PROGRAMMING?

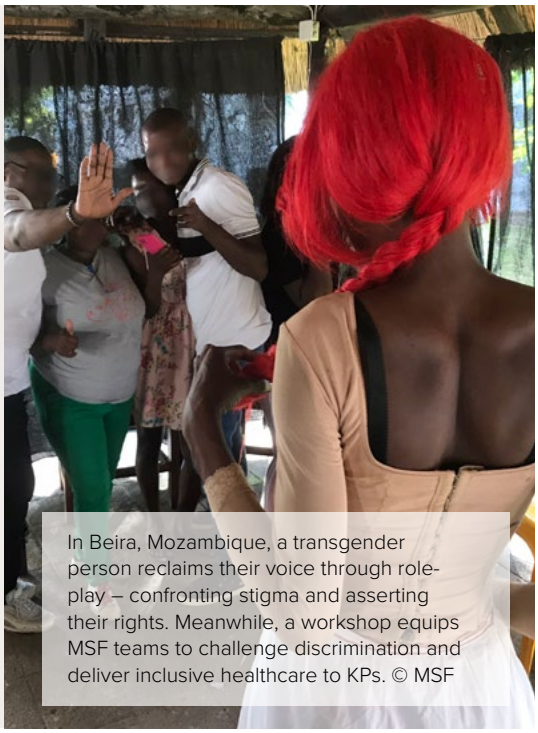
As a medical humanitarian organisation, MSF operates in challenging environments, striving to guarantee access for the most marginalised and excluded populations. MSFs intersectional commitments to the inclusion of key populations are further emphasised in a number of motions, strategic ambitions and operational plans.[10] Aligned with the MSF principle of impartiality, we strive to provide services in an equitable and non-discriminative way regarding politics, race, religion, sex or any other similar criteria[11]. MSF's commitments to KPs are further emphasised through the MSF OCB Strategic Ambitions 2026-2031 and the MSF-OCB Operational Roadmap 2026-2028.

KPs are among the most excluded, vulnerable and hidden groups in every community. Wherever MSF operates, KPs are present – yet we are often unaware of their needs. Many individuals conceal their risk exposure due to stigma and discrimination from their communities, government, harassment by police, and even healthcare workers (HCWs), resulting in their needs going unmet. While it may not always be feasible to fulfil every community's needs, acknowledging their presence, requirements, health risks and the barriers they face in accessing care is crucial for providing health services to the most excluded. MSF should make proactive efforts to understand the KPs' priority needs and particular barriers to care, assess how they would like MSF to respond to their needs, and how MSF can contribute with their skills and resources.

FAQ: After years of developing KP programmes at MSF, we have compiled a list of **Frequently Asked Questions (FAQ)** on the MSF intranet. We invite you to explore and find answers to common queries.

Key Population programming risks further setbacks due to the 2025 funding gaps

The funding for HIV programmes targeting KPs is woefully inadequate. UNAIDS estimated a funding gap of 80% for KP programming in low- and middle-income countries in 2018[12]. Since then, the situation has deteriorated[13]. Recent developments, following the temporary freeze of US foreign aid, have resulted in substantial reductions in funding for civil society organisations (CSOs), leading to reduced advocacy, activism, and legal support; the loss of peer and lay health workers; closure of health facilities; and significant stockouts, leaving many individuals without access to essential treatment, prevention services or contraceptive methods[14]. Legal and socio-political barriers in many countries make it even more difficult to secure funding for programmes serving these communities.



In Beira, Mozambique, a transgender person reclaims their voice through role-play – confronting stigma and asserting their rights. Meanwhile, a workshop equips MSF teams to challenge discrimination and deliver inclusive healthcare to KPs. © MSF

A sex worker celebrates with song and dance after receiving a negative HIV result during a discreet home visit by MSF's counsellor and community health worker in Dedza, Malawi. MSF Sex Worker Project. © Isabel Corthier/MSF

SETTING UP A **KEY POPULATION PROGRAMME**

While there is nowhere MSF works without the presence of Key Populations, these groups often remain unseen due to stigma, marginalisation, and criminalisation.

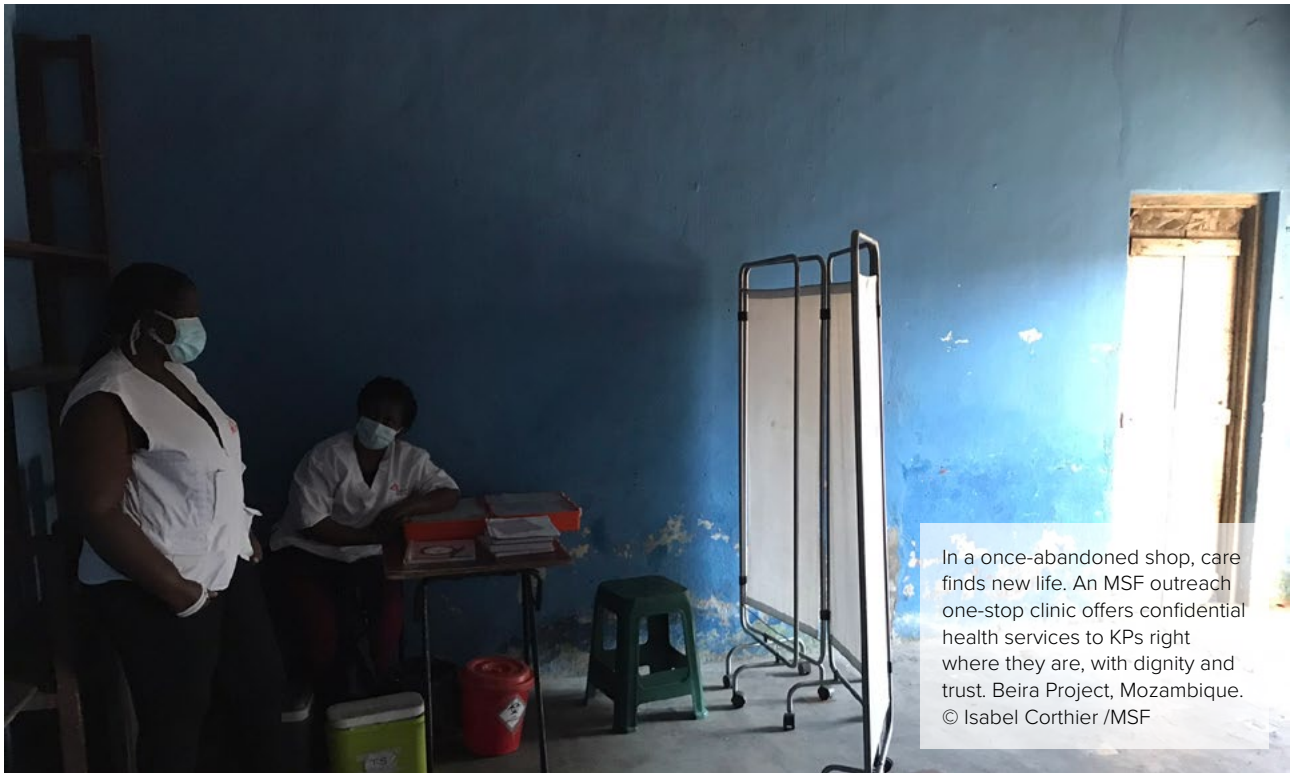
Recognising the complex intersections of gender, socio-cultural background, poverty, migration, minorities, disability and the diversity of sexual and gender identities within KPs is essential. These factors shape their experiences of exclusion, criminalisation, and human rights abuses, and often compound their vulnerability to health risks and violence. Addressing these intersecting challenges is central to MSF's commitment to supporting the most vulnerable and excluded populations and ensuring equitable access to care.

Over time, MSF has developed models of care and medical care packages, but when it comes to KPs, adaptations to these packages have been essential to ensure that we successfully include the most marginalised[15,16].

There are often opportunities to set up KP activities within existing MSF projects, particularly if the interventions are focused on:

- HIV/TB
- Viral hepatitis
- Sexual and reproductive health (SRH)
- Sexual violence (SV)
- Survivors of torture
- Migration projects
- Emergency and conflict situations

In the following chapter, we highlight the stumbling blocks and enablers encountered in KP programming and introduce its essential components. In general, it is crucial to make adaptations to programming to respond to the specific needs, barriers, skills and resources of KPs and this can be framed as part of MSF's wider commitment to person-centred care and people-centred approaches.



In a once-abandoned shop, care finds new life. An MSF outreach one-stop clinic offers confidential health services to KPs right where they are, with dignity and trust. Beira Project, Mozambique. © Isabel Corthier /MSF

STUMBLING BLOCKS AND ENABLERS

The intentions to develop KP programming often encounter hurdles that can delay or undermine the implementation. Conversely, various enablers can facilitate and increase the likelihood of successfully implementing KP programming. Various stumbling blocks and enablers will be discussed below:

Engaging with community networks

Acknowledging KP communities as experts on their own needs and experiences is key to winning trust and respect and constitutes the crucial type of engagement that will lead to successful KP programming: enabling a peer-led response. A peer-led response promotes peer support and community empowerment among KPs and has been shown to optimise the coverage and impact of programmes. Read more about the role of peer workers in the chapter below on "Models of Care".

Understanding the local context

Assessments are needed to analyse the specific context (e.g. legal framework, cultural and religious beliefs, available health structures, presence of CBOs). Connecting with individuals who identify as members of KPs, often through established KP-led organisations, is central to an understanding of their specific needs and how to adapt KP-friendly services in their unique context. Therefore, these organisations must be part of the needs assessment, programme design, implementation, and monitoring of the project if we wish for MSF's work to respond to the priority health needs of KPs[17,18].

In Zimbabwe's Mbare Matapi Flats, MSF supports adolescent and young KPs facing the challenges of overcrowded living through vital health services and engagement.
© Doris Burtscher/MSF

Migration and mobility

Migration and mobility are integral aspects of the lives of many KP groups, and it affects their ability to access essential health services while on the move. Frequent relocations can disrupt ongoing treatments and access to healthcare, creating barriers due to differing local health policies[19]. Understanding migration patterns is essential for addressing continuity of care challenges and creating effective solutions. Continuous engagement with KP networks is vital for sharing accurate and relevant information within communities. KP peers are key in this response and often the only ones who have information and can mobilise and track those needing care. There isn't a "one-size-fits-all" approach, as each geographic, demographic, social, and political context presents unique issues concerning policies and laws.

Stigma and discrimination

Myths and misconceptions about KP groups often need dispelling to enhance access to healthcare[20]. Even within MSF, attitudes that we may not always be aware of can implicitly exclude populations if our staff do not identify with or approve of SWs or MSM. As a first step when setting up a KP programme, HCWs, including those in MSF, must be sensitised to the realities that contribute to the vulnerabilities and risks faced by KPs, as well as educated about their overlapping and unique health needs. This is essential for ensuring quality prevention and treatment as well for effectively integrating services for comprehensive healthcare[21].

Criminalisation

The main difference between KPs and the general population is that KPs are widely subjected not only to stigma and discrimination, but also criminalisation. For example, in many countries, sex work is criminalised through direct laws or by targeting associated behaviours. Mistreatment and criminalisation make it very challenging for healthcare providers to reach and engage with individuals from KPs. This unique context of social marginalisation and exclusion requires differentiated service delivery (DSD) or differentiated models of care to ensure equitable access.

HIV prevalence is higher where key populations are criminalised

Evidence suggests that HIV prevalence is higher among SWs[22], PWUD[23] and MSM in settings that criminalise KPs.[24]. This is particularly worrisome given the high prevalence of laws criminalising sex work, same-sex sexual relations, possession of small amounts of drugs, same-sex and gender non-conforming sexual relations, or HIV nondisclosure, exposure, or transmission. UNAIDS analysis in 2024 found that 190 out of 193 surveyed countries had such laws in place at the time[25]. Furthermore, when KPs face the threat of arrest or abuse, this creates additional barriers for them to adopt protective behaviours against HIV and discourages them from accessing HIV and other health services.

Hate crimes and punitive laws against LGBTQI+

Hate crimes and punitive laws against same sex relations individuals have profound and detrimental effects. These laws and acts of violence not only perpetuate stigma and discrimination but also lead to severe physical and emotional harm. Such victimisation can result in long-lasting trauma, mental health issues, and insecurity. Additionally, punitive laws can restrict access to essential services, including healthcare, education, and housing, further marginalising these communities. It is crucial to advocate for inclusive policies and protective measures to ensure the safety and well-being of LGBTQI+ individuals.

Violence against key populations

Along with stigmatisation and discrimination, KPs face multiple threats and abuse from police, clients, partners, and their families and communities. Their often-denied access to justice exacerbates this abuse.

Even in contexts where sex work and same-sex relations are legal, KPs still face higher levels of violence due to stigma. Until sex work, same-sex relations and other KP identities are decriminalised, they remain victims of structural violence. In the absence of legal changes, many KP communities have organised themselves to provide peer support and advocate for their rights. Unfortunately, such organised KP communities are rarely present in settings where MSF operates, or our teams are unaware of their presence and importance. With increased awareness, however, MSF has supported development and empowerment of such grassroots movements including by facilitating linkages to strong regional actors with expertise, which have helped inform and initiate community-led initiatives including access to healthcare and psychosocial support. More information about this is below in the chapter about “Advocacy and Activism”.

Violence against sex workers

Violations of the human rights of sex workers are under-reported. Studies have shown that female sex workers face an extraordinarily high risk of homicide. In one study of cisgendered female sex workers, they were estimated to be 18 times more likely to be murdered than women of the same age and race from the general population. This heightened risk is often attributed to factors such as the nature of their work, societal stigma, and targeted violence[26].

