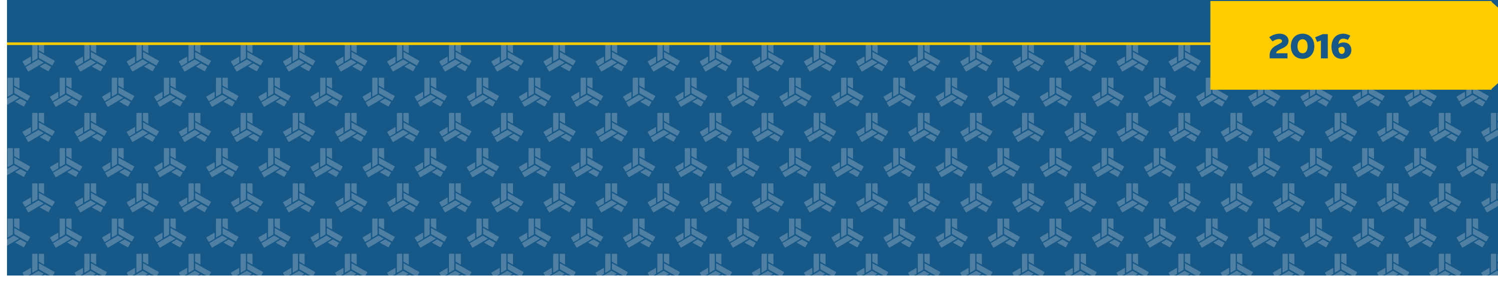
Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs

2016



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Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CSO	Civil society organization
DIC	Drop-in Center
FP	Family planning
GBV	Gender-based violence
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HTC	HIV testing and counseling
HTS	HIV testing services
IA	Implementing agency
KP	Key population
M&E	Monitoring and evaluation
MSW	Male sex worker
NASCOP	National AIDS and STI Control Programme
NGO	Nongovernmental organization
ORW	Outreach worker
PEP	Post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PID	Pelvic inflammatory disease
PID	Program ID
PLHIV	People living with HIV
PWID	People who inject drugs
SHARPER	Strengthening HIV and AIDS Response Partnership with Evidence-based Results
SOP	Standard operating procedure
STI	Sexually transmitted infection
TB	Tuberculosis
UIC	Unique identifier code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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1. Introduction

This publication provides guidance to governments, civil-society organizations (nongovernmental organizations [NGOs] and community-based organizations), and other partners implementing HIV prevention, care, and treatment programs with key populations.[1] The approach recognizes that site-level monitoring and individual tracking are needed to ensure that key population individuals access high-quality outreach and clinical services routinely, and that these services are run efficiently. This guide is designed to assist these programs as they establish monitoring systems that are used by frontline workers, including peer outreach workers, staff outreach supervisors, program managers, and others to understand performance. It includes comprehensive tools and forms that various levels of staff can use to collect and analyze data to manage and improve the program. These include population size estimation tools, mapping tools, facility monitoring tools, and client registers.

In addition to showing how to collect the necessary data, this guide provides guidance on how to establish a "data-use" culture so that frontline workers not only collect data but also analyze them to track monthly targets and trends and find ways to improve management and service quality. A data-use culture allows peer outreach workers from key populations to assume a stronger role in the program and decide how to improve their daily outreach efforts based on data they collect.

The tools presented in this guide are designed to ensure the conformity of data and systems when implemented at scale to generate individual, site-wide, and program-wide monitoring of program infrastructure, and service transaction data that can inform analysis of reach, testing, treatment, and viral load status of key populations. Program managers can use simple data-monitoring dashboards and tools for visualizing data that will help them set targets for scale-up, identify program gaps, and make immediate course corrections to improve efficiency.

Many countries already have systems to collect data at a macro level, and there is global guidance on monitoring key populations. However, the guidance in this publication also addresses micro-level data collection and additional topics and can be used by frontline workers. Some of the challenges addressed by this guide are common in key population programs today:

- Many sites operate without routine data other than clinic registers or an Excel spreadsheet that tracks outreach and is kept at the NGO office. In programs where data are only collected and aggregated semi-annually or quarterly — or not collected at all — program managers must rely on unreliable methods to determine the performance of their outreach and referral systems. If collected, clinical data are often not analyzed but just reported up.

- Programs only initiate data collection at clinical sites when key population members self-identify. This process cannot track individuals from the point of contact during outreach to when they access services at a clinic. Clinic-based tracking depends on clients (who are from discriminated-against or criminalized populations) self-identifying as members of key populations, so clinical data on the number of key population members tend to undercount because individuals do not self-identify. Conversely, records may over-count when it is assumed that all clients in a facility close to a hotspot are key population members.

1. "Key populations" in this guide refers to female sex workers, high-risk men who have sex with men, transgender people, and people who inject drugs. "Key population" is sometimes abbreviated as KP.

- The UNAIDS "90-90-90" goal[2] requires that programs track the access of key population individuals to prevention, care, and treatment across the population denominator. It is impossible to measure reach, testing, treatment, and viral suppression without individual tracking that follows a person and the different services they use. This can be achieved through unique identifier codes (UICs) that are secure and used nationally; monitoring that supports the empowerment of peers in the program; and tracking that covers both outreach and clinical services.

- Programs hire staff and operate sites without routine data on efficiency. Without collecting and reviewing routine outreach and service delivery data alongside staffing, commodity, and denominator data, programs find it difficult to know whether staff and resources are allocated optimally across sites. Bottlenecks in service delivery are often uncovered only by chance, rather than systematically and immediately.

- National programs need to maximize their resources in a funding-constrained environment but do not have data to inform their decisions. Site-level efforts to deliver services must be tracked to feed into national program strategies. Evidence from the grassroots is needed to inform program scale-up.

1.1 THE PURPOSE OF THIS GUIDE

Donors and governments have aligned around the goal of 90-90-90. However, key populations often share a disproportionate burden of HIV but have much lower access to HIV services and rights. There is widespread recognition that the HIV response must address this disparity. Tracking systems must safely collect and monitor data from public, private, and non-profit programs to effectively track sites and key population individuals, regardless of the funding structure or service delivery model. Only with this tracking can sites understand the extent to which they are serving key populations, so that the key population response can be scaled up, site by site. Monitoring systems must tell managers in real time the specific individuals in the site they need to reach with which services, and at a higher level give partners a picture of which sites are performing well, which are not, and which factors are contributing to poor or good performance. National programs need this type of data to plan, and civil society needs this data to advocate for key populations.

This guide responds to these demands with practical, ready-to-use advice and tools to collect and analyze data for monitoring peer outreach, clinical services, and support programs for key populations. It contains examples of tools and forms from around the world that may support efforts in monitoring programs and services, and describes issues that should be considered when using these tools. This guidance can improve existing programs, be applied in new ones, and can contribute to a single monitoring system for multiple programs in a national response.

The tools are designed to be administered by different kinds of staff, including clinical staff, outreach managers, M&E managers, and peer outreach workers. They allow teams to build a program over time, from a basic starting point to a mature and scaled effort. The tools can be used as they are, and incorporated into monitoring today. In the long run they should be linked to important shifts in key population programs: an effort to improve peer outreach, the empowerment of key populations, data use at the site and district level, and an effort to build national systems. These tools can also evolve as the building blocks of a systematic, software-based solution that allows programs to do away with paper and optimize their efficiency using IT solutions for tracking, data analysis, and reporting.

2. By 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression.

1.2 HOW THIS GUIDE HELPS TO MONITOR INTERVENTIONS

This guide is designed for use by national governments as well as other funders or implementers of key population interventions, including the Global Fund, USAID/PEPFAR, World Bank and other donors interested in implementing a scaled program with key populations. It guide supports several basic strategies for effective prevention, treatment, and care interventions for key populations:

1. **UNDERSTANDING THE EPIDEMIC:** knowing where and how many key population members to reach
2. **PROGRAM DESIGN:** establishing program infrastructure, capacity, and personnel
3. **PEER-DRIVEN PREVENTION, CARE, AND TREATMENT CASCADE:** conducting intensive peer-based outreach and regular contact including effective registration, tracking, and referral processes
4. **EFFICIENT AND HIGH-QUALITY SERVICES:** providing high-quality sexually transmitted infection (STI) and HIV testing and treatment, and other health services
5. **COMMUNITY MOBILIZATION AND PARTICIPATION, AND CREATING AN ENABLING ENVIRONMENT:** providing and supporting community- and facility-based services that will empower community members to make healthier decisions about condom use and health-seeking behaviors.

These strategies underpin the program indicators that support the cascade of HIV testing, antiretroviral therapy, and viral suppression for achieving the UNAIDS goal of 90-90-90 by 2020.

Key features of this guide include:

- Carefully tailored monitoring tools to collect data at the grassroots level so that the data can be used for immediate program course correction at the site level and to track trends, gaps, and bottlenecks across a program at the sub-national level, and can be aggregated and used for higher analysis at the national level.
- Simple analytic tools that show site statistics on various services provided to key population members, with a focus on behavioral, biomedical, and structural interventions.
- Dashboards and techniques built into tools that will help program teams to routinely see progress against targets in terms of coverage, scale-up, different components of the cascade, and the quality of clinical and outreach services.
- A program-wide, team approach to data use for decision-making, data collection, data analysis, and action-oriented program planning processes. The team approach means that data use is designed and implemented with the full engagement of key population communities and staff who manage outreach, clinical services, and commodities.

The program elements and guidance in this publication are compatible with the 2014 *Consolidated Guidelines for HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (WHO) and the companion target-setting and monitoring guidelines, as well as the *Operational Guidelines for Monitoring and Evaluation of HIV Programs for Sex Workers, Men Who Have Sex with Men, and Transgender People* (2012). This guide differs from these publications in that it focuses on data collection, use, and program management at the site level as the foundation of a monitoring system. It assumes that program scale is driven by staff and peer outreach workers at the site and spot level, and that real-time data use in the management of programs will help the program reach targets at scale while delivering quality services.

The program monitoring system introduced in this guide has sufficient flexibility to conform to national guidelines, and for the tools and indicators to respond to epidemiological, technological, or social changes. Data from the system are reported up to the macro level, and can be used to verify the accuracy of clinical data collection at the micro levels, and to verify self-reported clinical service utilization data from integrated biological and behavioral surveys.

1.3 KEY POPULATIONS

Key populations are population groups disproportionately affected by HIV, often because of punitive laws, regulations, and policies, and because they are stigmatized and marginalized. This includes men who have sex with men (MSM), transgender persons (TGs), sex workers (SWs), and people who inject drugs (PWID).[3] The following groups are the key populations that are considered for this document:

SEX WORKERS: includes female, male, and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less "formal," or organized. As defined in the United Nations Convention on the Rights of the Child, children and adolescents under the age of 18 who exchange sex for money, goods, or favors are "sexually exploited" and not defined as sex workers.

MEN WHO HAVE SEX WITH MEN: refers to all men who engage in sexual and/or romantic relations with other men. The words "men" and "sex" are interpreted differently in diverse cultures and societies and by the individuals involved. Therefore, the term encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group.

PEOPLE WHO INJECT DRUGS: refers to men or women who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives, and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous, or other injectable routes. People who self-inject medicines for medical purposes — referred to as "therapeutic injection" — are not included in this definition. The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. While these guidelines focus on people who inject drugs because of their specific risk of HIV transmission due to the sharing of blood-contaminated injection equipment, much of this guidance is relevant also for people who inject other substances.

TRANSGENDER PEOPLE: an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender, or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, transsexual or, in specific cultures, as hijra (India), kathoey (Thailand), waria (Indonesia), or one of many other transgender identities. They may express their genders in a variety of masculine, feminine, and/or androgynous ways. The high vulnerability and specific health needs of transgender people necessitate a distinct and independent status in the global HIV response.