Sex work and human trafficking

The Global Network of Sex Work Projects (NSWP) notes, “the conflation of sex work and trafficking, migration and mobility is no accident. It is not a misunderstanding of terminology but is a conscious attempt to abolish prostitution and prevent people, in particular women, from migrating for sex work. But evidence shows that when adult sex workers are organised, they play a key role in identifying and reporting abuse, strengthening their human rights and protection[27].”

KEY POPULATIONS PROGRAMME COMPONENTS

Even with an extensive package of healthcare services that healthcare workers (HCWs) and clinics can offer, when it comes to KPs, **the ways in which we deliver** these services are integral to engagement, access to care, and treatment. This means we must ensure that we deliver services in the ways in which KP individuals would like us to and, for that, it is crucial to co-design the projects with them. For example, each additional venue an individual must visit to access all their healthcare needs represents an additional barrier. In the design of healthcare services for KPs, MSF has learned that the following four components are essential for successful engagement and delivery:

"Nothing about us, without us!"

This is a commonly used slogan in the KPs sector, which underscores the importance of involving these communities in the decision-making processes that affect their lives. This approach ensures that policies and programmes are more relevant, effective, and respectful of the needs and rights of these KPs.

1. Peer-led Service Delivery

Access to and delivery of care for excluded populations critically depends on the inclusion of trained and remunerated peers of these populations, working as community health workers (CHWs) both independently and alongside sensitised HCWs. A key element of this is microplanning, which is described in the box below.

INSIGHT

Microplanning for peer-led outreach

Microplanning involves a decentralised approach where trained peers and CHWs plan and manage outreach activities. This method focuses on identifying and mapping hotspots or clusters where individuals of KP groups are concentrated, and tailoring peer-led services. Elements include building rapport and trust within these communities, health promotion education, distribution of prevention materials (i.e., condoms and lubricants, clean needles and syringes (NSPs)), and supporting linkage to services. The approach employs a set of simple tools – including site mapping (as seen in the drawing opposite) and analysis, peer outreach schedules and planning – which allow peer educators and outreach workers to collect and use data (see also M&E section) in their work with KPs. This information is updated regularly to guide outreach activities (see M&E section for more information).

A peer from the PWUD community maps hotspots in the Kiambu MSF project, Kenya – turning lived experience into actionable insight. © MSF

A peer sex worker serving as an MSF community health worker conducts a health promotion session in the waiting area of a joint Ministry of Health (MoH) and MSF 'one-stop' clinic for sex workers. © Isabel Corthier/MSF

2. 'One-Stop' Services

A service delivery model with an integrated package of care, including HIV/TB and SRH services and Mental Health and Psychosocial Support Services (MHPSS), should be provided at the same site, on the same day, and ideally by the same HCW. KP-friendly one-stop services integrated in the MoH, can encourage access to care along with the general population. However, keeping in mind that turnover of MoH staff, lack of safe spaces within facilities, fear and stigma within waiting areas from other community members and bad past experiences with MoH health providers results in barriers in access to care. The continued sensitisation of both MoH and MSF HCWs is essential to ensure that newly recruited staff provide de-stigmatised services.

INSIGHT

Building Spaces for Dignity and Resistance

The KP intervention in San Pedro Sula, Honduras, evolved from an outreach mobile clinic to a static one-stop clinic that provided a wide range of services for the needs of the target population. Regular sensitisation with the involvement of and representation from the communities has been what keeps this service thriving and increasing its catchment.

Inclusion in action. MSF's San Pedro Sula project works hand-in-hand with LGBTQI+ and KP communities, centering their voices to shape care and challenge stigma. © MSF

3. Strategic Mix of MoH and NGO/CBO Services

Ideally, MoH-led services should be friendly to KPs and integrate their needs effectively. However, such services are rarely present and, while it is important to support integration in this manner, it is critical that parallel KP-specific services exist both at community and primary care level. Maintenance of this balance is important and should include early consideration of how to ensure financing and investment to maximise the sustainability of KP services.

4. Advocacy and Activism

Creating an enabling environment for equitable access to healthcare for KPs is essential for effective programming. This entails supporting local KP groups, community-led organisations or CBOs in challenging the criminalisation of these populations, changing societal attitudes, and building capacity to empower MoH staff and partners to develop friendly and sustainable services.

In environments where KPs are highly stigmatised, MSF can play a pivotal role showcasing its commitment by providing support to KPs. By using its leverage, MSF can help correct misconceptions and address stigma, removing barriers to care. MSF can also help by advocating for KP-friendly services through national guidelines, including ensuring the recognition of the KP peers as an essential lay cadre in service delivery.

Recognising that KPs often face harassment, abuse, and criminalisation, it is crucial to create a safe and supportive environment where they can openly discuss and learn about their basic rights. Providing this foundational knowledge empowers individuals, ensuring they are well-informed and equipped to seek support, mobilise, and actively protect their rights.

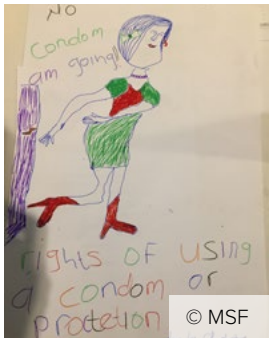
It is through the ownership and realisation of human rights that individuals build self-respect and empowerment. Additionally, being aware of and supported by the MSF Patient Charter and other MSF safeguarding measures can ensure that patients rights are protected, further enhancing security, dignity, and autonomy in healthcare.

The Red Umbrella is an internationally recognised symbol of solidarity with sex worker communities facing violence and discrimination. © MSF

Sexual and Reproductive Health and Rights (SRHR) are fundamental for preventing the acquisition of HIV and other related SRH issues. It is important for MSF staff to understand the relationship between punitive laws, policies and practices that block an effective HIV response, as well as issues related to HIV transmission, such as inequality, violence against women and girls, denial of SRH services, same-sex sexual relations, sex work, and drug use.

MSF showcases its support to decriminalise KPs

MSF shas shown commitment to ensuring inclusion and integration of excluded populations in various voted motions at MSF general gatherings and assemblies, decriminalisation submissions and inclusion statements, as well as through organising or participating in sensitisations at community level, including among police and local authorities.



© MSF

Human Rights Defender workshops

As part of its capacity-building and empowerment initiatives for KPs, MSF can provide practical workshops for staff and peers of KP groups such as the Human Rights Defender (HRD) by SWEAT, a partner of the sector. These workshops include real-life scenarios and provide tips and tools for self-protection, both mental and physical, to minimise risks to personal safety while at work or using drugs.

Criminalisation of key populations limits access to essential SRH, HIV, and TB services and increases vulnerability to violence. Survivors often face complex, overlapping needs requiring integrated care. MSF should support inclusive healthcare and access to legal and psychosocial services. We must also back those advocating for the rights, dignity, and safety of KPs.

Social workers and human rights lawyers support KP programming by providing legal representation, advocacy, counselling, resource connection, and public awareness to protect and promote the rights and well-being of marginalised groups.

In Her Heels: An immersive workshop that invites participants to step into the lived realities of sex workers, confronting stigma, limited choices, and violence. Designed to spark reflection, empathy, and action toward more inclusive care and advocacy. © SWEAT

INSIGHT

Empowering Sex Workers through referrals to sociolegal services

In Blantyre, MSF and the Centre for Human Rights Education, Advice & Assistance (CHREAA) partnered to support sex workers through legal aid and practical coaching tools aimed at reducing violence and exploitation. One key strategy involved encouraging sex workers to request payment in advance, helping to prevent non-payment and assert their rights. This simple approach enhanced financial security and promoted greater autonomy and safety in their work[28].

Advocacy for funding of health services

The sudden funding cuts to PEPFAR in 2025, which specifically targeted prevention services for KPs, showed the vulnerability of KP services. Informed KPs can play a major role in advocating for investment in parallel services, friendly services, and in access to specific commodities. Of particular importance is injectable lenacapavir PrEP, which as of 2025, recently approved, remains inaccessible and unaffordable to the most vulnerable. Advocacy and activism by KPs and others will be essential to demonstrating demand and, ultimately, ensuring price reductions and scaled-up access.

TOOLS

KP Programme Components

Within an MSF migration project in Greece, a transgender woman with lived experience of displacement from Cuba, supports Cuban transgender migrants in accessing essential healthcare and social services. © Maro Verli/MSF

Shoes belonging to a mother who is a sex worker and her daughter. Many women are survivors of violence each year, often unreported. Through MSF's project in Malawi, trained sex worker peers provide vital care in the community. © Isabel Corthier/MSF

MODELS **OF CARE**

KPs require service delivery approaches that are tailored to their needs. This approach – commonly used in HIV programming – is known as differentiated service delivery (DSD).

DSD recognises that a one-size-fits-all model does not address the needs of diverse populations. Instead DSD provides a responsive, person-centred approach that simplifies and adapts services to better meet individual needs and reduce unnecessary burdens on the health system[29,30].

Communities in general, and KPs in particular, are the experts of their own experiences. Therefore, the appropriate model of care for a given population in a specific context should be determined collaboratively with KPs themselves. Different models of care have been employed based on the specific context and population, ranging from community-based to facility-based, or managed by peers or HCWs.

Models of care for adults are often not suited to the needs of adolescent or young populations, nor are they appropriate for specific needs related to male sexual health. Creating the right environment at the appropriate time for the target population is essential to ensure their access to care. Services for all KPs are described below, along with specific considerations for each KP group and a more detailed description of the services package.

Differentiated service delivery (DSD) for key populations programming

The decision framework below deals with the question of how best to adapt services for the target population, instead of expecting them to adapt to our systems and services.

Building Blocks for KP Programming

WHO

Peer educators, counsellors, psychologists, nurses, midwives, clinical officers, medical doctors and social workers.

WHAT

Health promotion, harm reduction, medical package of care, socio-legal support.

WHEN

Frequency of clinical and refill visits

Time of day of visits

Both adapted to the needs of KPs

WHERE

Facility based (hospital, primary care)

Out of facility services (mobile, drop-in centres)

INSIGHT

How do we build KP-friendly services?

To be 'friendly', a service requires staff who are welcoming and do not stigmatise or mistreat KPs. Such services also need to be offered at times and sites that are acceptable to KP groups. Further adaptation may also be needed for subgroups such as adolescents and members of the LGBTQI+. Staff sensitisation is essential so that they are comfortable and non-judgemental when discussing issues related to sexuality and sexual behaviour. Similar efforts are needed to sensitise police to provide support and protection for KPs. (For more information See 'Who' Toolbox)

WHO PROVIDES SERVICES?

There are many people responsible for the implementation of a project responding to the healthcare needs of KPs, including MSF staff at both projects and headquarters, MoH HCWs, peer educators, rights advocates and social support providers. Given the stigma surrounding KPs, regular sensitisation and de-stigmatisation training should be a cornerstone of programming to ensure inclusivity and understanding for everyone involved. It is essential to include local stakeholders in these sensitisation workshops, namely police, justice, social services and those from education sectors.

At the core of implementing KP programmes is the focus on capacity-building and task sharing of care delivery to KP peers working as CHWs. This approach empowers community members by equipping them with the necessary skills and knowledge to provide care and support. By involving KP peers in the delivery of services, programmes can more effectively engage and reach their groups and communities, fostering trust and ensuring that services are accessible and relevant to their specific needs.

Peer workers from KPs and communities are vital in driving screening, diagnosis, and linkage to care, especially for HIV, viral hepatitis, and STIs. Their involvement ensures services are tailored to their needs, addressing barriers like stigma and discrimination. Community-driven initiatives enhance testing uptake and linkage to care by fostering trust and engagement. This collaborative approach improves health outcomes and empowers these populations.

INSIGHT

Task sharing: Recognising peer cadres

Peers of KPs who have not completed their formal education are often prevented from obtaining official validation to perform and provide essential services, such as HIV testing, even when they have received formal training and mentorship. MSF can play a crucial role in advocating for the recognition of these cadres in new guidelines. By doing so, we can ensure that their valuable contributions are acknowledged and utilised to improve public health outcomes.

A member of the KP community working as a HCW with the outreach team in Beira consults with a patient during a mobile clinic visit to an underprivileged community. During their mobile clinic visits, they offer services to KPs.
© Miora Rajaonary/MSF

Peer Workers

The most important aspect of any KP programme is community engagement and involvement. Numerous benefits arise when KPs are involved in the design and implementation efforts[32]. Often, KPs prefer receiving services and information from their peers, as trusted members of their communities. In such cases, MSF can support peer workers with training, supervision, and remuneration for their work[33]. Peer-led programmes are effective because:

- Peers are generally more knowledgeable about local contexts and may be better able to communicate with other beneficiaries in their local languages and dialects.
- Peers' personal experiences can enhance their credibility as educators in the eyes of other beneficiaries.
- Peers can give detailed advice about practicing safer sex and harm reduction in their own 'lingo' and specific contexts.
- Peers are often the first responders to violence against their own peers in the communities.

Tip: See these videos on Harm reduction:

1. Peer work in harm reduction programmes
2. Peer work with sex workers and people who use drugs: Key recommendations

See more about the role of the peers in the Health Promotion (HP) chapter below.

The involvement of peers in providing care has proven indispensable in MSF KP projects. Peers play a crucial role as mobilisers, educators, counsellors, health providers and advocates.

Peers of KPs are recruited from the local community and selected for their trustworthiness with the community they represent, motivation, talent, and knowledge of the health challenges and vulnerabilities they face. As paid MSF staff, peers receive trainings and opportunities to job-shadow healthcare providers who serve as mentors, raising awareness and sharing information about comprehensive HIV/TB, SRH and MHPSS treatment or services.