1.4 FURTHER RESOURCES

Additional publications that may be valuable when scaling up HIV prevention, treatment, and care for key populations include:

- *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. 2014, WHO. http://www.who.int/hiv/pub/guidelines/keypopulations/en/
- *HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. 2014, WHO. http://apps.who.int/iris/bitstream/10665/128049/1/WHO_HIV_2014.8_eng.pdf

3. WHO has added a fifth group (people in prisons and other closed settings); however, the inclusion of this group has not yet been formally adopted by PEPFAR and does not apply to KP-related targets or MER indicators (i.e., KP_Prev). The source of the key population definitions on this page is the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014).

- *Tool to Set and Monitor Targets: Supplement to the 2014 Consolidated Guidelines for HIV Prevention, Diagnosis, Treatment and Care for Key Populations*. 2015, WHO. http://www.who.int/hiv/pub/toolkits/kpp-monitoring-tools/en/

- *90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic*. 2014, UNAIDS. http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

- *Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low and Middle Income Countries: Recommendations for a Public Health Approach.* 2012,WHO. http://www.who.int/hiv/pub/guidelines/sex_worker/en/

- *Prevention and Treatment of HIV and Other Sexually Transmitted Infections among Men Who Have Sex with Men and Transgender People: Recommendations for a Public Health Approach*. 2011, WHO. http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/

- *Implementing Comprehensive HIV/STI Programs with Sex Workers: Practical Approaches from Collaborative Interventions* [the "SWIT"]. 2013, WHO. http://www.unfpa.org/publications/implementing-comprehensive-hivsti-programmes-sex-workers-practical-approaches

- *Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men: Practical Guidance for Collaborative Interventions* [the "MSMIT"]. 2016, UNFPA. http://www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-men-who-have-sex-men

- *Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions* [the "TRANSIT"]. 2015, UNDP. http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html

- *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. 2012,WHO. http://apps.who.int/iris/bitstream/10665/44068/1/9789241597760_eng.pdf

- *Peer Led Outreach at Scale: A Guide to Implementation: Avahan - India AIDS Initiative*. 2009, Bill & Melinda Gates Foundation. https://docs.gatesfoundation.org/Documents/Avahan_PeerLedOutreach.pdf

- *Micro-planning in Peer Led Outreach Programs: A Handbook Based on the Experience of the Avahan India AIDS Initiative*. 2013, Bill & Melinda Gates Foundation. http://docs.gatesfoundation.org/nosearch/Documents/Microplanning%20Handbook%20(Web).pdf

- *Operational Guidelines for Monitoring and Evaluation of HIV Programs for Sex Workers, Men Who Have Sex with Men, and Transgender People: VOLUME I National and Sub-National Levels*. 2013, UNAIDS/PEPFAR/Global Fund. http://www.cpc.unc.edu/measure/resources/publications/ms-11-49a

- *Operational Guidelines for Monitoring and Evaluation of HIV Programs for Sex Workers, Men who have Sex with Men, and Transgender People: VOLUME II for Service Delivery Providers*. 2013, UNAIDS/PEPFAR/Global Fund. http://www.cpc.unc.edu/measure/resources/publications/ms-11-49b

- *Use It or Lose It: How Avahan Used Its Data to Shape Its HIV Prevention Program in India*. 2008, Bill & Melinda Gates Foundation. https://docs.gatesfoundation.org/Documents/Avahan_UseItOrLooseIt.pdf

- ACQUA: Aastha Continuous Quality Assessment: FHI 360/Aastha, India http://www.fhi360.org/sites/default/files/webpages/India_Aastha_Cont_Quality/foreword.html

2. A Strategic Approach to Monitoring Key Population Programs

2.1 THE LOGIC MODEL

The models displayed below show how macro-level and micro-level monitoring is approached in this guide. Figure 1 is an overview of the program impact pathway for a combination HIV prevention strategy.[4] Indicators are included for each part of the pathway. All program impact pathways reveal the logical sequence from program inputs to outputs to outcomes to impact on HIV incidence. Reduction in HIV transmission is always the ultimate objective.

Figure 2 depicts how front-line workers use site-level monitoring to address factors critical to the success of a program with a focus on site-level performance. The program uses real-time data through the program monitoring system to engage in a cycle of continuous quality assurance to assess the effect of program strategies and address gaps in service delivery to key populations.

4. Source: *Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men Who Have Sex with Men, and Transgender People: Volume I*, UNAIDS/Global Fund/PEPFAR.

FIGURE 1: General Program Impact Pathway for Key Populations

Required Inputs

- Funds
- Commodoties
- Equipment
- Personnel
- Facilities

To provide a well-defined package of services and critical enabler interventions

Services

- Targeted condom/lubricant promotion and distribution
- Targeted education & risk reduction counseling
- STI screening, diagnosis and treatment
- Voluntary testing & counseling
- HIV treatment
- Harm reduction for people who inject drugs
- HBV/TB/other health services

Critical Enabler Interventions

- Community engagement
- Safe spaces/drop-in centres
- Community networks
- Advocacy
- Legal and policy interventions
- Stigma/violence reduction
- Redressal and judicial services
- Program quality improvement

At Sufficient Scale To Achieve Output and Coverage Targets*

Service availability in each sub-national area:

- Map of services in each area

Outputs - Services

- HIV testing and treatment cascade
- Number of individuals reached by each service
- Number of individuals reached by the package of services
- Number of trained service providers implementing services
- Number of persons tested for HIV

Outputs - Critical Enablers

- Number of improved laws/policies
- Number of judicial redness cases resolved
- Number of stigma reduction interventions

Coverage

- % of population reached by each service
- % of population reached by all services

Outcome Indicators* of Direct Biologic Determinants Decrease

- % of population engaging in unprotected sex
- Number of new STI cases
- STI incidence
- % of HIV positive persons not on treatment
- Number of non-sterile injections

Outcome Indicators* of Critical Enabler Interventions to Improve Environment

- % of population participating in community engagement
- % retporting violence
- % reporting stigma

Leading to Program Impact:

Reduction of HIV Transmission

* Indicators shown here are illustrative. Countries should identify the most meaningful set of indicators to monitor based on programme priorities.

FIGURE 2: Importance of Monitoring at Various Levels

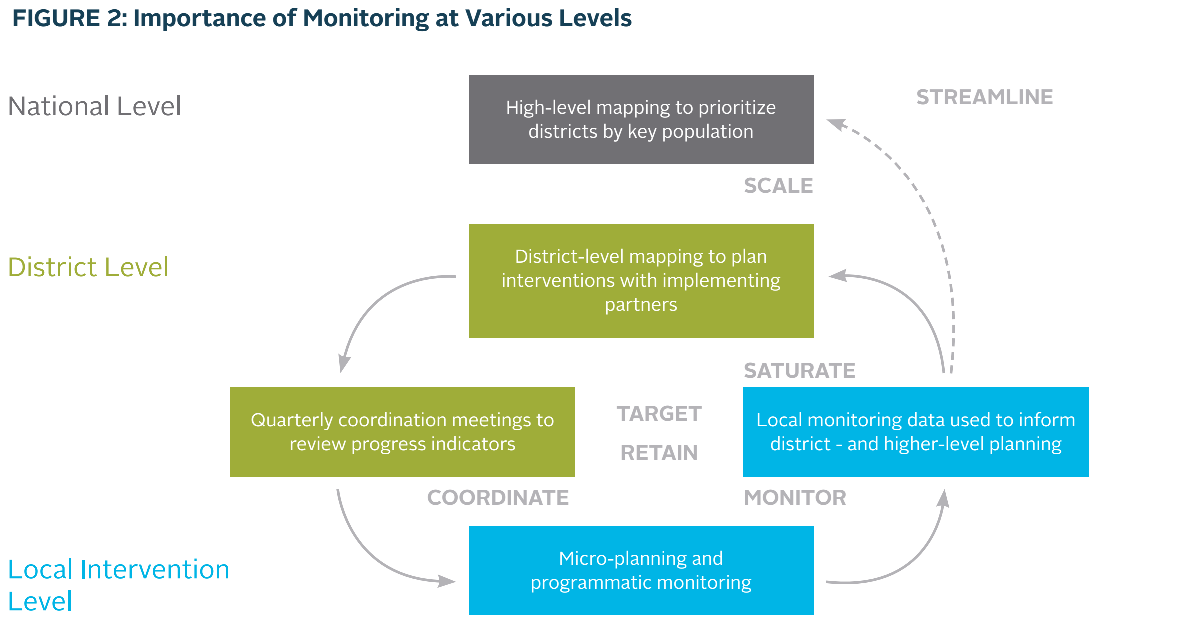
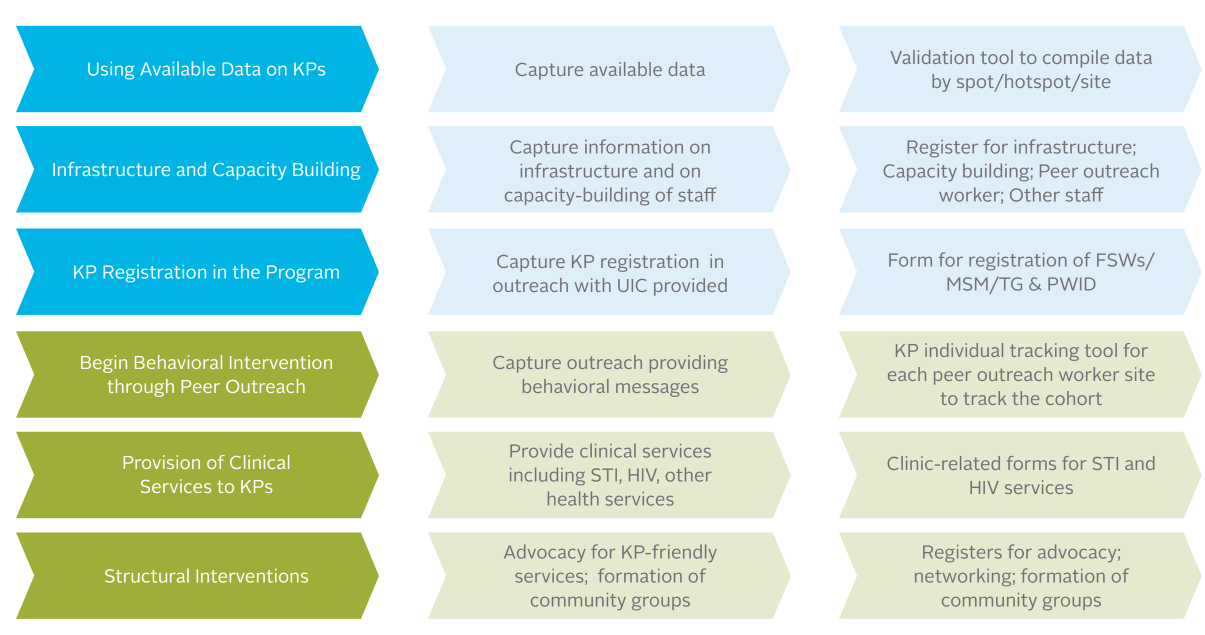


Figure 3 shows the various components of a program and the tools needed to collect data that will inform the program. These tools are explained in detail in the following chapters.

FIGURE 3: Logical Flow of Data Collection within an Intervention for Monitoring



2.2 DEFINING GOALS AND OBJECTIVES

At the beginning, a key population program defines its ultimate objective of the HIV response for key populations along with the package of services and quality standards necessary for impact. These may be defined in national guidelines and informed by monitoring system data on targets, optimal use of resources, and feedback from key population communities. Before implementing the monitoring system, some of the quality standards that need to be set include the number and location of clinics, outreach spots, drop-in centers, human resources, and commodities. In addition, targets should be set for service delivery: reach, commodity distribution, routine clinical visits (STI testing and treatment, HIV testing, HIV referrals and treatment and care), and community support for key population individuals living with HIV. Well-defined objectives and targets set a benchmark for interpreting data and help the program maintain focus as activities change over time. Beyond objectives and targets, national programs or scaled efforts must develop and train workers on standard operating procedures (SOPs), while at the same time continually updating the SOPs to reflect best practices and knowledge gained from analyzing program data.