INSIGHT

Peer-led response to violence against sex workers during COVID-19 pandemic

In 2021, during the COVID-19 lockdowns, MSF's Beira project in Mozambique observed a rise in violence against sex workers. In response, peer educators were trained using a First Responders to Violence care package, which included psychological first aid (PFA), post-exposure prophylaxis for HIV (PEP), emergency contraception (EC), condom distribution, and referrals or accompanied navigation through health facilities. This initiative also encouraged community-led monitoring and surveillance of violence. While this was an intended outcome of the training, data on its implementation and impact was not systematically collected, highlighting the need for MSF to explore alternative monitoring and evaluation systems that can better capture community-driven responses. See video by MSF: International day to end Violence against Sex Workers

INSIGHT

Important considerations when working with Key Populations Peers

For those who take on the position as a peer educator, training and supporting their peers requires certain skills, and not every member of the KP community will be up for the task. The most effective peer workers are those who are identified by their peers, based on agreed-upon criteria with MSF. To perform the role effectively, these peer workers must have basic communication skills, including being observant, a good listener, and maintaining confidentiality. The impact of peer workers is reduced if they are not identified and selected by their peers.

In various contexts, beliefs and cultural norms may also conflict with MSF values and principles, such as with the provision of SAC. Including and recruiting KP peers requires an understanding and certain sensitivity to the specific population group[34]. Also, because no one-size-fits-all, KP peers should belong to their specific community. For instance for adolescent-oriented programming, recruited peers must also be young or adolescent, or a sex worker from one site will not necessarily be the right person to provide services in another site[35].

INSIGHT

Awareness of peer provider well-being

Not all peers may be effective or friendly providers, and many non-peers can offer excellent services. To maximise the value that comes from peer workers, clear frameworks for recruitment, training, and supervision of peers are essential, alongside investments to increase competence and friendliness of health providers who are not peers. Awareness and mitigation of risks, such as exposure to addiction cues for peer drug users and legal or medication challenges, are necessary. Always consider the well-being of the peer cadre.

Sex workers receive male and female condoms and lubricant during a health promotion session conducted discretely by their peer educator at a hotspot in Nsanje, Malawi. © Isabel Corthier /MSF

Healthcare Workers

Assumptions, bias (explicit or implicit) and negative feelings – whether overt or unconscious – can blind HCWs to the health needs of KPs or lead to deliberate exclusion and mistreatment. Concerns regarding country legal rules and norms may also make it difficult for HCWs to engage with KPs needs. Poor quality of care because of discrimination by healthcare providers and other staff members is often cited as one of the most significant barriers to healthcare in KPs.

"We are shy, others feel ashamed to be seen at the clinic at a young age. I went once and I got a bad result. They asked me: 'are you a girl or a boy?'"

— Adolescent peer from the LGBTQ+ community, Mbare, 2025

Workshops, role-plays, and exercises specifically designed to immerse participants, including HCWs and other MSF staff, in and explore the lived experiences of individuals of KP can be transformative. Sensitivity training for HCWs or counsellors is invaluable to explore how long-held beliefs and attitudes can block access to care with otherwise criminalised populations. See sensitivity training manuals available in the toolbox at the end of this chapter.

"Bringing MSF and MoH staff to work in the community where they can immerse with the lived reality of KP groups is one of the most effective ways to promote awareness, empathy, friendly attitudes and an understanding of the health needs of these groups."

– MSF SW project coordinator

Specific considerations

For SWs: The attitude of HCWs is the most common barrier for SWs to access healthcare. This is compounded by further stigma challenging multiple social norms such as gender and sexual diversity, not having a 'husband', leaving their children alone in their homes at night, etc.

For MSM: Offering a choice in who to confide in regarding health issues is important. Many men might prefer to be seen by another male healthcare provider, but this might not be a requirement by all.

For TGP: The lack of awareness, confusion and reluctance to embrace gender diversity shows up in rejection by healthcare providers, and the system overall.

For PWUD: Efforts should focus on reducing stigma, employing harm reduction strategies, addressing complex health needs, and ensuring ethical care.

For people in prisons: HCWs should be aware of legal obligations, higher rates of chronic and mental health issues among inmates, security and resource constraints, the public health impact of inmate living conditions, and the need to overcome stigmatisation to provide equitable care.

MSF Staff

It is essential to sensitise MSF staff on friendly attitudes, from members of medical departments, managers of operations at headquarters and project level to clinicians providing care. Much of this work involves demonstrating how attitudes (stigma and prejudice) translate into action (discrimination) and, in turn, affect health-seeking behaviour (shame, fear, self-stigma). Clear policies and feedback mechanisms are also needed to protect against abuse, exploitation and harassment. This should include clear referral pathways for case management to protect teams and beneficiaries.

Staff should be familiar with the MSF Patient Charter, MSF behavioural and safeguarding commitments, and follow protocols for handling incidents if/when they arise. Starting points include spending significant time and effort to understand the nuances, challenges, and dynamics of this field of work (immersion in the field); provision of structured mentorship and role modeling; and embracing a KP-friendly attitude. It is essential that staff are aware of structural sexism, racism and power imbalances. (See evaluations on this in M&E toolbox)

"I have a challenge that I am encountering as a peer educator for the LGBT community, that the nurses are ill treating people, they can just say that there is no treatment, but the treatment will be there."

— Adolescent peer in a focus group discussion, Mbare, 2025

INSIGHT

Risks for MSF operations and staff

MSF teams are often unsure of the best and safest way to navigate complex legal contexts, especially with activities where conservative social norms and sometimes legal restrictions apply, such as with the provision of SAC, needle exchange programmes, and the inclusion of sexual and gender diversity in healthcare. These activities often attract legal and political scrutiny, potentially jeopardising the safety of staff and patients. MSF must navigate complex legal environments and societal stigmas, which can hinder the delivery of essential health services and expose both providers and recipients to risks of arrest, harassment, or violence. **To mitigate these risks, MSF projects can conduct risk analyses to inform safer, more effective programming and advocacy strategies.**

Social Workers

Social workers play a crucial role in supporting KPs by advocating for their rights and ensuring access to essential services. They provide counselling and emotional support to help individuals cope with challenges such as discrimination and mental health issues. Additionally, social workers can help KPs connect to social, protection, legal services; can provide support to communities to promote awareness and understanding; and offer crisis intervention in emergency situations or a safety plan when personal security is compromised. Their efforts are fundamental in addressing the social needs and improving the well-being of marginalised groups.

INSIGHT

Empowering adolescents: The role of social workers in community-based support

Social workers play a crucial role in enhancing the well-being of adolescents from KPs by identifying social needs within the framework of applicable legislation. Through individual assessments and collaborative action plans, they connect adolescents with essential sociolegal services such as addressing psychosocial needs. Social workers can also help empower young people and their families to develop long-term strategies for managing relationships and overcoming risks. This holistic approach not only meets immediate needs but also fosters sustainable well-being and resilience, such as in the Zimbabwe Adolescent SRH project, linking adolescents back into school and safe housing.

An MSF social worker and a nurse meet with office-bearers of Tikondane, a sex worker Community-Based Organisation as they prepare for their annual activity review meeting, Zalewa, Malawi. © MSF Australia

Police and Other Stakeholders

Stigma towards KPs may originate either from social or personal attitudes, or both. Regardless, when negative attitudes are further bolstered by the legal system, we must engage in this arena to provide care effectively and without judgement. Updated information and education for all parties about civil rights, support and action on the part of representatives of KPs, the development of alliances with local grassroots organisations as well as regional and national KP sector networks, and the ability to monitor and document human rights abuses are all important tools in building safer spaces for KPs to practice and seek quality healthcare.

Forums conducted with local police, community leaders, municipalities, districts, the education system, civil society organisations (CSOs), community-based organisations (CBOs), and non-governmental organisations (NGOs) are essential for shifting attitudes and enhancing understanding. This effort should be reinforced by continuous monitoring and evaluation of services. Since police are often involved in perpetrating violence against KPs, it is important to conduct a thorough risk analysis with peers of KP groups themselves to understand the best and safest way to engage police, without unintentionally putting them at higher risk of violence or exclusion.

INSIGHT

Key Populations programmes and the police

During MSF's interventions for KPs, project teams have engaged with police for protection and sensitisation purposes, often in response to specific incidents affecting sex workers or other KPs. In Malawi, the project held regular meetings with local police and stakeholders to ensure protection and reduce reprimands for loitering. In Maputo, Mozambique, a HCV testing campaign for police officers in the surrounding neighbourhood was used as an entrance door for sensitisation.

Night outreach in Tete, Mozambique, where sex workers seeking work risk arrest by police. Through MSF's Corridor Project, teams provide prevention commodities and testing services to sex workers and their clients, supporting safer access to care. © MSF

"When MSF leaves the area, I'm leaving too. I know I won't be safe here. The police stopped bothering us because they know there is MSF backing us up. When there is no MSF, we will be vulnerable again."

– Sex worker community mobiliser, Tete, Mozambique

Specific considerations:

For SWs: SW movements can provide significant solidarity and support. Staying informed about laws and having the ability to defend rights or offer paralegal assistance is often crucial.

For MSM: self-identification as part of the LGBTQI+ community can only happen when there is an environment of safety, non-judgment and acceptance. It is MSF's staff's responsibility to create that environment. This can be supported by regular sensitisation trainings.

For TGP: Representatives of TGP are best placed to speak about the issues they encounter and how they need to be understood. MSF can provide safe spaces for these important conversations to occur, to help challenge deep-seated myths and misconceptions regarding sexual orientation and gender identity.

For PWUD: When working with police and civil society, it is crucial to prioritise harm reduction and human rights. Collaboration should focus on reducing stigma, ensuring non-criminalisation, and providing access to health and social services. Building trust between PWUD and law enforcement is essential, as is involving PWUD in decision-making processes to address their needs effectively. Additionally, fostering intersectoral cooperation and advocating for policy reforms can help create a supportive environment for PWUD.

For people in prisons: A focus on human rights and rehabilitation by ensuring humane treatment, reducing relapse through support programmes, and promoting reintegration into supportive environments is essential. Collaboration should provide access to education, healthcare, and legal aid for people in prisons. Building trust among people in prisons, law enforcement, and civil society is crucial for effective rehabilitation and reducing stigma.

The head of the sex worker-led CBO in Zalewa leads a health talk on STI awareness. CBOs promote access to health services and support women's entrepreneurship. MSF Project, Malawi. © Diego Menjibar/MSF

Community-Led Organisations

Creating an enabling environment for equitable access to healthcare for KPs is an essential component of effective programming. This entails supporting local grassroots community building; encouraging KP-led CBOs to participate and conduct sensitisation campaigns regarding needs; and gathering health data that challenges the criminalisation of these populations and develops efforts to change societal attitudes.

INSIGHT

Peer-led community groups

Until effective inclusion and integration of KPs in healthcare is fully funded, having tailored community-led services that are run in parallel with existing local health services is helpful. The sustainability of such services is a major challenge because they often depend on NGO or donor funding. While MSF services can sometimes be handed over, strong collaborations are needed to ensure their good governance, accountability, and capacity for the continuity of interventions by and for KPs.

INSIGHT

Engaging with Key Population-led community groups

When we meet with existing KP-led support groups or associations, depending on the context, these are seldom funded sufficiently or effectively managed to sustain their objectives. We have been learning how to offer help to such groups by using needs assessments, networking them with organisations in the broader sector, and supporting their capacity-building towards their vision within their means.

TOOLS | Who provides services

WHEN AND WHERE ARE SERVICES PROVIDED?

To maximise accessibility, the timing and location for service delivery should be flexible and align with the work and lifestyle patterns of the specific KP community. Peers are ideally situated to advise on the best times and places to reach other KP individuals.

Mobility is a common feature given the changing demand associated with seasonal work. This requires regular adjustments of place and timing when it comes to defining where so-called 'hotspots' are located.

One-stop mobile clinics, or community Drop-in Centres (DICs), often serve as a solution to bridge gaps and ensure continuity of care. DICs have increasingly proven effective for both service delivery and as safe spaces for regular gatherings that foster dialogue and further education opportunities. However, in certain contexts, where the risk of stigma and criminalisation is particularly high, there is sometimes a preference for regular clinics not to be associated with KPs, to avoid the risk of identification. KPs are best positioned to advise MSF on where and how to provide services, and their advice should be followed whenever possible.

The choice of 'where' and 'when' to provide services for KPs should, therefore, be determined through consultation involving both the target population and HCWs. Flexibility, trust, and community involvement are essential for effective and acceptable service delivery.

INSIGHT

Medication-Assisted Treatment (MAT) decentralisation for PWUD

The Kiambu decentralisation of MAT from the expert medical centre to DICs by prison sites enabled patients to continue to access their daily opioid medication effectively and in acceptable sites for them[36].

A pharmacy technician packages methadone doses to be delivered to patients in prisons and hospitals in Kiambu project, Kenya. Prison and hospital deliveries ensure continuity of care. © Eugene Osidiana/MSF

INSIGHT

Adolescents of Key Populations

The Teen Club is a regular, weekly meeting facilitated by peer leaders to support each other and to discuss barriers and other issues they face, which can then be fed back to the programme coordinators. **For adolescents, the 'Teen Club' case study in Malawi illustrated how timing of services should be separate from adult services.** Standard operating hours in healthcare facilities can often create barriers to access. However, designating a specific day each week when a trusted, known-by-name HCW is available to provide care can help overcome these challenges[33].

Voices in Color: Teens and young people in San Pedro Sula, Honduras express their vision for inclusive, youth-friendly health services through collaborative artwork in an MSF project. © MSF

An MSF peer worker distributes safe injection kits to drug users in Maputo, Mozambique. As part of MSF's harm reduction programme, the outreach van travels through Mafalala, offering clean needles, syringes, bandages, and more, bringing care directly to the community. © Tadeu Andre/MSF

Sites of Delivery

Optimal service delivery sites are frequently found near community hotspots, such as bars, hotels, restaurants, parks, or roadside areas. Discreet locations, like private rooms, can offer greater confidentiality and comfort, while other sites where a car or van can be parked for service delivery may offer improved accessibility. The package of care will depend on the space available as well as the consideration of confidentiality and clinical management. The quality of comprehensive care is enhanced by proximity, which further supports health, psychosocial, and legal needs.

INSIGHT

Physical Spaces

Based on MSF experiences in projects, buildings such as empty houses in neighbourhoods where sex workers live can be rented to run a mobile clinic for a day once a week or twice a month, depending on local needs, and peers can help mobilise their community one day prior to the clinic team's arrival.

"We are so happy MSF supports this space for us. We can do 'Safe Space' meetings and talk about things we cannot say in our homes. This is a place convenient for us to have a one-stop clinic for education and basic service delivery."

– Peer outreach worker from Praia Nova, Beira, Mozambique

Timing and Frequency

Service delivery should also be adapted to the work schedules and lifestyles of KP individuals, including variations by day of the week and seasonality. Proximity to the community is important as it reduces travel, costs, and the risk of discrimination, making higher visit frequency less concerning.

The frequency of visits – whether weekly or monthly – should be tailored to medical needs and client preferences. In stigmatising environments, reducing clinic visits may be beneficial unless the client prefers frequent visits. Long refill cycles and easy community pickups ensure continuous access, reducing the need for frequent travel.

Logistics of Service Delivery

Effective logistics include providing accessible and discreet locations, trained staff, efficient supply management, patient-friendly scheduling, accurate data management, community engagement, safety and security measures, coordination with local organisations and stakeholders, and reliable transportation for staff and patients.

Drivers of MSF cars are a core part of the outreach teams in KP projects, often sharing many roles in the intervention, from local expert to safe keeper, counsellor and health educator. See video.

Specific considerations:

For SWs: It is important to ensure services are available at times and locations that are convenient and safe for them, often outside typical sex work hours.

For MSM: services to target men can be delivered near their social or work hubs, out of working hours, close to where they spend most of their time in the day, ensuring a non-judgmental and supportive environment to reduce stigma and encourage regular use of services.

For TGP: Make sure care feels safe and respectful, always use their chosen name and pronouns. Choose times and places that are welcoming and private. Having trained peers involved helps build trust and makes access easier.

For PWUD: Given the typical level of extreme poverty for this KP, services should be delivered within a short distance from their hotspots, drug dens or neighbourhoods.

For people in prisons: Health services should be available within the prison at convenient times, ensuring accessibility despite the constraints of the prison schedule. Ensuring continuity of care upon release is also vital for successful health outcomes in the person's process of reintegration into society.

TOOLS | When and Where Services are Provided

WHAT SERVICES ARE PROVIDED?

A vast set of resources exist regarding the medical package of care in the fields of HIV/AIDS, tuberculosis (TB) and hepatitis, SRH, GBV and psychosocial services; and most can be adapted to address the needs of KPs. We have learnt that until we are sure that other healthcare partners are accessible at a site, a comprehensive package of care needs to be integrated – a so-called 'One-Stop Shop' – to ensure the population has access to minimum services. Outlined below are the considerations and adaptations that may be helpful.

"I'm happy MSF can give us the ARVs now, but what still kills us is the problems of our wombs."

– Female peer sex worker in a former MSF project

Health Promotion

Health Promotion (HP) approaches for KPs should include KP members in every phase of the programme, building on the principle of **"Nothing about us, Without us"**. This comes down to:

- Co-design of the project and medical strategy, HP activities and approaches.
- Active involvement of KP members in the implementation and monitoring of the different HP activities and approaches.
- HP teams including representatives of the KP groups for the MSF KP intervention.

The type of HP activities for and with KPs will reflect the overall **MSF HP framework**, with its **six HP actions areas**:

1. Health education and service promotion, prioritising peer-to-peer approaches, as well as digital health platforms such as Grindr for MSM.
2. Rapid qualitative assessments to foster sensitivity and trust with the communities and have better understanding of the lived experience of these different groups with regard to access to health services. These may need to be done quickly in response to sudden changes, for example among LGBTQI+ adolescents when services of other providers are closed due to funding cuts.

As part of MSF's Corridor Project in Tete, Mozambique, outreach teams – including peer educators, nurses, and counsellors – engage KPs and their communities with health talks, boxes of condoms, and testing services, promoting safer practices and access to care. © MSF

3. Community-based surveillance, case identification and linkage or referrals to care through a KP peer network such as First Responders of Violence. (See more information about this under the section on GBV below.)
4. Active social networking with and mapping of formal and informal KP organisations, associations and key actors.
5. Support for bottom-up or grassroots models of advocacy for KP rights. (See advocacy section.)
6. Building supportive environments for individuals and groups of KPs at health facility and community level to mitigate risks of stigma, exclusion, harassment and violence in collaboration with health and psycho-social actors.

A **participatory approach** to KP programming is essential to understand the context in which people live – political, socioeconomic, and cultural – and how this affects their health and impacts their access to care.

Information should be gathered and assessed with the involvement and consultation of KP representatives to provide an insider perspective when first initiating a project as well as in an on-going way to help guide the intervention and strategies.

"When it comes to this population, we must keep in mind that our models, strategies, and approaches should be periodically reviewed together with our peers to adapt to a developing and ever-changing scenario."
– Coordinator of a sex worker project

INSIGHT

Recruitment of peers

Including, recruiting, and training peers of KP groups into MSF projects may not be easy at first. Successfully tasking HP and health education activities to selected peers of KP requires a bottom up approach – one that focuses on capacity-building to empower KP peers, which is perhaps the most sustainable element of KP programming. Knowledge is power, and this translates into increasing social capital in communities once MSF leaves.

HP Approaches

Effective KP programming relies on research and sector informed-knowledge as well as sharing among peers within communities, using language and contexts that resonate with their realities. Facilitating dialogue through testimonies and sharing experiences, such as police assault and HCW stigma, is crucial. Moreover, prioritising the overall health support for educators, who confront these stark realities daily, is essential for sustained impact.

'Popular education' tools can help ensure that target populations acquire knowledge in a way that resonates with them, allowing them to share their insights effectively. Lecture-style educational sessions are less effective than dialogue-based sessions or those that incorporate fun, role play, and theatrical activities.

Various tools have been developed for health education by peers in the field along with MSF. Visual materials – such as cue cards, flipcharts and placards, condom demonstrations and contraceptive choices – are important means of raising awareness, eliciting discussion, and mobilising action for a wide range of beneficiaries. Many of these materials will need adaptation for different audiences to allow for greater reach.

Informal discussions featuring role-plays and case studies, the use of theatre for education, and regular training sessions in the field are excellent methods to enhance sensitisation and deepen understanding among various population groups. At a more formal health facility level, following the updated WHO recommendations for counselling and education serve as effective components of programming.

In Beira, Mozambique, peers trained as actors use community theatre to raise awareness and promote access to health services among KPs – a creative outreach approach supported by MSF. © Miora Rajaonari/MSF

INSIGHT

Theatre for Education

A group of sex worker peers in an MSF project won a theatre competition at a World AIDS Day event, marking the beginning of their involvement in HP activities through theatre. The group "Tendene" received training in "Theatre of the Oppressed" techniques to raise awareness about health and human rights issues, overcoming communication barriers such as language, culture, and stigma. The performance in the street and health facility waiting area empowered audiences by transforming spectators into actors, promoting timely healthcare and awareness of health rights. This approach highlights societal issues and fosters self-realisation, making theatre a powerful tool for education and social change. See project video.

It is important to use communication channels that the target population of our intervention most commonly use. KP peers, particularly those who are sex workers and LGBTQI+, often have their own grassroots network groups on social media platforms considered safe and comfortable in the local context, where MSF can support the incorporation of HP digital tools to expand health information reach, awareness of available services and campaigns, as well as promoting their networks with similar groups. Other social media platforms have also been seen to prove useful, like the use of YouTube channels to support PWUD in harm reduction.

In Nsanje, Malawi, an MSF community health worker leads a health session with a SW group, using peer-designed flip charts and interactive tools to promote knowledge on HIV, STIs, SGBV, contraception, cervical cancer, and SAC – part of MSF's comprehensive medical package of care. © Isabel Corthier/MSF

Medical Packages of Care

MSF applies either a minimum package or a comprehensive package of clinical care, depending on the feasibility of providing these services. A minimum package of care can typically be accessed via outreach, while the full comprehensive package is provided mainly at facility level, although both packages can be offered through outreach services. Regardless of which package is used, the most important element is to maintain the principle of friendly spaces and inclusion in healthcare delivery.

Packages of Care for Key Populations

MINIMUM PACKAGE	COMPREHENSIVE PACKAGE
• Provision of condoms and lubricants • HIV testing, self-testing, ART services • PEP & PrEP* • Triple elimination and referral for ANC/PMTCT • STI screening and treatment • TB screening and linkage to care • PT and EC • Contraception • SMA • Hep B screening and vaccination • Hep C screening (in high burden context) and treatment • Psychosocial care and referral for MHPSS needs • Sociolegal support • Harm reduction (see Toolbox)	Minimum package plus: • Viral load, CD4 and PMTCT • TB, cryptococcal meningitis and other opportunistic infection (OI) diagnosis and treatment • HPV vaccination and cervical/anal cancer screening, and treatment • SAC and PAC • Hep A vaccination (during outbreaks) • Hep B vaccination or treatment • Hep C screening and treatment • Psychiatric care

*Multiple methods for PrEP include pills, injectables, and vaginal rings.

1. HIV Prevention, Testing & Treatment

The barriers faced by KPs in accessing HIV care at routine health services make it critical that any site where services are provided (whether vertical or integrated) and where KPs feel comfortable to attend should offer a 'one-stop shop'. This approach should encompass a comprehensive prevention and treatment package that meets as many of their specific and general health needs as possible. Wherever possible and following the HIV country guidelines, such services should aim to maximise access, including community distribution and peer-delivery of commodities, particularly those that enable self-care such as condoms and lube, self-tests for HIV and pregnancy, and contraceptives. This is especially important for the tools of prevention and testing described below. Note that various SRH services are directly relevant to HIV: Human papillomavirus (HPV) vaccination or STI treatments help prevent HIV transmission, and contraception is a pillar of PMTCT. For more information, see below under SRH.

It may also be important to consider a care package for the primary partners and children of sex workers or other KPs, especially if their circumstances could affect access to routine healthcare for their families. This package should address general healthcare needs for those individuals who may be unable or reluctant to seek standard services, encompassing vaccinations (for both adults and children) and other routine primary care. Additionally, special attention should be given to support for trauma and all forms of violence, ensuring comprehensive and responsive care.

Specific elements of relevance to KPs in general include:

HIV prevention: Comprehensive prevention tools for HIV, including condoms, female condoms, lubricants, dental dams and finger cots, oral, vaginal and injectable PrEP and PEP.

Testing: HIV tests, including self-tests for KPs and partners, Advanced HIV Disease (AHD) screening and testing commodities such as CD4 (ideally PoC), TB (ideally LAM and Genexpert at PoC), CrAG (for crypto), viral load (Genexpert PoC or DBS sampling).

Care: ART medications, including up to six-month refills and a variety of DSD models, OI prophylaxis as well as cotrimoxazole, tuberculosis preventive treatment (TPT), and fluconazole are relevant. Referral to friendly and free in-patient services where needed. Ambulatory treatment initiation and follow-up of TB and potentially crypto to be considered.

When providing access to HIV testing services, extending this to the children of SWs, other KPs, and their immediate partners can be an inclusive strategy for HIV prevention and early treatment access.

Injectable PrEP: A game-changer

Injectable PrEP offers a long-acting HIV prevention alternative to daily oral PrEP, reducing adherence challenges. Cabotegravir (CAB-LA), given every two months, and lenacapavir (LEN), every six months, have shown near 100% efficacy across diverse populations, including cisgender, transgender, and gender-diverse individuals[37]. For KPs, injectable PrEP can help overcome barriers like stigma, pill fatigue, and inconsistent access. Access remains very limited, prices very high, and advocacy will be essential to ensuring access to these essential prevention tools.

INSIGHT

ART continuity in mobile lifestyle

Disclosure of HIV infection to immediate partners or clients because ART tablets cannot be safely concealed in travel belongings or accommodation can be a huge disincentive for individuals needing to be consistent with their medication. Some also fear their children might discover the tablets. A few strategies have been adopted, such as hiding the bottles in rice or maize meal baskets or packing the number of daily tablets away in a small plastic bag.

INSIGHT

Self-Testing

Education and distribution of HIV self-testing kits in KP communities have resulted in wider uptake of testing in various MSF KP focused interventions, increasing the re-testing rates for prevention and treatment of HIV and other STIs.