Setting goals for the program

Clearly defined goals and objectives are important, whether for a National AIDS Control Program, an NGO, a community organization, or a community activist. Goals help align all stakeholders around a program's intent. What does the program want to accomplish? Examples of program goals used by groups working with key populations include:

- *Decreasing HIV incidence among key populations*
- *Decreasing mortality/morbidity among key populations*
- *Increasing capacity of key population individuals to make independent choices and exert control to act for her/himself or as a group*

Setting objectives for the program

While goals are broad, objectives are more specific. When setting objectives it is important to understand how the program will accomplish them. At the same time, management at the sites should be involved in developing site-level objectives that they will be responsible for achieving. These site objectives should be based on programmatic mapping data and national guidance in particular to inform the program about who the population is, what their needs are, and where the program needs to work. Objectives will be tracked through dashboards that the program uses to automatically analyze data and show achievements against denominators at the frequency required.

A good way of setting objectives is to make them *SMART.*

- ***Specific*** – Does the objective say exactly what needs to be achieved?
- ***Measureable*** – Can the progress of achieving the objective be measured by the program?
- ***Assignable*** – Who in the end will be responsible for making sure the objective is achieved?
- ***Realistic*** – Can the objective be completed with the resources available?
- ***Timely*** – When can the objective be expected to be accomplished?

SMART objectives will keep the program focused. The following is an example of a SMART objective:

Objective: The program wants to develop an initial outreach-based platform to improve key population access to testing, treatment, and care.

Using mapping data, program leaders begin by asking questions that will inform SMART objectives. These initial questions are a start, but not the fully developed SMART objectives.

- **SPECIFIC** – Who is the population? Where are they? If they are sex workers, for example, how many clients do they have daily? Where do they get condoms and lubricant? How often do they go to a clinic? What proportion have an STI? Are they living with HIV? Do they know their status? Are they being treating for STIs or HIV?

- **MEASUREABLE** – Does the program want peer outreach workers to reach (with one-to-one contact) only one person a day? 10 people? 20% of a set denominator in a week? How do the targets differ by individual risk profile or typology? By HIV status? How do other targets map out into site-specific objectives?

- **ASSIGNABLE** – Without knowing more information on what the program is trying to achieve (e.g., the number and frequency of peer contacts or objectives for prevention or targets for identification of HIV-positive individuals), it will be difficult for the person in charge to see if the objective is achieved.

- **REALISTIC** – Program objectives may need to change over time to determine what can be achieved when a program is new and peer outreach workers are not as skilled, or the objectives may need to be adapted to particular settings. For example, in contexts where sex between males is criminalized, the ratio of peer outreach workers to men who have sex with men may need to be adjusted so that they can find individuals and new spots that are frequently shifting.

- **TIMELY** – To drive scale-up, the timing for the objectives should be aggressive, with short time-frames (three months), to keep management focused on the near term. The timing for objectives can be mapped out with near-, mid-, and long-term objectives and adjusted semi-annually.

Sample objectives:

- *Objective 1:* To ensure that prevention coverage (or reach) of the key population denominator is increased to 100% and that coverage includes peer support and condom and lubricant distribution, and distribution and use of new needles among PWID within the next year.
  - Near-term objective: Undertake site peer management planning to ensure the ratio of peer outreach workers to key population is efficient (1:50 is the general recommendation).
  - Train peer outreach workers and staff outreach supervisors on targets and tools for data collection and analysis.

- *Objective 2:* To provide information to 80% of the enumerated key population to increase their awareness of STI and HIV status, including early testing for STIs and HIV and seeking and adhering to HIV treatment within next one year.

- *Objective 3:* To bring the key population members together with an increased ability to organize and form groups and networks for better negotiation ability to decrease violence, stigma, and discrimination.

Are these objectives SMART?

- **SPECIFIC** – The target population and the information being provided are defined.

- **MEASUREABLE** – Want to reach out to 80% of enumerated population in the site with STI/HIV awareness information and 100% coverage with peer outreach support and commodities.

- **ASSIGNABLE** – A person, the program coordinator, is responsible for making sure the objective is achieved.

- **REALISTIC** – It appears to be realistic given the number of people being reached and the time-frame.

- **TIMELY** – There is a time-frame specified when the objective needs to be accomplished (one year).

2.3 PHASES OF THE INTERVENTION

A newly established HIV prevention, treatment, and care program for key populations usually goes through the following stages as it begins and matures:

1. Preparatory phase
2. Implementation and scale-up
3. Intensive service delivery and refinement of services
4. Consolidation and transfer to community ownership

Table 1 summarizes some of the main activities undertaken during each phase.

TABLE 1: Stages of Prevention, Care, and Treatment Program Implementation

PHASE I: PREPARATORY

Validation of mapping data

- List of spots/hotspots for implementing the program, including number of key population individuals at each spot
- Basic training of NGO/CBO staff, including staff outreach supervisors and peer outreach workers

Recruitment of staff according to the coverage need

Setting up systems, infrastructure, and referral systems

PHASE II: IMPLEMENTATION AND SCALE-UP

Conduct outreach through peer outreach workers

- Identifying key population individuals in the hotspot
- Registering key population individuals for services
- Prioritizing needed structural interventions for key population (e.g., advocacy, self-help groups, legal literacy, etc.)

Provide services

- Distribute condoms and lubricant, needles and syringes
- Clinical services for key population, such as HIV testing, STI testing and treatment (referral or through program-run clinics)
- Anti-retroviral (ARV) services
- Other related health services (tuberculosis [TB], hepatitis B, hepatitis C)

PHASE III: INTENSIVE SERVICE DELIVERY AND REFINEMENT OF SERVICES

Provide all the services at program scale

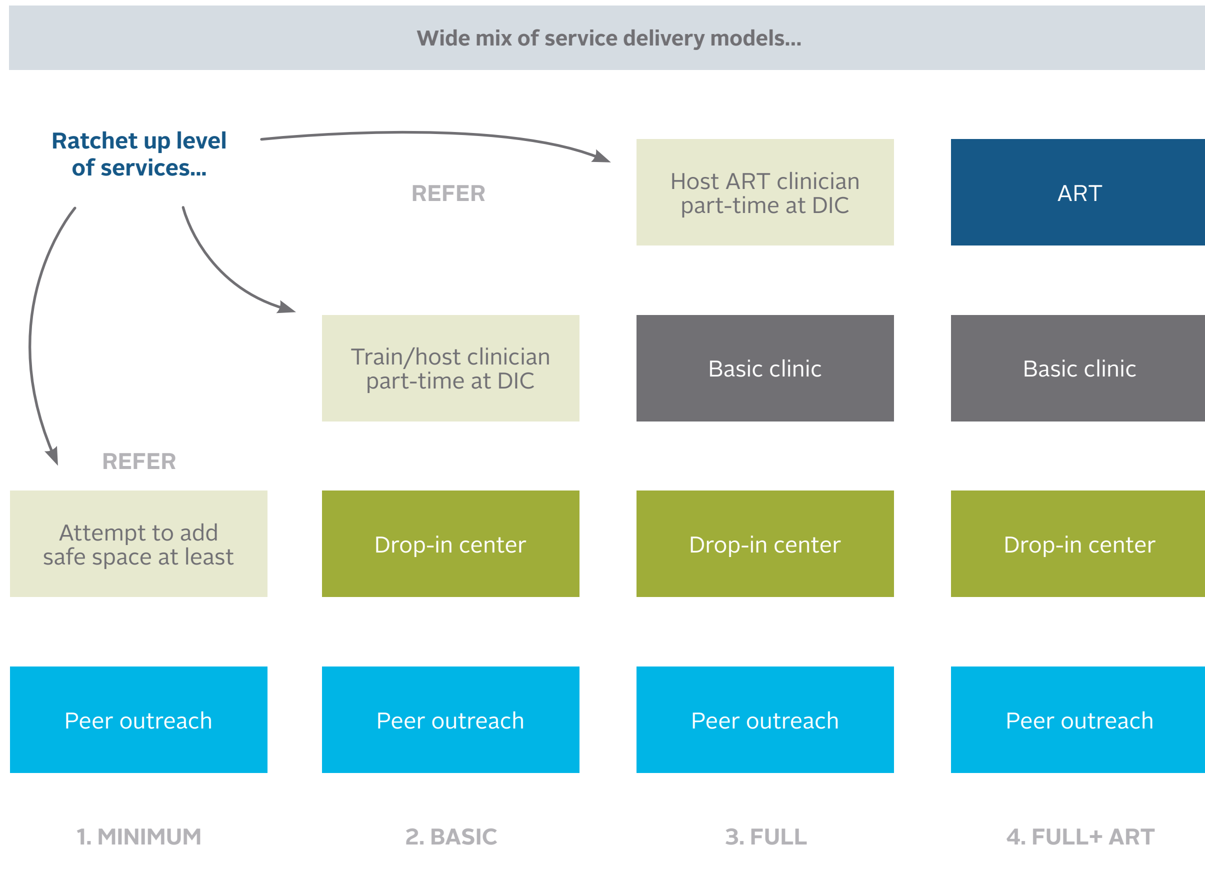
- Key populations receive condoms and lubricant, needles and syringes
- Behavior change communication
- Health services, including STI, HIV testing services, antiretroviral therapy (ART), pre-exposure prophylaxis
- Treatment of other opportunistic infections
- Revalidation of mapping and key population estimates

PHASE IV: CONSOLIDATION AND TRANSFER TO COMMUNITY OWNERSHIP

Sustain efforts from earlier phases, including the following activities:

- Formation of groups of key population members (e.g., community organizations and self-help groups)
- Key population members lead their own initiatives
- Key population members empowered to take up and operate the program on their own

FIGURE 4: Service Delivery Models by Increasing Intensity



2.4 KEY OUTPUT MONITORING INDICATORS

Table 2 lists key output monitoring indicators that are recommended for an HIV prevention, treatment, and care program, and the phase of the program when data collection begins for this indicator (see Table 1). This list can be amended to meet your program's needs; however, it is important that all NGOs/CBOs participating in your program collect data for a minimum agreed-upon set of indicators. Across NGOs/CBOs when monitoring is introduced, oversight and comparisons across sites are needed to ensure indicators and definitions are consistent.

Data collection and analysis may be carried out at the spot level, the NGO/CBO level, and/or the program/national level. Different staff can collect data at the different levels. The frequency of data collection also varies: indicators may be collected on a one-time basis at the beginning of the project, weekly, monthly, semi-annually, or yearly, depending upon the needs of the program. In other words, don't be overwhelmed by the number of indicators listed here — data for many of the indicators are collected only once or only a few times during the course of a year.

TABLE 2: List of Indicators for Program Monitoring by Program Areas

Color key: Phase (Table 1) during which data collection begins for this indicator.

1. Understanding the epidemic: knowing where to reach key populations

1	Mapping of spots
1.1	Number of mapped spots in a geographic area where key population individuals can be reached
1.2	Number of mapped spots which are in priority geographic areas where key population individuals can be reached
2	**Estimation of key population size (Population types are disaggregated)**
2.1	Estimated key population individuals in the priority geographic areas
2.2	Number of key population individuals planned to be covered as per the contract for one year

2. Establishing program infrastructure, capacity, and personnel

3	Recruitment and training of intervention team
3.1	Number of staff outreach supervisors and peer outreach workers needed (ratio of key population individuals to be covered per peer outreach worker = number of peer outreach workers needed)
3.2	Number of active peer outreach workers
3.3	Number of clinical staff (doctor, nurse, counselor, etc.)
3.4	Number of management staff (program manager, accountant, etc.)
3.5	Number of M&E and other staff
3.6	Number of staff outreach supervisors/peer outreach workers who discontinued working in the last month
3.7	Number of peer outreach workers/staff outreach supervisors/clinical staff/project management staff, etc. who received initial training
4	**Establishment of offices and services (direct or through linkages)**
4.1	Number of project-supported health facilities providing STI services, HIV testing, HIV care, family planning services, CD4 count, viral load, TB screening
4.2	Number of project-supported drop-in centers
4.3	Number of prevention and care services where formal linkages are established with other services like TB, hepatitis B and C, family planning services, reproductive health, etc.