At a hotspot in Dedza, Malawi, a peer educator demonstrates HIV self-testing to a group of SWs as part of MSF's outreach under the sex worker project. © Isabel Corthier/MSF

Specific considerations:

Intersectionalities across the KP groups mean that a package of care designed for any one group is likely to be needed for many members of other groups. Thus, while certain considerations may be emphasised in care packages for a particular group due to their specific risk behaviours, these should not be viewed as exclusive to that group. For example, a sex worker may also be MSM and a drug user and their needs will relate to the various specific risks they face. Additional considerations relate to the age group within a KP population and particularly to the extra risks faced by adolescents and young KPs and elderly KPs. The lines between high-risk sexual behaviour in young people and informal sex work can be difficult to identify, and focus should be on the risks and behaviours and enabling open discussions of these issues rather than labels.

For SWs: Female SWs represent a large risk group for unplanned pregnancies and subsequent HIV transmission. A focus on the pillars of PMTCT is especially critical, including contraception and SAC (ideally at community level), access to ART and PMTCT drugs, follow-up of the infant to 18 months, and screening, care, and treatment for all children of female SWs.

For MSM: MSM may have greater concerns about risks of disclosure than other groups although they also find it easier to remain hidden. This means that specific packages, including the promotion of PrEP, condoms and lube, and screening for rectal, oral as well as genital STIs and cancers, require well thought out and often peer-led approaches. Chemsex in some contexts may also require specific attention.

For TGP: MSF does not currently offer hormonal treatment or surgical support but, in certain settings, integration of this care (where obtained privately or from other actors) into MSF-supported care may be needed.

For PWUD: it is important to know which drugs are used and how they are taken. Injecting any drug brings the risk of unsafe injection practices, but in many settings drugs are smoked. PWUD are at very high risk for HIV and hepatitis, so prevention, diagnosis, and care are required as part of comprehensive harm reduction services.

For people in prisons: TB risk is a specific consideration, especially amongst HIV-positive imprisoned people, and routine TB screening and TPT are a priority for them.

2. TB Prevention, Testing & Treatment

TB is a disease of poverty and of weakened immunity, particularly in those infected with HIV, and KPs are often at high risk of TB.

Stigma associated with HIV and TB, added to other forms of discrimination against KPs and their children, leads to exclusion or delayed access. Efforts are needed to ensure TB services are KP-friendly and are integrated within parallel KP services wherever possible. Particular attention must be paid to access for the children of sex workers who are particular risk of TB.

Early screening for TB in KP individuals, especially those with HIV, requires efforts to ensure treatment is started early for those who are positive and that TPT is made available for those who are negative but at risk.

Risks and transmission of drug-resistant TB may be particularly high amongst networks of drug users and people in prison in some regions, particularly in Eastern Europe and Central Asia, and specific efforts are needed to ensure effective treatment and control of transmission.

A handful of TB medication. MSF and Armenia's Ministry of Health are tackling drug-resistant TB with determination and care. But the fight isn't over: global support is vital to ensure access to treatment for all. © Clement Saccomani/MSF

INSIGHT

TB medication

TB treatment regimens – in particular for drug-resistant TB – require high adherence to daily medication. This can be challenging for some, particularly during chaotic periods in their lives. For example, in one case, the judgemental staff attitude to an individual's addiction to methamphetamines and her transgender identity undermined her commitment to adhere to medication, and she defaulted after being denied the opportunity to leave the clinic to access the drugs she was craving. While drug-taking was undoubtedly harmful, the denial of access to it led to a greater harm to the patient and to society because she defaulted from the drug resistant TB treatment.

Specific considerations:

For SWs: regular targeted screening and interventions can help reduce the risk of TB, especially if living in overcrowded spaces during work seasons.

For MSM: diagnosis and treatment may be delayed due to issues around access to adequate health services as well as stigma and discrimination.

For TGP: TB risks may be higher due to stigma, discrimination, and limited healthcare access, necessitating a rights-based, gender-responsive approach for equitable care.

For PWUD: TB and drug-resistant TB transmission is often particularly high amongst networks of PWUD due to poor nutrition, co-infection with HIV, and poorly ventilated shelters[38]. TB services should be integrated into harm reduction programming and other access points for these communities.

For people in prisons: Over-crowding and poor conditions as well as co-morbidities and intersectionality with other high-risk behaviours mean imprisoned people may be at extremely high risk for TB infection. Programming measures must include ensuring adequate ventilation in enclosed spaces, offering routine TB screening at intake and regularly during incarceration, providing treatment for drug-sensitive and drug-resistant TB, and access to appropriate TPT. Prisons in principle offer both an opportunity to ensure complete coverage of TB (and HIV) treatment as well as a major risk.

An adolescent peer educator facilitates a discussion about healthcare in a recreational space of the 'Wana wa mola' children's home in Mombasa, Kenya. © Nora Nussbaumer/MSF

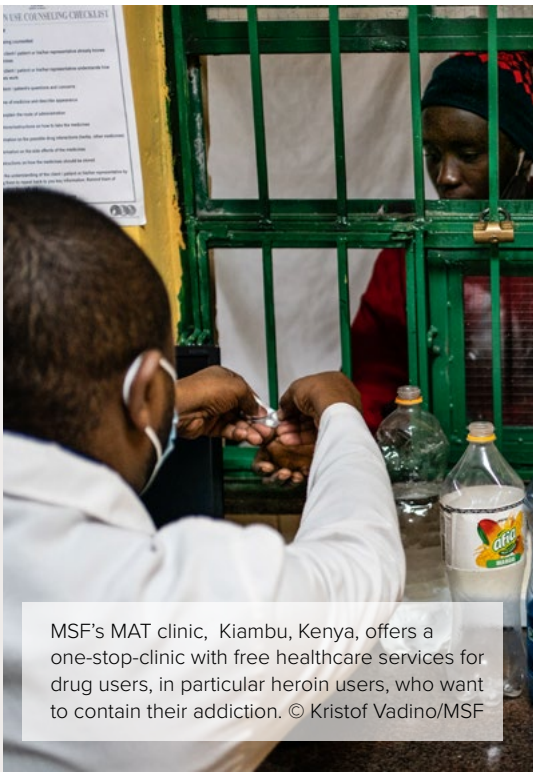
3. Hepatitis Prevention, Testing and Treatment

Health programming for hepatitis B and C prevention, testing and treatment is crucial in addressing the high burden in KPs. Targeted prevention strategies, including vaccination for hepatitis B and harm reduction services for PWIDs, greatly reduce risk of infection. Comprehensive screening helps ensure early detection and linkage to care, while tailored treatment plans address the specific needs of each KP group. By integrating these efforts into accessible and inclusive healthcare environments, we can significantly improve health outcomes.

INSIGHT

Hepatitis C and harm reduction

PWIDs are at a significantly higher risk of HCV infection, with studies showing that up to 90% of new HCV infections in developed countries occur among this population[1]. Harm reduction approaches mitigate the harms of drug use and include reducing unsafe injections as a major objective in reducing blood-borne infection transmission, particularly of HCV and HIV. This is achieved by reducing either the use of injections by providing oral 'opioid' substitutes, such as methadone, or ensuring needles are not reused by giving free needles and syringes. This highlights the critical need for targeted prevention, testing, and treatment interventions within this group.



MSF's MAT clinic, Kiambu, Kenya, offers a one-stop-clinic with free healthcare services for drug users, in particular heroin users, who want to contain their addiction. © Kristof Vadino/MSF

Vaccination for Viral Hepatitis A during outbreaks

Hepatitis A is a contagious liver infection spread through contaminated food, water, anal-oral sex, or close contact, posing a high risk to KPs like MSM, PWID, and those in crowded or unsanitary settings. Outbreaks can escalate quickly in these groups, causing severe illness and straining healthcare systems. To safeguard KPs, it is important to include hepatitis A vaccination in care packages in areas with documented outbreaks, paired with education on hygiene and safe practices.

INSIGHT

Hepatitis B vaccine campaign increased uptake and completion

In Malawi, a hepatitis B vaccination campaign for female sex workers was highly effective in ensuring uptake and completion. The campaign was delivered as an outreach intervention in collaboration between peer educators who mobilised and sensitised their peers and medical staff who provided the vaccines directly in the community.

Specific considerations:

For SWs: selling sex is a high-risk activity for infection with HBV and HCV. Inconsistent condom use, multiple sexual partners, unsafe sexual practices and drug use, and co-infection with other STIs increase the risk of HBV and HCV transmission. HBV screening and vaccination is essential. HCV screening should be considered according to local epidemiology, and treatment made available.

For MSM: Although the transmission routes of the hepatitis viruses A, B and C differ, MSM mainly acquire viral hepatitis during sexual contact.

- All MSM should have access to screening for HBV and HCV followed by a complete laboratory diagnosis package if positive results are detected.
- MSM who test HBsAg negative should have access to HBV vaccination, and hepatitis A vaccination should be considered.
- Treatment initiation for chronic hepatitis should follow immediately after diagnosis in a test-and-treat approach.

For TGP: The risk factors are high because of late diagnosis due to healthcare exclusion and discrimination, structural violence and lifestyle behaviours.

For PWUD: HCV disproportionately affects PWUD. 52% of PWUD have antibodies to HCV, indicating past or present infection. Many PWUD with HCV have other co-morbidities, such as HIV and HBV, and do not seek care due to discrimination, stigma or being in prison. If treated, PWUD are at risk of re-infection with HCV if needle sharing continues. Sufficient coverage of NSPs and opioid substitution therapy (OST) can reduce HCV incidence.

For people in prisons: this could include be any of the overlapping above groups, but risks are also increased because of tattoo practices, lack of clean needles, and MSM sexual encounters with no condoms.

Many sex workers are also mothers. This image of a pregnant woman in an MSF project in Malawi reminds us of the urgent need for dignified, accessible healthcare, for themselves and for their children. © Isabel Corthier/MSF

4. Sexual & Reproductive Health

SRH services should consider the gender and sexual diversity within KPs and address their specific needs. SRH care includes services such as the prevention and treatment of STIs. For female members of KPs, SRH includes cervical cancer care, contraception including emergency contraception, SAC, triple elimination for PMTCT of HIV, syphilis and hepatitis B, as well as obstetric care.

SRH services are most effective when delivered by trained staff with strong communication skills, who can recognise and manage their own biases and who are aware of and sensitive to the needs of KPs so they can provide non-judgmental care.

A sex positive approach – an attitude towards human sexuality that emphasises openness, acceptance, and respect – is essential to be able to engage and respond to the specific needs of KP groups, irrespective of their gender and sex identities, their gender expression, sexual orientation or sex practices. It involves viewing sexual expression as a natural and healthy part of life, free from shame, stigma, or judgment.

We can improve MSF KP programmes by integrating menstrual health and hygiene for people who experience menstruation into our regular SRH services. This could significantly enhance their dignity, access to education, and economic resilience. This approach not only addresses a critical need but also empowers women and girls and TGP to thrive in various aspects of their lives. In general, MSF projects should prioritise concerns that are of highest priority to the population with whom we are working.

"When I go to the doctor and I am worried because I didn't use a condom, they ask me about my wife, but they don't know I have sex with men, so I don't know if I'm getting the right treatment."

– Male peer educator in Beira, Mozambique

Sexual and gender-diverse people often have poor access to appropriate sexual health services, as it is often difficult to find in mainstream healthcare. Men often delay accessing health services, which are sometimes seen as female spaces, but MSM have the additional barrier of stigma and criminalisation. Healthcare providers need to have or develop consultation competencies such as asking the 'right' questions when taking a sexual history and adapting their service delivery to be more inclusive and welcoming. Skilled and sensitive patient-centred care for males includes conducting genital, anal, and oral STI screenings.

Ask how the person wants to be addressed, including name, pronouns, and gender identity. When relevant, sensitively ask about sexual orientation, partner(s), and sexual activity – always privately, non-judgmentally, and with a clear medical reason.

INSIGHT

Engaging trusted peers from MSM and TGP communities proved effective, as they can discreetly connect hidden gay, male, and transgender populations to care in a safe and confidential way.

TGP have particular SRH needs, insofar as their physical needs might differ from those normally associated with their gender identity. For example, trans men may need to prevent unintended pregnancies, monitor menstrual health and hygiene, or be screened for cervical cancer. It is only by working with them to understand their preferred way to receive dignified care, that MSF can ensure their needs are met[31].

INSIGHT

Adolescents who sell sex

Young and adolescent women who sell sex or are sexually exploited report higher rates of unprotected sex, unplanned pregnancy, experiences of violence, and are at higher risk for STIs and HIV. Conservative and discriminatory attitudes regarding unmarried sex and 'promiscuity', fear of being recognised by other community members, and, in some countries, legal restrictions on providing medical services to legal minors without parental consent, hinder their health-seeking behaviour[33].

Tailored models of SRH care that cater to the specific needs and vulnerabilities of KP adolescents are needed. Teen clubs can be such a model. In these spaces, which are co-led by young and adolescent peers, health education is provided alongside clinical services and is often supported by a social worker[39].

"I was so relieved when the MSF nurse asked me what kind of sex [oral, anal, vaginal etc] I was having. He was very respectful, and it was easy to tell them... Otherwise, I wouldn't have said...and I would have not got the right treatment for my sores."

A male patient attending a mobile clinic for KPs in Beira, Mozambique

Condoms and lubricants

The availability of condoms and lubricants is essential for KPs because it significantly reduces the transmission of STIs, including HIV, and helps prevent unintended pregnancies. These resources empower individuals to take control of their sexual health, promote safer sex practices, and enhance comfort during sexual activities. Additionally, access to condoms and lubricants can lower healthcare costs and support public health initiatives aimed at improving sexual health outcomes for vulnerable groups.

Lubricants are sometimes unknown or unavailable in certain contexts. MSF can play an important role in advocating for their supply to ensure they are accessible to those who need them.