3. Conducting intensive peer-based outreach and regular contact including effective registration, tracking, and referrals

5	Regular intensive contact with key population individuals
5.1	Number of key population individuals registered through outreach during the month
5.2	Number of key population individuals contacted at least once in the month
5.3	Number of new key population individuals contacted for the first time in the project during the reporting period
6	**Distribution of condoms, lubricant, and needles as per need**
6.1	Number of key population individuals provided with male/female condoms/lubricant/needles directly from the program during the reporting period (will have segregated data at peer outreach level)
6.2	Number of male/female condoms/lubricant/needles distributed to key population individuals by the outreach staff during the reporting period
6.3	Number of male/female condoms/lubricant distributed through condom outlets during the reporting period
6.4	Number of used needles/syringes returned by PWID to the program during the reporting period

4. Providing good quality STI, HIV, and other health services

7	Referral/provision of HIV testing services
7.1	Number of key population individuals who received risk reduction counseling at least once during the reporting period
7.2	Number of key population individuals tested for HIV and who received their results during the reporting period
7.3	Number of key population individuals testing positive for HIV during the reporting month among those tested and received results
8	**Referral/provision of HIV care and treatment services**
8.1	Number of HIV-positive key population individuals enrolled in clinical care during the reporting month
8.2	Number of HIV-positive key population individuals who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load
8.3	Number of key population individuals newly initiated on ART in the month
8.4	Number of key population individuals currently receiving ART in the month
8.5	Number of key population individuals tested for viral load during the month
8.6	Number of individual key population individuals provided with post-exposure prophylaxis (PEP)
9	**Referral/provision of STI services**
9.1	Number of key population individuals registered in the program-run clinic during the reporting period
9.2	Number of key population individuals who visited the program-run clinic during the reporting period
9.3	Number of key population individuals screened for STI during the reporting period
9.4	Number of key population individuals diagnosed with STI during the reporting period
9.5	Number of key population individuals treated for STI during the reporting period
10	**Referral/provision of other related services (TB, hepatitis, reproductive health, overdose, wounds, etc.)**
10.1	Number of key population individuals screened for TB
10.2	Number of key population individuals referred to TB testing centers
10.3	Number of female key population individuals in their reproductive age (15-49) provided with family planning services
10.4	Number of PWID treated for abscesses during the reporting month (who has injection wounds)
10.4	Number of key population individuals screened for Hepatitis B or C
10.5	Number of key population individuals treated for Hepatitis B or C

5. Community mobilization, participation, and creating an enabling environment

11	Provision of violence response services
11.1	Number of incidents of violence reported against key population individuals during the month
11.2	Number of incidents of violence addressed during the month
11.3	Number of key population individuals receiving post-violence care
12	**Sensitization/advocacy with power structures**
12.1	Number of advocacy workshops/meetings conducted with key stakeholders during the reporting period
12.2	Number of participants at the advocacy workshops/meetings conducted with key stakeholders during the reporting period
13	**Linkages to social entitlements**
13.1	Number of key population individuals with valid IDs, bank accounts, etc.
14	**Mobilize key population individuals to form groups**
14.1	Number of group meetings/events conducted with key population individuals during the reporting period
14.2	Number of key population individuals who participated in the group meetings during the reporting period

2.5 ENSURING KEY POPULATION CONFIDENTIALITY, AND OTHER ETHICAL CONSIDERATIONS

Designing and managing a program with key populations requires information on the location of sex work, transgender and MSM cruising sites, as well as locations where drug users inject. The location, size of the community, and individual personal identifiers must never be disclosed by the program or site. Individuals, groups, or organizations might cause harm to the population if their location, population size, or identities were exposed. To track an individual's service access, it is best practice to assign a unique identifier code (UIC) to each key population individual instead of using their name in written records. The UIC may be used across the national program to assess coverage and avoid double counting, particularly where there are multiple implementing organizations. (See the box on p.23 on how to assign unique identifier codes to protect the identity of each individual.) Data that identify locations or individuals must be handled with strict confidentiality and protected from access by anyone who lacks authorization. This type of data, whether on computers or written in log books, should be carefully stored in a locked and/or password protected location.

Non-discrimination and confidentiality are the cornerstone of high-quality prevention, care, and treatment services for anyone; they form part of all medical-provider training as characterized in the Hippocratic oath. All treatments, procedures, testing, and counseling must be performed to the highest professional and ethical standards. In all aspects, the basic human rights of each client must be respected and given the utmost importance. To support non-discrimination in service delivery:

- All staff members should receive training and sensitization relevant to working with key populations.
- The program should have a clear anti-discrimination policy and code of conduct.
- The program should seek regular anonymous feedback from clients.

Interventions should have a clear confidentiality policy that is publicized and vigorously emphasized through staff orientation and regular trainings. Aspects of the policy include:

- In all circumstances, the information contained in the client records must be kept confidential (i.e., it must not be communicated to third parties).
- Client information will only be disclosed with consent of the individual client. Without consent, no staff or other persons, even those who are directly involved in the service provision and counseling of the individual, can access client data.
- All client records will be kept in a secure place and only project staff with direct client responsibilities will have access to the records.
- A confidential accountability system will be in place for clients to report discrimination or poor treatment.
- The program should have an emergency response team ready in case the identity of an individual or a group of key population members is obtained by outsiders that will lead to harm for them or for other key population members.

All program clinic staff members are required to read and sign an oath of confidentiality. Signed oaths are to be kept in staff members' personnel files. An example of an oath of confidentiality is presented below.

In addition to this, a code of conduct for peer outreach workers and staff outreach supervisors can be used. In cases where peers are not literate, this code of conduct can be read and verbally agreed to.

SAMPLE CODE OF CONDUCT FOR PEER OUTREACH WORKERS

- I maintain the confidentiality of the individuals I serve.
- I work for the agreed number of hours per day for the program.
- I do not entertain customers/have sex with partners while working for the program.
- I am not intoxicated or under the influence of drugs while working for the program, and I do not carry any alcohol or drugs with me while working for the program.
- I do not get involved in fights because of drunkenness or drugs at any time, whether working for the program or not.
- I respect the opinions of others and abide by program decisions.
- I try hard to understand others and be friendly with them.
- I am open to learning new things and sharing what I have learned with others.

OATH OF CONFIDENTIALITY

I understand that, in the course of my duties in this service, I will come in contact with sensitive, personal information about individuals who would agree to be part of the intervention. I understand that this information is highly confidential, and I pledge to protect the confidentiality of all individuals attending the service. I will protect the confidentiality of patients by not discussing or disclosing any information about them to an unauthorized person, including the fact that they attended these services. Unauthorized persons may include, but are not limited to, my family, friends, co-workers and community leaders. I understand the potential social harm that may come to patients whose personal and medical information is disclosed to unauthorized persons.

I understand that willful disclosure of any information about any key population member in this program could result in termination of my employment or result in legal action against me.

Signature of staff member: Witness:

Date:

DEVELOPING UNIQUE IDENTIFIER CODES TO ENSURE CONFIDENTIALITY

Confidentiality is an important concern when recording data about key populations. Assigning a Unique Identifier Code (UIC) to each individual, instead of using their name, is a good method for ensuring confidentiality in records. When a key population individual is initially registered, s/he is assigned a UIC as part of this anonymous and reliable system for tracking key populations through prevention, treatment, and care services. UIC systems help the program monitor their work and the services delivered to key populations by:

- Creating a confidential service recognition system that uniquely identifies each individual without disclosing personal information about the individual
- Avoiding duplication in the counting of key populations attending services
- Identifying new individuals engaging with prevention and/or treatment services
- Enabling analysis of treatment cascades through continuum of care indicator data
- Assessing the mobility of key populations through outreach services and health facilities
- Assisting in reorienting services to meet the changing needs and attendance patterns of key populations

HIV prevention programs have been using UICs to identify individuals on their forms and tracking systems, and several examples from India (Avahan) and Ghana (SHARPER) are included below:

India – Avahan/Karnataka Health Promotion Trust – 11 digit UIC code

- First 2 digits – District
- Next 2 digits – Taluka (sub-district)
- Next 3 digits – City/Town/Village
- Next 4 digits – Serial number of sex worker assigned in order within locale

India – Avahan/FHI 360 – 9 digit UIC code (if the intervention is working in a single district)

- First 2 digits – NGO code
- Next 2 digits – Staff outreach supervisor code
- Next 2 digits – Peer outreach worker code
- Next 3 digits – Key population individual code (within peer outreach worker's area/spot)

Ghana – SHARPER – 7 digit UIC code

- First digit – Male or female write 1 or 2
- Second and third digits – Last two digits of year birth
- Fourth and fifth digits – First letter of first name and last name
- Sixth and seventh digits – Last two digits of telephone number

Clients are not required to remember the UIC assigned to them since the code can be recreated based on the different items that make up the code. For example, if an individual in Ghana knows the last two digits of their year of birth, first letter of their first and last name, and the last two digits of their telephone number, then their UIC can be recreated based on those things. Digital IDs created through mobile phone applications may be a more efficient way of assigning and verifying the uniqueness of IDs across national systems.

Note that some programs may assign a Program ID (PID) instead of a UIC. For instructions on how to generate this code, see Annexure 3, instructions for Tool 6A.

VERIFYING THE VALIDITY OF THE UIC AND INDIVIDUAL ATTACHED TO IT

It is important to occasionally randomly verify the individual attached to a UIC and check that the person is still at the site and is receiving services. For example, the program manager and senior staff, as part of quality assessment, can visit the site and meet key population individuals and seek their opinions of the services they are receiving. This validates the UIC assigned to the person and the services provided to the person. This can be done for 10% of the people that are currently receiving services, which would be around 5-6 individuals per spot. If you can verify 4-5 of these KPs in the field (80%-90% of the randomly selected KPs), it could be considered as valid data in a peer outreach worker's spot.

CASE STUDY OF UIC FROM UKRAINE UNDER GLOBAL FUND PROJECT

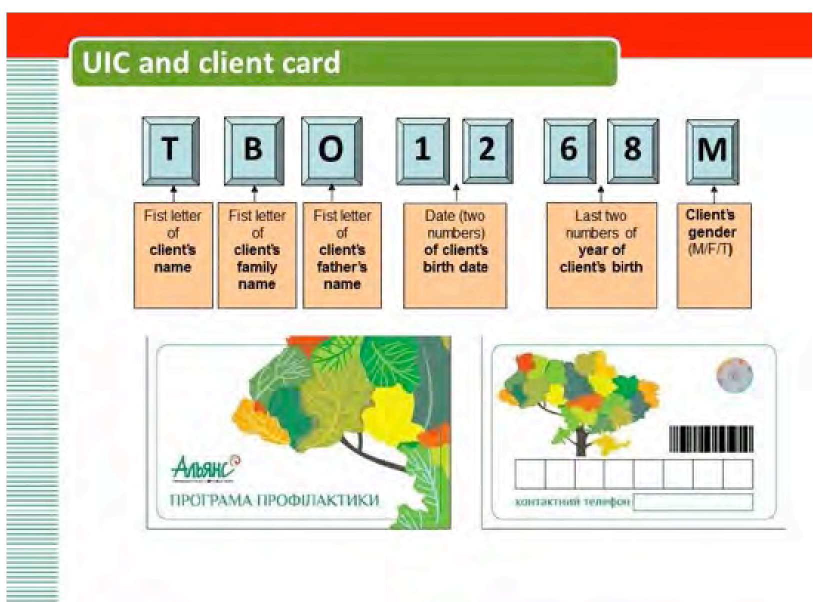
An HIV prevention program in Ukraine has demonstrated experience with UICs. The program has been implemented by Alliance Ukraine with Global Fund and USAID support since 2004, serving PWID and their sexual partners, MSM, sex workers, and vulnerable youth. The program reaches over 200,000 people annually with syringes and/or condoms, information materials, and preventive messages and provides access to HIV and STI testing and referrals to treatment.

INDIVIDUAL DATA RECORDING PROCESS THROUGH SYREX

- Data on service provision is recorded into SyrEx – a data-collection tool for program monitoring and evaluation.
- SyrEx allows per-client data tracking using UICs, bar codes, or biomedical identifiers, thus accounting for individual people reached with services, and provides individual-level cascade data on testing, case identification, and enrollment into care and treatment.
- SyrEx was initially used to enter only services provided by NGOs, but the system has been expanded over time.
- Currently, SyrEx integrates NGO data with AIDS center data on line and provides linkages to care and ART based on data exchange at the local level.
- SyrEx is undertaken with ethical standards in place, assuring confidentiality.

Figure 5 shows a client card which on which the client's UIC is written. It also shows how the UIC is generated. The client uses the card to access services without having to identify themselves by name.

FIGURE 5: UIC Example Used in Ukraine under a Global Fund Project



3. Common Tools for Data Collection in HIV Prevention, Treatment, and Care Programs for Key Populations

The data, and the tools used to collect data, can be grouped into three categories, in terms of the type of data and how often they need to be collected:

1. Special or one-time only tools
2. Routine monitoring tools
3. Other tools

1. **SPECIAL OR ONE-TIME ONLY DATA COLLECTION TOOLS** include tools that may be used only once during the life of a program or only at sporadic intervals, such as initial site mapping and validation, key population size estimates, polling booth surveys, peer outreach worker communication quality assessments, service quality assessments, etc. Although these are referred to as "one-time only," they may need to be repeated annually or on an as-needed basis, when there are major changes to the site in terms of migration or changes in venues or places where high-risk activities take place.

2. **ROUTINE MONITORING TOOLS** form the core of a strong data collection and analysis system. Most routine monitoring data are collected and analyzed on a daily, weekly, or monthly basis, depending upon the tool. Routine monitoring data are used to inform and guide the successful scale-up of the program and continuous program improvement. These tools include:

   - **ADMINISTRATIVE RECORDS**, which collect data on the number of staff trained, new staff, service availability, condoms distributed, expenditure tracking, etc.
   - **TRANSACTION DATA** (i.e., data from any time that the program "touches" a key population individual with outreach or services), including peer outreach worker daily records, patient cards, referral forms, clinic registers, and stock registers.
   - **INCIDENT REPORTS**, such as a crisis management register.

Routine monitoring information is generally collected and shared across multiple levels by the program implementer — from the spot level, to the NGO/CBO level, to the national level. The data inform program managers, funders, and policy-makers in a frequent and timely fashion about outcome trends among the beneficiaries.

3. **OTHER TOOLS** include enrollment forms and registration data for key population individuals. These data are collected as needed, or when a new key population individual joins the program. Other tools may also include surveillance data, academic research, and other miscellaneous surveys of key populations.

Program staff will spend the greatest amount of time on data collection and analysis for the routine monitoring tools. Some data are collected on a daily basis by peer outreach workers to record interactions with their peers, while other routine data are collected and aggregated on a weekly or monthly basis by a range of staff working in the program.

The remainder of this guide introduces the data collection tools commonly used by programs working with key populations. Each section contains a brief description of the tool and how it is used, followed by an example of what the tool or form looks like. Table 3 lists all of the tools discussed in this guide, along with the frequency of use, person responsible for using the tool, the key population it is appropriate for, and whether the tool is essential to the program or optional, depending on the amount of time and money the program has at its disposal.

For more details and step-by-step instructions on how to use each tool, refer to Appendix III.

TABLE 3: List of Tools in this Guide

Note: PM = Program Manager ORW = staff outreach supervisor

TOOL #	NAME OF THE TOOL	FREQUENCY	RESPONSIBILITY	INTERVENTION	ESSENTIAL(E)/ OPTIONAL(O)
1	HOTSPOT VALIDATION FORM	One time and Updated Regularly	M&E	All	E
1A	HOTSPOT LIST	One time and Updated Regularly	M&E	All	E
1B	HOTSPOT LIST (PWID)	One time and Updated Regularly	M&E	PWID	E
2	INFRASTRUCTURE STATUS	One time and Updated Regularly	PM	All	E
3	STAFF REGISTER	One time and Updated Regularly	PM	All	E
4	PEER OUTREACH WORKER REGISTER	One time and Updated Regularly	PM	All	E
5	CAPACITY-BUILDING REGISTER	Updated regularly	PM	All	E
6A	OUTREACH ENROLLMENT FORM (FSW/MSM)	One time and Updated Regularly	M&E/ORW	FSW/MSM	E
6B	OUTREACH ENROLLMENT FORM (PWID)	One time and Updated Regularly	M&E/ORW	PWID	E
6C	MASTER REGISTER (FSW/ MSM)	One time and Updated Regularly	M&E/ORW	FSW/MSM	E
6D	MASTER REGISTER (PWID)	One time and Updated Regularly	M&E/ORW	PWID	E
7A	INDIVIDUAL TRACKING SHEET/PEER CALENDER (OUTREACH)	Daily	Peer Outreach Worker	All	E
7B	ORW COMPILATION SHEET BY PEER OUTREACH WORKER SITES	Daily	ORW	All	E
8A	CONDOM OUTLET REGISTER	One time and Updated Regularly	M&E	All	E
8B	CONDOM AND LUBRICANT INVENTORY REGISTER	Updated regularly	PM	PWID	E

TOOL #	NAME OF THE TOOL	FREQUENCY	RESPONSIBILITY	INTERVENTION	ESSENTIAL(E)/ OPTIONAL(O)
8C	NEEDLE AND SYRINGE INVENTORY REGISTER	Updated regularly	PM	PWID	E
8D	CONDOM/LUBRICANT OUTLET INVENTORY/ DISTRIBUTION REGISTER	Updated regularly	PM	All	E
8E	NEEDLE/SYRINGE OUTLET INVENTORY/DISTRIBUTION REGISTER	Updated regularly	PM	All	E
9A	MSM/TG CLINIC ENROLLMENT FORM	Daily	Clinic Staff	MSM	O
9B	FSW CLINIC ENROLLMENT FORM	Daily	Clinic Staff	FSW	O
9C	REFERRAL SLIPS	Daily	Clinic Staff	All	E
10	FSW/MSM CLINIC VISIT FORM	Daily	Clinic Staff	All	O
10A	KP INDIVIDUAL TRACKING SHEET FOR CLINICAL SERVICES	Daily	Clinic Staff	All	E
11	KP PLHIV TRACKING SHEET	Daily	Clinic Staff	All	E
11A	CASE MANAGER/PEER NAVIGATOR – INDIVIDUAL FORM	Daily	Peer Navigator	All	E
12	CRISIS MANAGEMENT REGISTER	Regularly	ORW	All	O
13	ADVOCACY/SENSITIZATION REGISTER	Regularly	ORW	All	E
14	REFERRAL REGISTER (FOR NON- MEDICAL SERVICES)	Regularly	PM	All	E
15	SUPPORT GROUP REGISTER	Regularly	ORW	All	O
15A	GENDER_NORM – INDIVIDUAL FORM	Regularly	ORW	All	O
16	TOOL FOR ASSESSMENT OF COMMUNICATION BY PEER OUTREACH WORKERS	Six monthly/yearly	PM	All	O
17	ASSESSMENT OF REFERRAL SERVICE POINT	Six monthly/yearly	PM	All	O

4. Monitoring Program Coverage

4.1 MONITORING GEOGRAPHIC COVERAGE

Programmatic mapping of key populations is an example of a special data collection exercise — it is performed once at the beginning of the program and then periodically (annually or biannually) to update the results. Mapping is the systematic identification of the locations of public sites where key populations congregate and can be reached with services. It usually includes an assessment of service availability near these sites and also provides information on *how many* individuals are there, the *types* of individuals, and the *times* when they are present. The term "programmatic" is used to indicate that the mapping is done in order to improve program coverage among key populations.

Mapping is necessary to give the prevention, care, and treatment program a strategic direction, and to build sound evidence for resource allocation and for planning targeted interventions. Programs often do not have enough financial resources to cover all key populations in the entire country with the same package of services. Mapping and estimation data can help determine which types of services and support can be scaled up for geographic locations with large concentrations of key populations. The information generated from mapping helps inform program planners more precisely about what kind of services and how many to place and where, and what their staffing and infrastructure (clinics, drop-in centers) footprint should be.

Unlike various size estimation methods which provide an overall number of key population members, programmatic mapping produces estimates at the level of a particular location or "spot," adjusts numbers for duplication between spots and within geographical sub-units, and rolls them up to a city-wide estimate. Planning for and calculating coverage requires an understanding of where the key populations are located and an estimate of various sub-populations in each of these locations. Thus, one of the key strengths of this approach lies not only in its development of estimates, but also in providing a consequential distribution of key population members at different spots. For planning services and subsequently monitoring coverage, this approach has been shown to be one of the best possible and has proven valuable in ensuring high levels of coverage at all levels — spots, program intervention area, district, state/province, and national.

Comprehensive programmatic mapping is implemented at the beginning of the process to assess coverage, set coverage targets, and estimate resources required to meet targets. Subsequently, programmatic mapping data are periodically updated. Information from the initial programmatic mapping study informs planning at the national level (the macro plan) and at the local level (the micro plan). Each of these is described below.

The national level (the macro plan)

At the national planning level, reliable information about the location and size of key populations obtained from the initial programmatic mapping forms the basis for allocating resources for scaling up programs, setting performance targets, assessing coverage, and determining national funding requirements. National programs can use mapping data to effectively prioritize geographies where interventions should be scaled up to ensure the highest coverage possible within the available resources. Generally, national level-plans should first scale up the key population program in counties/states with the highest concentrations of key populations to ensure higher coverage. Saturating coverage of key populations in high-concentration geographies is preferable to spreading services thinly across a wider area (i.e., it is better to saturate coverage of key populations with the level of routine contact required to ensure 90-90-90, rather than sprinkling funding and management bandwidth across widespread geographies/locations).

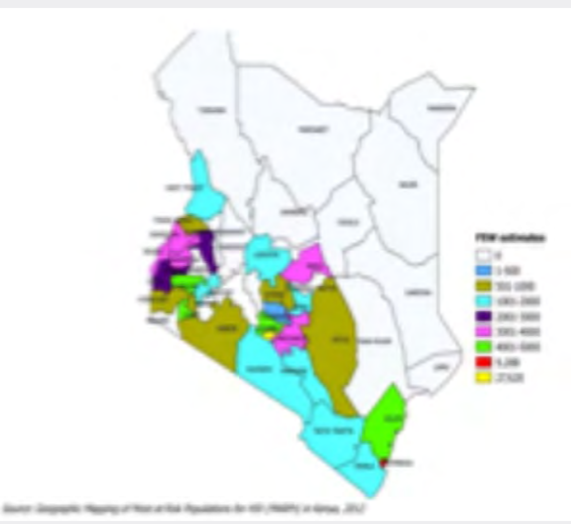
EXAMPLE: MACRO-LEVEL AND MICRO-LEVEL PLANNING IN KENYA[5]

Macro Level

Since 2006, several small-scale size estimation studies have been done to understand the size and distribution of sex worker populations in Kenya. In 2012, a large-scale programmatic/geographic mapping exercise was conducted by Kenya's National AIDS and STI Control Programme (NASCOP), with support from the World Bank, to provide accurate information on the size, locations, and characteristics of populations of sex workers, men who have sex with men, and people who inject drugs in key urban and semi-urban areas. The goal was to improve the scale, quality, and impact of HIV prevention programs among these populations. A total of 51 urban centers were mapped, representing 70% of towns with a general population of 5,000 or more in each province. These data, and data from other studies conducted since 2006, were then compiled to finalize the 2013 national estimates for populations of sex workers, men who have sex with men, and people who inject drugs.