To effectively prevent both STIs and unplanned pregnancies, it is crucial to consistently use dual protection. This involves using condoms along with another contraceptive method; a key message we emphasise in both community outreach and clinic settings.

Sex workers often say that sex with no condom pays more. It is, therefore, important to understand the needs a sex worker has at times and offer other prevention methods in advance as necessary. This could be self-managed PEP or PrEP and emergency contraception, plus a follow-up health check at a clinic.

Ensuring the availability of condoms is not always straightforward. **AS MSF we have a critical role to play in ensuring condoms are available and distributed – they are essential health commodities intended for the communities who need them most. Our role is not to control access, but to facilitate it.** As MSF, we must monitor and maintain a continuous supply, including innovative varieties such as female (internal) and male (external) condoms, as well as options with different flavourings, textures, and colours based on the preferences expressed by the target population.

To enhance perception and raise awareness about preventing the various risks associated with unprotected sex, it is effective to conduct condom use campaigns and share practical information through peer education.

INSIGHT

Condom use skills

Sex worker peers can "show and tell" with their communities, offering tips on risk prevention and tricks of the trade, such as how to hide and fit a condom with the mouth or how long in advance to insert a female condom when dealing with a potentially drunk or violent client.

Knowledge is power! A sex worker leads a peer session on female condom use, promoting safety, autonomy, and confidence in the Malawi Sex Worker Project. © Isabel Corthier/MSF

INSIGHT

Moonlight outreach and condom distribution

Moonlight outreach, typically towards sunset between 5:00pm and 8:00pm, is an effective way to engage with communities and provide a wide range of condoms, including various colours and flavours. Female condoms have been increasingly requested by female sex workers in particular, which has helped build trust between MSF staff and the community.

Contraception

As part of a person-centred approach, the opportunity to offer choice in contraception should be given, as there might not necessarily be a follow-up visit. We must offer condoms and wide choice contraceptive methods, while also prioritising self-care strategies such as providing emergency contraception and "just-in-case" packs to cover gaps in contraceptive use or access. These back-up options are critical in empowering individuals to manage their reproductive health proactively, especially in contexts where regular access may be disrupted.

There can be a number of myths and misconceptions about contraceptives among female sex workers and adolescents who sell sex, which require consistent HP approaches. We can also discuss the various ways that men can take responsibility in contraception to explore not just the methods available, but also the role of communication and shared responsibility in sexual relationships.

INSIGHT

Promoting uptake of contraception

Some of the tools that showed high levels of engagement and acceptance were participatory dialogues using an apron (see toolbox) holding samples of different contraceptive options to trigger discussions, or talks held by 'champions' who could inform and explain choices in contraception methods.

At a hotspot in Dedza, Malawi, an MSF peer sex worker community health worker leads a contraception session as part of MSF's outreach to promote informed choices and access to care. © Isabel Corthier/MSF

Safe Abortion Care

Many female sex workers, females who use drugs, adolescent and young females who sell sex are at high risk of unintended pregnancies and unsafe abortion due to the barriers to access healthcare.

MSF often works in countries with restrictive legal frameworks for SAC, where safe abortion is prohibited or only permitted under specific circumstances. This, combined with the stigma associated with requesting an abortion, makes it particularly dangerous for already criminalised or marginalised populations.

The MSF Exploring Values and Attitudes (EVA) workshops about SAC, followed by the six-step approach towards its implementation in projects, remains the cornerstone of the provision of care. This can be significantly strengthened by effective networking with sector activists and local actors to secure the sustainability of these lifesaving services.

Despite restrictive laws in many countries, innovative approaches following simple evidence-based protocols can enable access to SAC for KPs. Self-managed abortion (SMA) using oral medication can be safely provided at community level, supported by trained peers along with mentorship, supervision, and clinical support for referral in case of need.

INSIGHT

SMA in the community

In Southern Africa, MSF developed peer-led projects focused on empowerment and HIV/SRH care with sex workers, including a ground-breaking training for lay cadres leading and providing SMA care. The project saw an increase in the number of adolescents who sell sex not only requesting SAC but also engaging in contraception. Even after MSF closed its sex worker-focused project, the continued supply of medication and an accessible, well-known and trusted healthcare supporter allowed for many women's lives to be saved.

Sexually Transmitted Infections

Demand for unprotected sex is the greatest 'risk factor' for STIs in sex work. Other KP groups are also affected by a variety of power dynamics that often leads to no condom use. Strategies to change the power differential in favour of members of KPs would be conducive to safe sex or safer sex. Negotiating safer sex is at the core of STI prevention, yet it is often difficult to consistently achieve.

KP members benefit from having good knowledge of STIs, the modes of transmission, symptoms and treatment. This increases awareness and agency to access the appropriate treatment. Self-care for treating STI-like symptoms is very common, and this can often lead to the wrong treatment for the wrong pathogen. Presumptive Periodic Treatment (PPT) is a strategy commonly practiced with KPs, but it has generated some controversy related to antibiotic resistance. Evidence is lacking, so more research is needed to prove its benefit over the self-managed random antibiotics bought over markets or online.

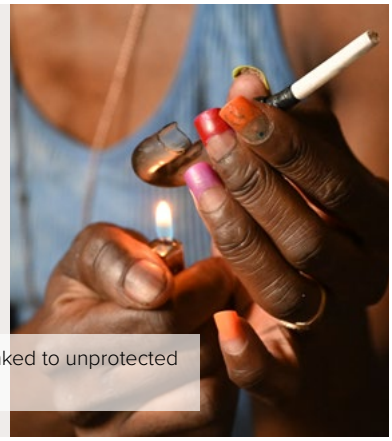
Understanding risks for STIs and assessing these correctly by taking a good sexual history can increase the chances of diagnosing the possibility of an STI and recommending appropriate treatment while also enhancing HIV prevention with PrEP.

It is important for HCWs to be sensitised and trained to speak about sex and sexual practices in a sex positive way, and be open to learning from the experiences of KPs, so that the language should feel empowering, non-judgemental and supportive of healthy choices, such as when individuals disclose being involved in chemsex, and MHPSS services might be also needed.

Testing and diagnostic strategies for the majority of STIs are largely unavailable in the humanitarian contexts where MSF works. The only laboratory tests commonly available are for HIV and syphilis, so diagnosis of STIs tends to rely on syndromic algorithms and focuses on symptomatic infections only.

Chemsex

Chemsex, the use of recreative drugs during engagement in sexual relations, is a sexual practice among MSM and TGP in certain contexts. In contexts involving SWs, clients often use drugs, raising the risk of neglecting prevention of STIs and increasing the risks of sexual violence. Additionally, PWUDs can neglect their risk perceptions when influenced by substances and could engage in risky sexual behaviours.



In Mbare, Zimbabwe, MSF's adolescent project highlights how meth use among youth is linked to unprotected sex and increased HIV risk. © Doris Burtscher/MSF

Presumptive Doxycycline post-exposure prophylaxis (DoxyPEP)

DoxyPEP is a promising biomedical approach to prevent bacterial STIs, such as chlamydia, syphilis, and gonorrhoea[40]. Taken within 72 hours after condomless sex, it has shown high effectiveness against chlamydia and syphilis among MSM and transgender women, although results for gonorrhoea are mixed. As a self-managed option, DoxyPEP can enhance sexual health services for KPs, complementing HIV PrEP, STI screening, and risk-reduction counselling.

Presumptive Periodic Treatment (PPT) for STIs

A proactive strategy used to reduce STI prevalence among groups at high risk, such as SWs and MSM, involves administering treatment at regular intervals, regardless of symptoms, to quickly lower infection rates and improve overall health outcomes. Studies have shown PPT's effectiveness in significantly reducing infections like gonorrhoea and chlamydia, especially in settings with high STI rates and limited access to healthcare services[41,42].

HPV and cervical cancer

HPV care and cervical cancer screening are particularly crucial for KPs, including SWs, LGBTQ+ individuals, and people living with HIV. These groups often face higher risks due to factors like increased exposure, limited access to healthcare, and social stigma.

Tailored approaches are essential to address their unique needs, ensuring culturally sensitive, non-discriminatory, and accessible services. Early detection through regular screening and vaccination can significantly reduce the incidence of cervical cancer, thereby improving overall health outcomes for these vulnerable populations.

Individuals assigned male at birth including MSM and TGP, also face significant risks related to HPV. These groups are more susceptible to HPV-related conditions, such as genital warts and anal cancer. Tailored healthcare services are essential to address their specific needs, including targeted education, vaccination, and regular screening.

While implementing cervical cancer treatment services for SWs, an MSF project recognised the critical importance of understanding and addressing the economic vulnerability that can follow the procedure. This period of recovery often disrupts income-generating activities, potentially affecting their ability to support their families.

Staff with positive, patient-centred care attitudes and skills will find it easier to address the taboo of anal sex, HPV, and HSV in both men and women when taking a sexual health history.

"When we started to do moonlight outreach [between 5:00 pm and 8:00 pm] with boxes and boxes of condoms and lube, we started to see many more individuals, and we talked about emergency contraception if the condom broke…of course we spoke about HIV and other STIs as well."

– A nurse from the outreach team visiting the sex work hotspots such as bars and truck stops in Tete, Mozambique

Specific considerations:

For SWs: Many female SWs are mothers or would like to have children and, in many contexts, having children is considered a sign of prosperity and social status. It is crucial to engage with women's realities in a non-biased way. Health facilities should offer comprehensive SRH care, including education, contraceptive choice, abortion services and safe pregnancy practice.

For MSM: services need to ensure confidentiality and be delivered at a convenient location and time, addressing male-specific overall wellbeing and sexual health needs.

For TGP: Healthcare workers must be equipped to provide gender-affirming, patient-centred care, including appropriate referrals and services such as cervical cancer screening for TGP people who are men.

For PWUD: people under the influence of drugs or at cessation with MAT may increase their sexual activity, whereby the risk of unprotected sex also increases.

For people in prison: the assumption that sex does not happen in prison results in a lack of service provision. However, prevention commodities such as condoms of all sorts, lube, contraceptives and access to services must be prioritised, despite this assumption.

Led by sex workers and supported by MSF, the community of Las Claritas, Bolívar State, Venezuela, united in a powerful World AIDS Day walk, standing together for dignity, awareness, and inclusion. © MSF

5. Gender-Based Violence

GBV is a common and deeply rooted issue that affects individuals across all societies, with particularly severe impacts on groups of KPs. These populations often face heightened vulnerability to GBV due to intersecting factors such as stigma, discrimination, and marginalisation and are frequently subjected to physical, emotional, and sexual abuse, both in their personal lives and within broader societal contexts.

INSIGHT

Survivors of Violence

An Epicentre study conducted among sex workers in Nsanje district in Malawi found that more than half of participants (53.3%) reported an episode of sexual violence in the previous month, and more than one-tenth (14.2%) of all respondents experienced sexual violence perpetrated by a police officer[43].

Economic violence, such as the denial of payment for sex or extortion of money and belongings is a very common experience for sex workers. In conflict-affected and humanitarian settings, sex workers are at highest risk of GBV due to the higher presence of armed forces. Sex workers rarely receive protection from the state as victims of GBV[44].

A comprehensive understanding of GBV, its manifestations, and its profound effects on the health and well-being of KPs is essential. By exploring the unique challenges faced by these groups, we can co-design and develop targeted interventions that address their specific needs and foster partnerships. It is also important to recognise that male victims of sexual violence are not automatically categorised as MSM, and their experiences must be addressed with appropriate sensitivity and distinction.

KPs may not identify as "survivors of violence" due to the regular occurrence of violence in their lives. Recognising them as such highlights the urgent need for targeted support, protection, and advocacy to address their unique challenges and promote their safety, dignity, and well-being.

Including peers of KPs in trainings as co-facilitators where they use their voice to give testimonies of their experiences can be not only very sensitising for learners but also empowering for the survivors of violence who participate in building awareness to support their lives and the well-being of their communities.

Accessing GBV services can be difficult for KPs due to stigma and discrimination. Sector-specific hotlines staffed by KP community members, along with tailored support like accompaniment to services, can improve access. While SV is a form of GBV, the care packages differ: **SV care includes clinical interventions like emergency contraception and PEP, while GBV care may also involve psychosocial, legal, and protection services.** Clear distinctions help ensure survivors receive the right support.

In addition to providing PEP, Pregnancy Test (PT) and emergency contraception (EC) as a first response in the community, peers of KP groups should be trained to provide counselling and support, including PFA, to their communities. By equipping HCWs with the knowledge and tools to address GBV in KPs, we can work towards creating safer, more inclusive environments. An integrated system can also help guide individuals seeking social or legal support, potentially connecting them with relevant partners.

Law enforcement partners such as police should prioritise protection over persecution. For more information see chapter on "Advocacy and Activism".

INSIGHT

Murders of sex workers

In December 2023, the murder of 10 sex workers in Beira project shocked the community, including the MSF project staff. One of the women who was brutally murdered was part of the sex worker group accessing services with us. This was not the first time a female sex worker was murdered in the city, but it ignited the Beira project to engage with the sex worker networks, police and authorities to participate in the response to and advocacy for this issue[45].

Community march in response to sex worker murders, Beira Project, Mozambique, with participation from local police and KP community members. © Calven do Rosario/MSF

INSIGHT

Addressing violence against KPs

We have identified several informal strategies from MSF's work with KP communities that effectively respond to GBV. These include helplines, websites, or first aid response from community peers. For instance, in a sex worker project in Beira, Mozambique, a First Responders model was implemented where a peer would be available 24/7 using a toll-free cell phone to provide PFA and medical support, including emergency contraceptives, pregnancy tests and PEP.