The mapping study estimated that there were 133,700 female sex workers in Kenya. This served as baseline data for NASCOP to analyze gaps in funding and programming and develop a scale-up plan to reach female sex workers (along with other groups at risk) as part of the upcoming national strategic plan.

Results of this study showed an uneven distribution of female sex workers across the country. Certain counties like Nairobi and Mombasa had much higher numbers of female sex workers than others. Therefore, the HIV response was focused to scale up services and saturate coverage in those counties with more female sex workers. A coverage gap analysis was then conducted to understand the need for further funding and subsequent plans were developed to allocate resources to achieve 90% coverage of female sex workers nationally.



Micro Level

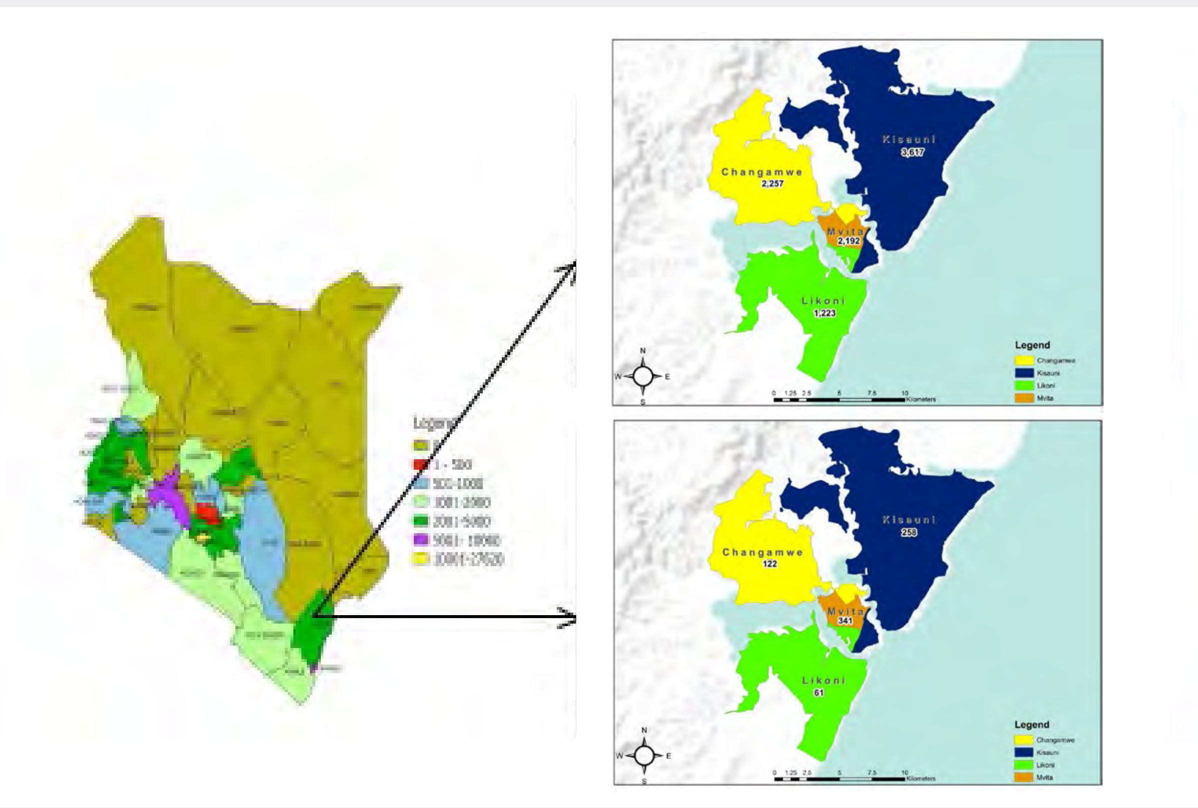
A similar logic is applied at the county level. Mapping and size estimation helped prioritizing counties where higher numbers of key populations were mapped and prioritized to saturate coverage. This prioritization also helped in effective management of resources.

Mombasa county, Kenya

The mapping and size estimate exercise conducted by NASCOP in 2012 reported that there were more than 9,000 female sex workers and around 800 men who have sex with men in Mombasa county. Further stratification of data by district showed that 70% of the female sex workers and the men who have sex with men were in Mvita and Kisauni districts. Based on this evidence, Kisauni and Mvita districts created objectives that prioritized service provision to reach at least 70% of the estimated female sex workers and men who have sex with men.

5. World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, The World Bank. *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions*. Geneva, World Health Organization, 2013.

Initially, there was a shortage of resources to reach the targeted number of female sex workers and men who have sex with men; however, the mapping data were used to mobilize resources for Mombasa county, which was clearly underserved. The country is now using this example to expand its coverage to other districts in Kenya.



At the grassroots level (the micro-plan)

The mapping and estimation approach, done across the program, creates simple classifications of spots and detailed characteristics about each spot to guide management of personnel and resources, such as mobile clinics. Like other micro-planning tools that are based on estimation approaches, micro-planning/mapping generates a list of all spots, assigns a range of estimates for key population members at each spot by sub-typology, and describes optimal timing for program delivery. This information serves as a valuable tool for planning services and interventions. This type of mapping can be confirmed by peer outreach workers who can draw their own pictorial maps and record details of each spot, including the typology of each spot (bar, street, brothel, etc.), the days when the spot is active (weekdays or weekends), timing when the spot is operational (evenings, nights, all day), and the estimated number of key population individuals (by typology) in each spot (see Figure 6 on p.32). Table 4 shows a sample of information generated by the mapping and estimation exercises for spots at the micro level in Mombasa.

This information augments the needs of service delivery planners and providers at the implementation level. For example, program planners need granularity of information at the spot level to:

- ***Determine human-resource needs:*** As per national guidelines, to provide adequate outreach services, one peer outreach worker should be available for

TABLE 4: Example of Mapping Data by District

DISTRICT*	SPOT NAME*	TYPE OF SPOT	PEAK DAYS	NO. FSW
District A	Spot 1	Bar	Wed, Fri, Sat	200
District A	Spot 2	Bar	Fri, Sat	200
District A	Spot 3	Bar	Wed, Fri, Sat, Sun	100
District A	Spot 4	Bar	Fri, Sat	100
District A	Spot 5	Bar	Fri, Sat	100
District A	Spot 6	Massage parlor	Fri, Sat	60
District A	Spot 7	Bar	Fri, Sat	50
District A	Spot 8	Street	Fri, Sat	50
District A	Spot 9	Street	Fri, Sat	50
District A	Spot 10	Bar with lodging	Fri, Sat	50

**names have been omitted for confidentiality*

every 50-60 female sex workers. Based on the mapping exercise, the implementation partners can determine how many peer outreach workers and other staff they need and from which site they should be selected. As an example, for a location with approx 600 female sex workers, at least 10-12 peer outreach workers should be employed.

- ***Target locations/spots for localizing interventions:*** Mapping helps the implementing partners to decide which spots to prioritize. For example, in Karachi, Pakistan, 75% of nearly 12,000 people who inject drugs congregate at 50% of the spots. Thus saturating coverage at half of the spots in Karachi would cover 75% of the people who inject drugs.

- ***Obtain information on the operational dynamics of key populations:*** This information helps inform the initial intervention design and includes the sub-typology (brothel, street, bar, night club, massage-parlor-based female sex workers), timing of operation of each spot, and also the days when most female sex workers visit these spots. If sex workers are brothel-based, the peer outreach worker ratio may be higher and a parallel plan needs to be devised to do advocacy with the brothel madams and managers. Likewise, if most of the sex workers are street-based, the intervention will have to invest resources and develop plans to prevent and respond to issues of violence by police and people on the street who exploit key populations.

- ***Have baseline data and denominators at the grassroots level:*** The concrete and defensible size estimates that are provided at the spot level can be used to estimate the specific number of condoms, lubricant, outreach testing supplies, and other materials needed. As venues close or become less popular, the estimates can be adjusted. Mapping data provide service delivery programs with denominators,[6] which are crucial to be able to set goals and establish benchmarks for key outcomes indicators. Key indicators related to program coverage and utilization of programs and services by target populations serve as markers for program success. Coverage gaps at the spot level can be evaluated through mapping of these spots on a continual basis.

6. "Denominator" refers to the total number of key population individuals who are supposed to be provided the project services and are tallied with mapping and population estimate process. This should be the maximum number of individuals that the program can reach.

4.1.1 Participatory validation mapping at the micro level

Although the implementation partners use the initial mapping and estimation data for planning and rapport building at the sites, once the program identifies key population individuals in the spots, they can assist with a participatory validation exercise to validate the earlier mapping. As programs begin to reach the key population and deliver high-quality services, the population size estimate tends to grow (i.e., demand for services grows).

How to perform validation mapping with peer outreach workers

At the start of a program or as part of training for peer outreach workers, they are asked to draw a pictorial map on poster paper of the areas where they work. The map should include streets, buildings, and major features such as parks, bus stops, cinemas, etc. The peer outreach worker should also identify the number and usual locations of key population individuals within the spot. They should also note the typologies of the individuals, and s/he could also note each individual's risk level. These maps are often displayed on the walls of the drop-in center or NGO offices where the staff and peer outreach workers meet regularly. The peer outreach workers can update these maps periodically (every six months) to track changes such as new key population individuals or ones who have moved away. In spots with high mobility, these maps may need to be revised more often.

FIGURE 6: Spot Mapping Example

The example above is a map drawn by a peer outreach worker for his outreach location working with men who have sex with men. The map highlights landmarks, pick-up points, and locations of condom outlets. The map also lists the numbers and types of key population individuals who go to the spot.

EXAMPLE OF PARTICIPATORY VALIDATION MAPPING IN KENYA

Key population members identified by the International Centre for Reproductive Health in Mombasa did their own mapping exercises with peer outreach workers to validate the initial mapping exercise, and they found a variation of around 10-15% in the number of key population individuals identified. As an additional benefit of this mapping, this validation exercise helped the organization and the community "own" the mapping data and use it in programming.

Site Validation Mapping – Example from Mombasa

Site Analysis – Example from Mombasa

Case study: Mapping high-risk locations for scaling up HIV prevention programs in Karnataka, India

In 2003, a rapid mapping exercise was conducted in Karnataka, India to assess the sites and spots in urban areas where activities that increase the risk of HIV transmission take place. The exercise was undertaken to inform the development of appropriately scaled targeted HIV prevention programs. Using this approach, the locations, population estimates, and operational typologies of groups at higher risk for HIV infection were identified. The key population sub-groups considered were female sex workers, high-risk men who have sex with men, and people who inject drugs.

Program implementers used the mapping information to prioritize the towns and sites for establishing HIV prevention interventions in Karnataka. The mapping information also helped to identify locations and spots for community mobilization and rapport-building. The identification of typologies of female sex workers provided information which was used to design the most appropriate targeted interventions in the given context. Once the program built rapport with the community and established basic outreach and clinical services, key population individuals helped perform site validation exercises to validate the population size estimated through mapping. Validated estimates differed from the initial mapped estimates by only 5-10%.

Ethical issues with mapping

As with all data on key populations, the mapping data as well as mapping activities must be sensitive to issues of confidentiality and ethics for the key populations. The issues listed below should be kept in mind for any data collection exercise with key populations and should be augmented to include any additional issues that key population community members identify as important:

- Meaningful engagement of key populations is important and includes: deciding whether it is safe to do any data collection or formative design, and determining adequate protections during data collection, data storage, and data use.
- In addition to consulting key population communities, an assessment of the risks and benefits of programmatic mapping should be conducted. If the decision is made to move forward, a written strategy should be negotiated describing reasonable and appropriate safeguards developed in collaboration with key populations and national agencies or others who will use the data.
- A standard operating procedure (SOP) should be written to describe the mapping exercise, its function within the program, how data will be stored, and who will have access to data. (See Annexure IV for a full description of a SOP for mapping and other considerations such as consent.)
- A procedure for obtaining informed consent for participation should be designed into all data collection protocols, regardless of how formal the study, monitoring exercise, or program planning method.