Specific considerations:

For SWs: The nature of sex work puts many at high risk of GBV not only from clients, but also from the medical and legal structures that are supposed to help them following an assault. Criminalisation of sex work or behaviour associated with sex work further exacerbates the challenges and structural barriers many SWs face. Networking, sensitisation and increased public awareness have proven useful as has having a contact person for instance at the police station for SWs.

For adolescents who sell sex: Healthcare and support services tailored to adolescents is important so that the adolescents feel safe despite their additional layer of vulnerability. Peers of their own age are essential for successful mobilisation as are non-judgmental, trusted adults. A social worker can advise those who are looking for social or legal support, and potentially help link with partners.

For MSM and TGP: tailored healthcare, including gender-affirming care, and decriminalising same-sex relationships can be helpful.

For PWUD: besides having accessible and non-judgmental healthcare and support services essential to all KP groups, advocacy supporting efforts to decriminalise drug use to reduce legal barriers and stigma would be useful.

For people in prisons: providing safe spaces and trusted support networks within the prison system is essential. Law enforcement and prison staff partnerships should focus on protection, while public awareness campaigns should challenge harmful stereotypes. Advocating for the rights and dignity of people in prison is also crucial in addressing their specific needs.

"I knew people who started working for MSF. I was sick at that time. They give me assistance, they help me with the HIV treatment. I see the doctor and get medication every three months. Before, it was difficult. Even in LGBT groups, I didn't feel that there was any confidentiality regarding my HIV status." – A male sex worker assisted by MSF © Giuseppe La Rosa/MSF

6. Mental Health and Psychosocial Support

Key populations are disproportionately at increased risk for mental health conditions due to a combination of social, economic and psychological factors.

- **Social factors:** People who experience stigma, prejudice, discrimination, and sometimes criminalisation, might experience social exclusion, feelings of shame and fear of legal consequences, leading to a reluctance for seeking help and essential services[46].
- **Economic factors:** Marginalisation and exclusion from society further limit opportunities and fuel the cycle of poverty, which can contribute to stress and suffering.
- **Psychological factors:** Experiences of violence and a history of trauma, abuse or neglect on a regular basis are likely to increase the risk for mental health issues, such as anxiety, depression, low self-esteem and more.

Increased risk of substance use

Biological factors that greatly increase the risk of presenting with mental health conditions include chronic medical conditions and medications, genetic factors and substance use.

Trauma-informed care can increase engagement, improve outcomes, and reduce retraumatisation among individuals who have experienced high levels of adversity or marginalisation. For more information see toolbox.

It is equally important to emphasise that individuals, families, and the communities of KPs have resources to deal with the impacts of the different vulnerabilities to which they are subjected, **particularly if understood and supported**. Identifying and strengthening existing community supports and working closely with families and communities is a key component.

INSIGHT

From lay counselling to holistic care

Within MSF, patient support counselling and education (PSEC) services – initially led by lay counsellors in HIV and TB programmes – were instrumental in engaging sex workers and other KPs. In projects like the Cross-Border Corridor intervention between Mozambique and Malawi, these roles have evolved to include mental health and psychosocial support, reflecting a shift toward more integrated, person-centred care that addresses both physical and emotional well-being.

Facilitated therapeutic activities – such as dance, song, theatre, and storytelling – along with the promotion of self-help peer support groups, can significantly enhance individual well-being. However, ensuring continuity of care remains a challenge, especially for those who are hardest to reach and most affected. Outreach models of care can be thoughtfully adapted to provide therapeutic support tailored to the needs of specific groups.

MSF staff play a vital role in addressing stigma and discrimination faced by KPs, and sensitisation is an essential starting point in this work. In this context, peer-led models of care are especially valuable, offering guidance and facilitating appropriate, evidence-informed interventions that are grounded in lived experience.

Ensuring safe environments where members of KPs feel accepted and understood can enable them to share their experiences and receive emotional support.

INSIGHT

The role of the social worker

Experience with KP programmes in MSF has demonstrated that involving a local social worker is an asset for identifying the socio-legal support needs of KP individuals. While this responsibility has often been assigned to project coordinators or HP cadres, it has become clear that dedicated social work expertise is invaluable. This is particularly important given the complex social determinants of health that affect KP individuals.

The integration of MHPSS into our medical humanitarian response can be particularly relevant in settings where we work with KPs, ranging from post-conflict situations where refugees have experienced violence, to survivors of natural disasters, epidemics, or GBV, and those who are marginalised, such as migrant people, sex workers, adolescents, people from LGBTQI+ communities, in prisons or in closed settings. Social workers can help strengthen referral pathways for moderate to severe mental health needs, including psychiatric care, and can train MoH staff to better support KPs.

Gender-affirming care

Gender-affirming care refers to a range of medical, psychological, and social services designed to support and affirm an individual's gender identity. This type of care can include hormone therapy, surgical interventions, mental health support, and social services that help individuals navigate their gender transition. The goal of gender-affirming care is to improve the overall well-being and quality of life for TGP and non-binary individuals by aligning their physical characteristics (or gender expression) and social experiences with their gender identity. It is a holistic approach that respects and validates each person's unique journey and needs.

At MSF's project in Kiambu, Kenya, people who use drugs participate in yoga sessions within the Medication-Assisted Treatment (MAT) clinic's safe space - fostering mental wellness, dignity, and community as part of a holistic harm reduction approach. © Doris Burtscher/MSF

Specific considerations:

Peer networks can enhance empowerment and protective factors by providing financial support and alternative livelihood options, for instance.

For SWs: Non-judgmental safe spaces for SWs, like DICs where they can meet to discuss their experiences, is important. Tailored MHPSS services are needed to prevent and address violence and trauma, anxiety, depression, substance use and other mental health conditions.

For MSM and TGP: HCWs can help by ensuring safe environments where MSM and TGP feel accepted and understood, thereby promoting self-acceptance and building self-esteem. HCWs should be trained to offer gender-affirming care and recognise the impact of discrimination.

For PWUD: Integrated health services should address co-occurring conditions by combining mental health support with substance use treatment.

For people in prisons: People should be regularly screened and have timely access to adequate care for mental health disorders. This is especially important given the high prevalence of mental health conditions among persons deprived of liberty. Peer support and therapeutic activities are helpful to focus on developing coping skills and fostering healthy connections can aid in rehabilitation. A safe and supportive environment is also key.

TOOLS | What services are provided

A male peer community health worker consults with a patient during an outreach clinic aimed at MSM. Being known and trusted in these networks helps improve the monitoring of patients in the programme. Beira MSF project, Mozambique. © MSF

MONITORING & **EVALUATION**

Monitoring and evaluation (M&E) are critical components of KPs programming.

Importance of quality data

When developing an M&E strategy for KP programmes, it is crucial to begin by reviewing the standard indicators list. This ensures that the selected indicators align with intersectional standards, the specific objectives of the programme, and the metrics used by other key stakeholders (e.g., national reporting guidelines, MoH tools).

Data is essential for understanding the health needs of KPs and for designing effective interventions. It helps identify gaps in service delivery and unmet needs, particularly among those who are often invisible in mainstream health systems. Separating data collection at the service level (e.g., number of services provided) and patient level (e.g., health outcomes) allows for a comprehensive understanding of programme effectiveness.

Community-led monitoring (CLM): CLM is an approach by which community members take the lead in identifying and routinely monitoring issues that matter to them, ensuring that programmes are responsive to their needs. It plays a crucial role in empowering KPs and enabling them to advocate effectively for their needs and rights to be met.

Ensuring reliability of data in the face of stigma

Gathering data on KPs is challenging due to stigma, denial, and criminalisation, and poorly protected data can threaten their safety.

These factors often result in underreporting and inaccurate information. To address these challenges programmes must build trust and friendly services, develop peer-led data collection methods, and ensure confidentiality and responsible data practices.

Taking steps to implement effective M&E

- **Framing and strategic alignment:** Begin by establishing the purpose and scope of M&E within your KP programme. Use a logframe to clarify expected outcomes, activities, and indicators, ensuring alignment with programme goals. Early engagement with medical advisors and eHealth teams is essential for harmonising clinical and programmatic relevance, feasibility, and data system support.
- **Selection of indicators:** Focus on a targeted set of standard indicators that are appropriate for your programme's position in the care cascade. Consider the following when choosing:
  - *Where you sit in the cascade:* Are you supporting prevention, testing, linkage to care, treatment, or retention?
  - *Services offered:* Consider what services you provide directly and how referrals or linkages are made between services (e.g., OPD, SRH, HIV, etc).
  - *Identifying KP groups:* Record KP group information only when it is relevant to the activity and context. If data collection poses any risk to the safety, confidentiality, or well-being of the individual, it must be avoided.
  - *Location of service delivery:* Consider whether services occur in the community, primary health centres, or hospitals, and how transitions across levels are managed.
  - *Data requirements:* Determine which services or activities need individual-level or cohort tracking, and where aggregate data are sufficient.
- **Selection of M&E Tools:** Choose paper-based, electronic, or hybrid tools that are appropriate to your indicator needs, the type of services provided, available infrastructure, and team capacity. Tool selection should be guided by both clinical/programmatic relevance and operational feasibility.

A clear strategy for how data will be collected, implemented, and used is essential. This includes:

- Ensuring privacy and data protection
- Involving key stakeholders in planning and operational decisions
- Consulting with eHealth teams, medical advisors, and KP focal points to select the most appropriate tools and approaches for each setting.
- Training your teams on how to collect data in a diversity-affirming manner

Well-matched tools enable smoother data collection, better coordination between services and providers, and stronger reporting for programme improvement.

INSIGHT

M&E and the integration of Key Populations in MSF projects

Despite increasing recognition of gaps in response to KPs needs by MSF project staff, and awareness of their specific vulnerabilities, evaluations from the MSF Stockholm Evaluation Unit have highlighted a lack of engagement and visibility. M&E systems are crucial in ensuring visibility and enabling all projects to effectively provide access for KPs.

Peers of people who use drugs play a vital role – registering and monitoring clinic attendance, and supporting access to methadone treatment in Kiambu Project, Kenya. © Kristof Vadino/MSF

M&E in Microplanning for Peer-Led Outreach

Microplanning helps peer educators transition from being passive data gatherers to active site managers who analyse data from their spots and networks. Such information is used by them to follow up with KP individuals they are responsible for, understand their risks and vulnerabilities and plan outreach and services based on their needs. The use of registers, forms, and diaries for documenting activities ensures accurate tracking and reporting of outreach efforts. Together with other elements of community-led monitoring, microplanning creates a robust framework for delivering, adapting, and advocating for services; assessing the impact and effectiveness of programmes; and ensuring they are both comprehensive and tailored to the unique challenges faced by KPs.

While ideally all KP needs are met at a single integrated site – a 'one-stop shop' – this is rarely possible and referral and linkage to different services is often required. Such services may not be always be friendly. Tracking of referral and follow-up outcomes can be challenging and must be considered in the M&E framework.

INSIGHT

Combining M&E approaches to get the whole picture

To design effective KP interventions, it is important to use a mix of M&E approaches. Monitoring requires quantitative data but it is not just about counting – it is about understanding. Qualitative methods, including focus group discussion, patient satisfaction questionnaires, field notes, journals, and informal observations, can help tell the story behind the numbers. In some cases, monitoring overlaps with operational activities, as seen in hotspot mapping used for microplanning. These insights are essential for adapting programmes in real time and ensuring they remain relevant and effective.

INSIGHT

Engaging with sex worker networks in research

Using methodologies such as Respondent-Driven Sampling (RDS) helped an MSF project understand the dynamics related to GBV and health among sex worker networks in a large rural zone in Malawi. This approach utilised random seed sampling, snowballing to access and reach sex worker groups, and multiple waves of recruitment to effectively reach and gather data from this hard-to-reach population. This was a useful way to engage people and further align project activities with the findings and recommendations[40].

Random seed sampling in action: A key step in reaching diverse networks of sex workers for inclusive representation in research at an MSF Malawi Project with Epicentre. © MSF

Research and Innovation

Research to provide evidence-based insights that inform programme design and implementation is helpful to ensure that interventions are grounded in proven strategies.

Documentation of innovations can capture novel approaches, which can be replicated and scaled to enhance programme effectiveness and inspire other MSF projects, too. Often, these innovations are shared in digital formats as lessons learned, making them accessible for future reference and adaptation.

Evaluations help to assess the impact design and its implementation. These are also useful for facilitating dialogues and reflections, to guide future efforts and resource allocation.

Qualitative assessments and monitoring are useful mechanisms to systematically record feedback from KPs and to gather community information. This helps ensure that programmes are responsive to the needs and experiences of the communities we serve.

Ethical considerations are paramount in all these activities, and we must ensure that we respect the rights and dignity of KPs, such as by maintaining confidentiality and prioritising their well-being. This ethical approach is crucial for building trust and fostering a supportive environment for all vulnerable groups.

When working with local partners such as CBOs, it is essential to ensure they uphold the rights and dignity of KPs, including maintaining strict confidentiality. This can be challenging but is critical to ethical and inclusive practice.

A participatory approach highlights the inclusion of KPs' voices and experiences in any evaluation process. This can be achieved through participatory methods, such as focus groups, interviews, and surveys, which allow KP individuals to share their perspectives on the effectiveness and impact of the interventions. This approach not only provides valuable insights but also empowers individuals by involving them in the decision-making process.