Mapping data should be treated with care, especially when individuals and locations are being identified. Size estimates, especially location information, should be protected and not given to media, nor in some situations to government departments, as dissemination or publication of figures may result in unintended political or law-enforcement action. This will push key populations further underground, increasing their vulnerability to HIV. These estimates should instead be shared at appropriate forums for policy and advocacy purposes.

Limitations with mapping

Like every research study, mapping does have some limitations:

- Mapping is extremely labor-intensive and time consuming. In a large city, thousands of community informants may need to be interviewed in order to obtain a full listing of sites.
- Data may underestimate the size of the population. Where large numbers of key population members do not visit public sites or geo-locations, the information on the size of the key populations may be underestimated.

Data are necessary to improve programming but should not stand in the way of providing services. The goal of the HIV program must be to build immediate access to services for key populations based on known spots, and mapping can later enhance these efforts. Once programs are established, local teams need to diligently pursue information on other sex work locations and networks in their vicinities to overcome the challenges of identifying all types of sex work settings.[7] Mapping cannot uncover all key populations, but an iterative process of program implementation and mapping is needed over time to identify and reach populations.

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7. Blanchard JF, Bhattacharjee P, Kumaran S, Ramesh BM, Kumar NS, Washington RG, et al. *Concepts and strategies for scaling up focused prevention for sex workers in India*. Sex Transm Infect. 2008 Oct; 84 Suppl 2:ii19–23.

4.1.2 Measuring availability and intervention coverage of sites/spots

Programmatic mapping

Programmatic mapping provides detailed data that can show where key populations can be found and the geographic areas where the program should focus services. To deliver services effectively, the program needs to focus on the areas with the greatest number of spots (neighborhoods with bars, brothels, streets or spots for solicitation, cruising areas, drug shooting houses) and develop sites (clusters of spots) with a clinical facility(s) positioned within a close distance.

Programmatic mapping not only identifies where to place services, but it can also help identify and map structures and partners (clinics, hospitals, health posts, mobile clinic services, outreach clinics, drop-in centers, etc.) within the targeted sites that could play a key role in providing services.

With a reasonable understanding of the area and the key populations working and living there, program planners should be able to determine where to place resources, personnel, and service provision mechanisms for optimum delivery of services.

KEY POPULATIONS DRIVING THE HIV RESPONSE

Focused HIV outreach and services for key populations are driven by active and engaged peer outreach workers and the key populations they mobilize and empower through behavioral support and initiatives that build community networks and reduce the vulnerability of key populations to HIV, violence, and stigma and promote other important priorities in the community.

For programs to be effective and accountable, the outreach system needs to have defined targets for those directly reached through peer outreach and targets for referring or bringing individuals to different services. Peer outreach workers are assigned geographic areas and a cohort of key population community members whom they know and provide with outreach information and referrals for services. Peer outreach workers have a defined number of peers to visit each week, a set number of spots, defined working hours, and a means to record who they saw and what services the individual obtained. Each peer outreach worker should be mentored by a staff outreach supervisor who observes the peer outreach workers at the spot and convenes groups of peer outreach workers (at least once every two weeks) at the NGO office or drop in-center to review data, discuss bottlenecks and solutions to problems, and gain insights from peer outreach workers into how the program can be improved.

Optimizing coverage

Once program planners use the mapping data to determine the spots to be covered, they can design the outreach system to ensure the right number of peer outreach workers are available to ensure saturated coverage. Regular monitoring of coverage at the spot level can be used to confirm that targets are being met and the program is in the right location.

Site validation

It is important for program managers to keep a close eye on newly emerging sites as well as sites that have closed for various reasons such as raids, demolition, development work, change in the laws, etc. To keep an up-to-date list of sites, a site validation exercise should be conducted on a regular basis (preferably every six months) to validate the existence of the sites for the intervention. **Tool #1: Hotspot Validation Form** below can be used (see Annexure III for more information on completing the form).

TOOL 1: HOTSPOT VALIDATION FORM

Name of NGO/CSO/IA: ______________________				**Name of Peer Outreach Worker: ______________________**	
Name of hotspot				Hotspot Type*	
Hotspot Code				Location	
Department				Commune	
Type of KP	1=FSW, 2=MSM, 3=TG, 4=PWID			Respondent	1=KP, 2=Others, 3=None
Nature of hotspot	1=Acive, 2=Inactive				
Date of visit 1 (DD/MM/YY):____ /_____ /________				Date of visit 2 (DD/MM/YY) :____ /_____ /________	

Sl No	**SPOT PROFILE**	
1	On a usual/typical day, how many KPs work at/visit this hotspot?	Min ☐☐☐ Max ☐☐☐
2	At this hotspot, what time of the day do we find the maximum number of KPs (peak time)? **CIRCLE AS APPLICABLE**	MORNING .... A AFTERNOON .... B EVENING .... C NIGHT .... D ALL 24 hrs .... E
3	At this spot, on which day(s) of the week is the number of KPs greater than usual (peak day)? **CIRCLE AS APPLICABLE**	MONDAY .... A TUESDAY .... B WEDNESDAY .... C THURSDAY .... D FRIDAY .... E SATURDAY .... F SUNDAY .... G
4	On a peak day of the week/month, how many KPs work at/visit this hotspot (min – max)?	Min ☐☐☐ Max ☐☐☐

Sl No	**INFORMATION ON OTHER SPOTS**	
5	Do you know any other place like this in this city/village/commune, where KPs work/visit?	Yes ☐ No ☐
S.N	**HOTSPOT NAME/ADDRESS**	**HOTSPOT TYPE***
A		
B		

***Codes** for type of hotspot: **1**=Bar with lodging, **2**=Bar without lodging, **3**=Sex den/brothel, **4**=Strip club, **5**=Streets/ highways, **6**=Home, **7**=Casino, **8**=Beach, **9**=Guest house/rest house/hotels/lodges, **10**=Massage parlor, **11**=Parks, **12**=Beer tavern, **13**=Public toilet, **14**=Others_______________(Specify)

The site validation will have to keep options open during the exercise to identify any sites that have emerged since the last site validation exercise due to an economic boom in the country, or an influx due to seasonal migration, festivals, or other extraneous factors.

One of the key dashboard indicators[8] the program needs to routinely monitor to optimize coverage is the number of spots, including the type of key populations and the number of key population individuals at each spot. The following **Tool #1A: Hotspot List** can be used to record this information. This tool provides an estimate of key population individuals available at each of the sites for the intervention.

TOOL #1A: HOTSPOT LIST

<Implementing Partner's Name >

Month/Year: ___________________________ **Type of KP:** FSW ☐ MSM ☐ TG ☐

NAME OF HOTSPOT	HOTSPOT CODE	LOCATION	NAME OF DISTRICT	TYPE OF HOTSPOT*	EST. NO. OF KPS (AVG.)	PEAK DAYS	PEAK TIME	PEER OUTREACH WORKER RESPONSIBLE
1	2	3	4	5	6	7	8	9

***Codes** for type of hotspot: **1**=Bar with lodging, **2**=Bar without lodging, **3**=Sex den/brothel, **4**=Strip club, **5**=Streets/highways, **6**=Home, **7**=Casino, **8**=Beach, **9**=Guest house/rest house/hotels/lodges, **10**=Massage parlor, **11**=Parks, **12**=Beer tavern, **13**=Public toilet, **14**=Others_____________(Specify)

4.2 MONITORING POPULATION-LEVEL COVERAGE

4.2.1 Using population size estimates data to plan coverage

Once the program knows the number, locations, and types of key populations (through mapping), the program should plan the infrastructure needed to meet targets with a goal for saturation within a fixed time-frame. Important infrastructure decisions include: number of drop-in centers needed, number and type of clinical services, number and type of outreach staff, and number and type of management staff. This process will be repeated, so that the costs and efficiency of delivery are informed by monitoring data and staff and peer insights. When planning the required infrastructure, the size estimation data can be used to calculate and plan coverage, as shown in the example in Table 5.

8. Dashboard indicators are the subset of key indicators that are monitored regularly to understand the progress of the program implementation. Typically, these are six or seven indicators that cover all important areas of the intervention.

TABLE 5: How to Plan the Intervention Based on the Mapped Numbers in a District

AREA	ESTIMATED SIZE				TOTAL KPS IN THE MAPPED DISTRICT	NUMBER OF SITES NEEDED (1,000 KPS PER SITE)
	FSW	MSM	TG	PWID		
district 1	1,500	1,800	1,000	500	4,800	5
district 2	1,800	1,000	500	250	3,550	4
district 3	2,500	1,200	500	1,000	5,200	5
district 4	500	250	500	250	1,500	2
district 5	3,500	1,500	250	1,000	6,250	6
district 6	1,000	1,800	750	1,000	4,550	5
district 7	1,200	500	500	1,500	3,700	4
district 8	1,000	3,500	1,000	1,500	7,000	7
Total	13,000	11,550	5,000	7,000	36,550	38

The above calculation shows that the program will need 38 site-level teams across eight districts to saturate the coverage of 36,550 key population members across the program. Across the program level, some managers may work across multiple sites or all sites. The above calculation is made based on the assumption that for management to be effective and efficient, a site could cover 1,000 key population individuals. However, it is important to note that the geographical spread of these populations across spots and the availability of facilities all must be considered when defining the unit for management. If the spots are widely scattered, where four spots with 500 key population individuals require substantial travel and coordination with facilities to reach targets, the coverage could be less than 1,000 key population individuals per site. Similarly, in densely populated urban areas, if spots are clustered close together, communities are somewhat mobilized, and facilities are experienced in serving key populations, the management burden may allow for a site to include more than 1,000 key population individuals per site.

The program also needs to decide on an organizational structure. Figure 7 below suggests how the human resources could be deployed to ensure that all operational areas receive the highest levels of coverage.

FIGURE 7: Sample Organization Chart

Source: *Micro-planning in Peer Led Outreach Programs: A Handbook Based on the Experience of the Avahan India AIDS Initiative*

4.2.2 Measuring intervention coverage of key populations at the spot level

Once a plan has been developed for covering the sites in the program area, the next step is to measure coverage and plan coverage at the spot level. Each site should list all spots in the site, the number of estimated key population individuals by type in each spot, and assign various outreach staff to be responsible for each individual in the spot (see Table 6). This will ensure that all key population individuals in the estimate are enrolled in the program and receive the services they need.

TABLE 6: Coverage Calculation by Spot

COUNTY	SPOT NAME	TYPE OF SPOT	NO. OF FEMALE SEX WORKERS	NUMBER OF INDIVIDUALS REGISTERED IN THE PROGRAM (TILL DATE)	% INDIVIDUALS REGISTERED AGAINST ESTIMATED
District A	Spot 1	Bar	200	148	74%
District A	Spot 2	Bar	200	125	63%
District A	Spot 3	Bar	100	90	90%
District A	Spot 4	Bar	100	95	95%
District A	Spot 5	Bar	100	80	80%
District A	Spot 6	Massage Parlor	60	75	125%
District A	Spot 7	Bar	50	25	50%
District A	Spot 8	Street	50	30	60%
District A	Spot 9	Street	50	60	120%
District A	Spot 10	Bar with Lodging	50	50	100%
		Total	**960**	**778**	**81%**

The program manager should conduct this exercise every month with adjustments made to add peer outreach workers, assign peer outreach workers to new spots, or to take on additional spots and people as s/he gains skills, until saturation, as defined by the program target, is achieved. Ideally the program target should be 100% saturation of the estimated key population. The program should be flexible enough to plan its activities in a phased manner in the first three years to achieve the target. This should be monitored on a regular basis to take corrective actions where needed.