Peer sex workers take the lead by interviewing fellow community members as part of a participatory research effort in Beira MSF Project, Mozambique. © MSF

Specific considerations:

For SWs: Health programs should prioritize confidentiality and safety to avoid stigma or harm. Data collection must be anonymous or coded, with informed consent clearly explained. Indicators should capture not only clinical outcomes (e.g., HIV/STI testing and treatment) but also access, acceptability, and rights-based dimensions such as empowerment and reduction of violence. Engaging sex workers in designing M&E tools ensures relevance and trust, while qualitative feedback helps identify barriers and improve service delivery.

For MSM: We need to assess the accessibility and inclusivity of services. This involves evaluating whether the services are easily accessible to MSM individuals and whether they are designed to be inclusive and culturally sensitive. Key indicators might include the availability of MSM-friendly healthcare providers, the presence of anti-discrimination policies, and the extent to which services address the unique health and social needs of MSM.

For TGP: Ensuring the use of gender-sensitive and inclusive indicators is important for this KP. This involves developing metrics that accurately reflect the experiences and needs of TGP, including their access to gender-affirming healthcare, mental health support, and social services. These indicators should be designed to capture the unique challenges faced by TGP and measure the effectiveness of interventions in addressing these challenges.

For PWUD: A crucial aspect is the assessment of the coverage and quality of harm reduction services. This involves evaluating how widely these services are available and their effectiveness in meeting the needs of PWUD. Key indicators might include the availability of NSPs, opioid agonist therapy, and access to naloxone for overdose prevention.

For people in prison: This KP requires extra attention regarding privacy and security issues and tracking the continuity of care post-release. This involves assessing how well healthcare services provided in prison are continued once people in prison are released, evaluating whether they have access to necessary medical follow-ups, medications, and support systems. This continuity is crucial for managing chronic conditions and preventing relapse or deterioration of health.

TOOLS | Implementing effective M&E

A patient outside the ward for terminally ill people with XDR-TB showing their lunch. This is the only food they can afford on his pension, in an MSF project in Karakalpakstan, Uzbekistan.
© Misha Friedman/MSF

CONCLUSION

MSF has observed various successful models of empowering Key Populations to engage in health service provision efforts.

Peer-based, KP-friendly environments, such as one-stop clinics, mobile clinics, and tailored friendly services integrated within existing MoH facilities, have significantly increased beneficiary engagement once local peer mobilisers effectively promote these services.

These models highlight the importance of intersectionality in health service provision, recognising the diverse and overlapping realities within KPs, such as SWs, MSM, TGP, and PWUD.

Besides capacity-building to empower MoH staff, HCWs, and other partners to develop friendly, inclusive and sustainable services, it is crucial to share relevant advocacy and activism tools. These tools address the broader context in which sex work exists, including the stigmatisation, abuse, and criminalisation faced by these KPs.

By integrating these elements effectively, health interventions can be more inclusive, participatory, successful, and responsive to the unique needs of KPs.

GLOSSARY

Adolescents of Key Populations: are individuals aged between 10 and 19. Young and adolescent KPs are particularly vulnerable due to their youth and face unique challenges.

Sex worker movement: is a collective effort by SWs and their allies to advocate for the rights, safety, and dignity of individuals engaged in sex work. This movement addresses a range of issues, including labour rights, gender-related violence, social stigma, migration, access to healthcare, criminalisation, and police violence.

Capacity-building: the journey of enhancing how a person, an organisation, or a system can thrive effectively and efficiently. It involves nurturing knowledge, skills, and capabilities to reach meaningful goals and aspirations.

Chemsex: refers to sexual activity undertaken while under the influence of stimulant drugs, such as methamphetamine or mephedrone, and typically involves several participants. This practice is often associated with men who have sex with men (MSM) and trans and gender-diverse people (TGP).

Community-based organisations (CBOs): are typically non-profit entities that operate within a specific community or geographical area, aiming to address local needs and improve the well-being of its residents. While focused on community needs, CBOs may not necessarily be fully controlled by their community members.

Community-led organisations (CLOs): those organisations that are formed and led by members of a community, such as KPs, and designed to serve their communities. They play a crucial role in KPs programming.

Concentrated epidemic: this describes a setting where HIV transmission is highly concentrated among KPs and their immediate partners. See also: Generalised epidemic.

CBOs vs CLOs: both implement various activities according to their capacity, including advocacy, campaigning, and holding decision-makers accountable; monitoring policies, practices, and service delivery; conducting participatory research; and facilitating education and information-sharing, as well as providing services.

Differentiated service delivery: a responsive, person-centred approach that simplifies and adapts health services – particularly for HIV and sexual and reproductive healthcare (SRH) – to better serve individual needs and reduce unnecessary burdens on the health system. In this document we apply the concept to models of care promoting access for KPs.

Empowerment: is the process of boosting an individual's or group's ability to take control of their lives and make positive changes. It involves increasing autonomy, self-determination, and the power to act effectively in various aspects of life.

Generalised epidemic: in many settings, HIV transmission is highly concentrated among KPs and their immediate partners – making up as much as 95% of all HIV cases in settings such as Eastern Europe, the Middle East, etc. This is known as a concentrated epidemic. In much of Africa, however, the epidemic has become generalised, meaning that most cases are not among KP communities, though they are still disproportionately affected and may make up 20-50% of HIV cases. See also: Concentrated epidemic.

Harm reduction: encompasses policies, programmes, and practices that aim to minimise the negative health, social, and legal impacts associated with drug use, drug policies, and drug laws. It also helps to reduce the adverse consequences of recreational drug use through provision of measures such as NSP and MAT. It acknowledges that those who are unable or unwilling to stop can still make positive changes to safeguard themselves and others.

HIV self-testing: involves the use of HIV (oral or finger-prick) self-tests, a process in which a person can test and interpret the result, often in a private setting, either alone or with someone they trust.

Hotspot: a location or area where members of KPs gather to meet, socialise, seek clients, or engage in behaviours that define their group. These locations typically include bars, nightclubs, town parks and

city squares, truck stops, brothels, isolated areas or private homes, streets, bridges, and motor parks where people gather to inject drugs. It is important to note that hotspots can also extend to social networking apps as virtual spaces. Websites and social media platforms, e.g. Grindr, are increasingly viewed as "virtual" hotspots where programming for LGBTQI+ people can take place, particularly through targeted health information, education, and communication initiatives.

Integrated service delivery: refers to health services that are managed and delivered in a way that ensures that people receive a continuum of care, such as integrated HIV/TB and SRH; also known as a one-stop approach. Integrated service delivery can be at different levels and in different sites according to the population's specific needs.

Intersectionality: is a concept that recognises how various social categories – such as race, gender, class, sexuality, and ability – may intersect and shape an individual's experiences and opportunities. For KPs, it highlights the unique challenges faced at the intersections of these identities, often resulting in compounded forms of discrimination and privilege. Understanding intersectionality is crucial for developing inclusive policies and programmes that address the specific needs of marginalised communities. For example a female sex worker may also be a drug user and lesbian or bisexual, and at times a prisoner, as well as being impoverished and female.

Key populations (KPs): groups who, due to higher-risk behaviours, are at increased risk of HIV, viral hepatitis or sexually transmitted infections (STIs) irrespective of the epidemic type or local context. Additionally, they are often stigmatised, discriminated against and criminalised. In this manual, KPs refer to: men who have sex with men (MSM); people who use drugs (PWUD); people in prisons and other closed settings; sex workers (SWs); and trans and gender-diverse people (TGP).

KP-friendly services: are service providers that meet KPs in a non-discriminatory, inclusive and accessible way and respect the dignity and autonomy of all individuals, including their sexual partners and families. Such services are also tailored to KPs needs, like opening hours and integrated services provided as community-led outreach.

Lay worker: a person without a formal certification or a degree who is trained to provide certain healthcare services.

LGBTQI+: an umbrella term referring to individuals who identify as lesbian, gay, bisexual, transgender, queer/questioning, or intersex. It focuses on sexual orientation, gender identity, and physical differences in sex characteristics. While not inherently tied to health risks, like HIV, it intersects with health concerns due to shared experiences of stigma and discrimination.

Men who have sex with men (MSM): refers to all men who engage in sexual relations with other men.

One-stop clinic: is a safe space and KP-friendly health service where comprehensive and multi-sector health and socio-legal care is provided usually in one facility or consultation room. A variation of the one-stop is referred to as a drop-in centre (DIC).

Microplanning for peer-led outreach: in KP programming, microplanning involves a decentralised approach where grassroots-level workers, such as peer educators and outreach workers, plan and manage outreach activities. This method focuses on identifying and mapping hotspots or clusters where KPs are concentrated. Elements of microplanning include building rapport and trust within these communities, engaging them in health education about disease, distributing prevention materials (i.e., condoms and lubricants, clean needles and syringes (NSP)), and encouraging visits to clinics for health services. The goal is to achieve comprehensive coverage and personalised services tailored to the needs of each hotspot.

Participatory approach: is essential in KP programming because it involves the active engagement of the affected communities in the planning, implementation, and evaluation of programmes. This approach ensures that the specific needs, perspectives, and experiences of KPs are addressed, and their suggestions are incorporated, which leads to more effective, relevant, and sustainable interventions. By fostering collaboration and ownership, participatory methods enhance the impact and acceptance of KP programmes.

People-centred care: is focused and organised around the health needs and expectations of people and communities rather than diseases.

People in prisons or other closed settings: refers to imprisoned people in all places of detention within a country where people may be held during the investigation of a crime, while awaiting trial, after conviction, before sentencing and after sentencing.

People who use drugs (PWUD): include people who use psychoactive substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal. People who inject drugs (PWID) are at high risk of HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) transmission due to the sharing of blood-contaminated injection equipment.

Peers: are individuals who belong to the same KP group such as MSM, TGP, PWUD or SW and use their shared lived experiences to provide support, information and services in a way that is relatable, respectful and trusted by their community. Peers are cornerstones in MSF KP programmes, often being employed as lay workers as they are essential to reach other members of their group. The motto, "Nothing about us, without us", captures the essence of the significant role of peers

Peer education: involves learning from one's peers. It is the process whereby trained individuals from KP groups share information and promote safer practices and behaviour among a specific group or community.

Peer-led outreach: are the actions and strategies employed by KP peers to reach out and engage with their communities in order to enhance health and human rights for others of their group, sometimes supported by community groups, CBOs and NGOs or non-peer institutions or funders.

Pre-exposure prophylaxis (PrEP): is the use of ARV drugs by people who do not have HIV, to prevent the acquisition of HIV before exposure.

Post-exposure prophylaxis (PEP): is the use of ARV drugs by people who do not have HIV, to prevent the acquisition of HIV after exposure.

Sensitisation: is any activity that aims to increase knowledge and awareness of the needs of a target population, particularly in relation to stigma, discrimination, and violence faced by KP groups. The main goal is to assist individuals or institutions in avoiding such biases. The objective is to create an enabling environment and help individuals or institutions (e.g. MoH, the community and the police) understand KPs, including their identities, lives, needs and challenges. It addresses issues like sexual or drug-using behaviours, sexual orientation (for MSM), and gender identity (for TGP).

Sex workers (SWs): include female, male, trans, and gender-diverse adults who receive money or goods in exchange for sexual services, whether regularly or occasionally.

Sexual and reproductive health (SRH) rights: are fundamental human rights that ensure individuals have access to comprehensive health services, information, and education related to their sexual and reproductive health. The Guttmacher-Lancet Commission defines it as: "The right of all individuals to make informed decisions about their sexuality and reproduction, free from violence, coercion and discrimination". For KP groups, such as LGBTIQ+ individuals and sex workers, these rights are often compromised. But they are crucial in addressing unique health needs and overcoming barriers to care. It requires KP-friendly health services and sensitisation of other actors, such as the police and social workers. Moreover, it requires protective laws and policies that eliminate stigma and discrimination, promote equality, and safeguard against violence and coercion.

Task sharing: involves the redistribution of health tasks within workforces and communities. It is a key strategy to address health worker shortages and improve access to services. Typically, it implies that tasks traditionally provided by a few higher trained health workers, such as doctors, are shared with lower trained cadres. Professional bodies may sometime resist sharing due to concern around protection of roles and jobs or misguided fears of reduced quality services.

Trans and gender-diverse people (TGP): refers to individuals whose gender identities and expressions do not conform to the traditional expectations associated with the sex assigned at birth. This includes transsexuals, transgender individuals, and those who are gender nonconforming.

Transactional sex: is considered non-commercial sex and typically involves sexual favours in exchange for food, clothes or other goods. Sexual partners are often known as “blessers” or “sugar daddies” or lovers, rather than clients of sex workers. It encompasses a broader spectrum of sexual exchanges than commercial sex work and is far more common. (Among adolescent girls and young women in Africa, it is found to range between 1.2% to as high as 52%).

Triple elimination: is the effort to eliminate mother-to-child transmission of three infections: HIV, syphilis, and HBV. In Latin America, this strategy also includes Chagas disease in endemic areas.

Unprotected sex: refers to sexual activity without the use of evidence-based prevention methods against unintended pregnancy and/or STIs, including HIV. These methods include condoms with lubricants – essential for protection against HIV, viral hepatitis, and other STIs – as well as PrEP. Additionally, successful ART with sustained viral suppression prevents HIV transmission to sexual partners.

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This manual brings together MSF experiences, materials, and tools tailored for MSF Key Population interventions. It has been developed in collaboration with KP programme leads and experts and KP representatives themselves, to ensure that it reflects the needs, preferences and perspectives of the KPs it is meant to serve.

The objective is to inspire and guide fieldworkers in designing and providing appropriate healthcare to individuals who often find it difficult to engage in care.

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