Table 6 above shows that of the 10 sites, six have achieved saturation, defined as registration of 80% or more of estimated individuals, among which two sites have exceeded the estimated number in terms of registration. This calculation also shows program managers that four of the sites are struggling to reach saturation, and the managers can investigate more to determine why those sites are not reaching the 80% target. Also, it is important for managers to understand why two sites were able to reach more than the estimated number of female sex workers (greater than 100%). Possible explanations include a sudden influx of new sex workers, or that old sex workers are currently part of the intervention but are not being counted as part of the denominator. Reviewing this coverage calculation will also allow the intervention to understand the turnover rate of sex workers within the area.

TRACKING COVERAGE:

Example 1: NASCOP learning site in Mombasa, Kenya

In the NASCOP learning site in Mombasa, Kenya, the mapping estimates showed that there were 5,900 female sex workers in Mombasa. After validation, the program used 5,900 as the denominator or target of female sex workers to be reached by the site. The site reaches the sex workers through a robust outreach program involving peer outreach workers and provides health services through static and outreach clinics. On a monthly basis, the site analyzes the coverage of outreach and clinical services by comparing the cumulative reach of the female sex workers against the estimate or denominator. The graph below shows that the site took almost one year to reach (one-to-one or one-to-group contact) more than 95% of the female sex workers through outreach. By the end of one year, only 48% (2,769) of female sex workers were reached by clinical services (see Figure 8).

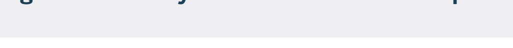
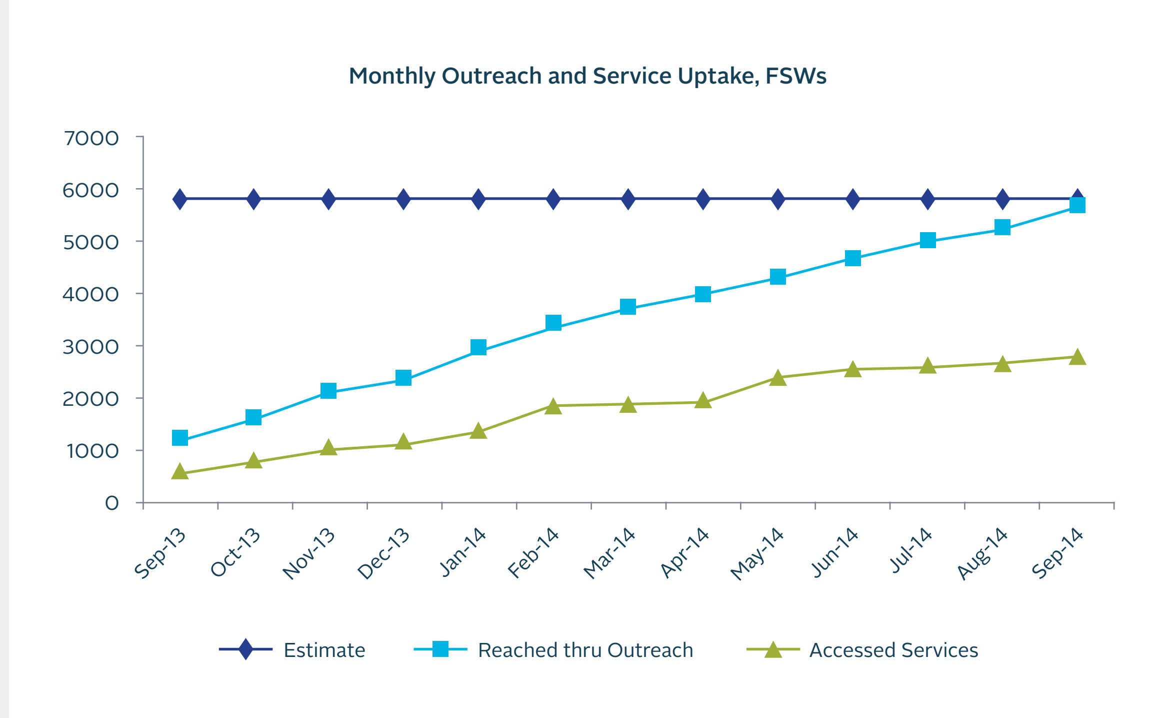


Figure 8: Monthly Outreach and Service Uptake

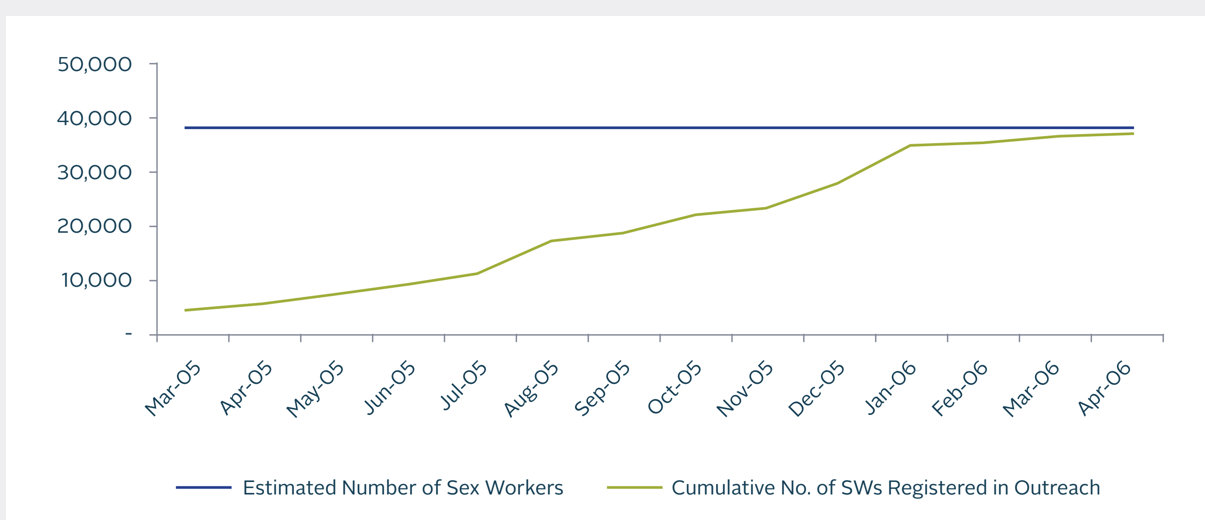


Example 2: Achieving rapid scale-up of coverage: FHI 360/Aastha, India experience

FHI 360 implemented the Aastha Project with sex workers under the Avahan AIDS Initiative program in two districts of Maharashtra state in India. In the two districts, 38,500 sex workers had been mapped, which was used as the coverage denominator for the project to enroll individual sex workers for outreach. Within one year of initiation, through project coverage data, the project could show that it achieved 97% enrollment of sex workers for HIV prevention services through an intensive peer outreach approach.

The graph below shows the rapid rate at which the project was able to achieve the desired scale-up of coverage of sex workers within a 12-month time frame.

Figure 9: Scale-up of Sex Workers Registered in Outreach



Source: Key Indicator Data – Aastha Project

Indicators	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05
Estimated number of Sex workers	38,500	38,500	38,500	38,500	38,500	38,500	38,500
Cumulative No. of SWs Registered in Outreach	4,278	5,321	7,380	9,052	11,246	16,744	19,140
Percentage Registered	11%	14%	19%	24%	29%	43%	50%

Indicators	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06
Estimated number of Sex workers	38,500	38,500	38,500	38,500	38,500	38,500	38,500
Cumulative No. of SWs Registered in Outreach	21,657	23,275	27,984	34,849	35,560	36,428	37,309
Percentage Registered	56%	60%	73%	91%	92%	95%	97%

4.3 MONITORING PROGRAM INFRASTRUCTURE, PERSONNEL, AND CAPACITY-BUILDING

4.3.1 Program infrastructure

Once the program understands the epidemic and has developed a plan for targeting and delivering the intervention, it is time to focus on quality. This step describes how a program can assess the required site capacity, personnel, structures, and infrastructure needed to cover the individuals across all spots. In addition to this, the management should also know the availability of funds to implement this type of program.

The basic infrastructure needed is:

- Project offices across the site
- Health facilities — clinics, hospitals, health posts, mobile clinic services, outreach clinics, technical support in health facilities (government and private)
- Outreach clinics
- Drop-in centers and other outreach structures

The program manager can use **Tool #2: Infrastructure Status** to determine what is needed and what resources are available. If a certain facility is not available, then it is important to flag that issue for finding a linkage to a suitable resource.

TOOL #2: INFRASTRUCTURE STATUS

SL. NO.	TYPE OF INFRASTRUCTURE	DESCRIPTION OF THE INFRASTRUCTURE	PROJECT-OWNED/ REFERRAL POINT	DATE ESTABLISHED	CONTACT DETAILS	REMARKS

4.3.2 Program personnel

Once the infrastructure plan is in place, it is important to have a personnel plan in place. It is extremely important to design staffing around a program that manages down to the individual peer outreach worker at the spot level, with a focus on monthly tracking of targets and the empowerment of peer outreach workers at the front line delivering the program. The management team should determine the number of staff required and available to work in the different parts of the program, what their current skills and training are, and track the number and type of staff who have left the program.

The project should track the number of all intervention-related project staff, including:

- Paid and unpaid workers in the program (to be listed separately)
- Healthcare providers — doctors, nurses, clinicians
- Project staff — managers, coordinators
- Staff outreach supervisors
- Peer outreach workers

The project also needs to determine the location where the staff work and the structures they work within. Personnel records should be maintained to monitor the personnel needs of the program. The following two registers, **Tool #3: Staff Register** and **Tool #4: Peer Outreach Worker Register**, can be used for this purpose.

TOOL #3: STAFF REGISTER

(To be completed by Program Administrator/Program Manager)

SL. NO.	NAME	POSITION	AGE	GENDER	DATE APPOINTED TO THE PROJECT	CATEGORY STAFF *	NO. OF HOURS WORKING	REMARKS
1	2	3	4	5	6	7	8	9

It is important to have a separate register to understand the peer outreach workers in the program and the attrition rate among them. This will also be helpful in planning periodic capacity-building activities for peer outreach workers.

TOOL #4: PEER OUTREACH WORKER REGISTER

(To be completed by Program Administrator or Staff Outreach Supervisor)

SL. NO.	NAME	ADDRESS	AGE	GENDER	TYPE OF KP	EDUCATION	DATE OF JOINING THE PROJECT	DATE OF DISCONTINUATION	REASON FOR DISCONTINUATION
1	2	3	4	5	6	7	8	9	10

4.3.3 Capacity building/training for program personnel

Once personnel have been recruited, the program needs a systematic training plan to ensure they have the skills they need. In addition to technical area knowledge, all staff should be aware of the issues of gender and sexual diversity, and stigma and discrimination faced by key populations, and the challenges key population individuals may face in accessing services and gaining acceptance in the wider community. It is also important that the program collects data to reflect the level of training for personnel needed to provide quality outreach and services. **Tool #5: Capacity-Building Register** documents how much training personnel have received, including external and internal trainings.

TOOL #5: CAPACITY-BUILDING REGISTER

(To be completed by project administrator/project manager)

SL. NO.	DATE		ORGANIZED BY	TRAINING NAME	TYPE AND NUMBER OF PARTICIPANTS					
	FROM	TO			PEER OUTREACH WORKER	NO.	STAFF	NO.	OTHERS	NO.
1. Objectives of the training										
2. Training methodology used										
3. Training curriculum and materials used										
4. Training process (summary of each day of the training)										
5. Participants' Feedback										

LIST OF PARTICIPANTS				
SL. NO.	NAME	ROLE IN PROJECT	AGE	SEX

4.4 MONITORING BEHAVIORAL INTERVENTIONS

4.4.1 Key population registration during outreach

An intervention program should register key population individuals at the spot and provide them the services offered by the program (referrals to clinic, condoms, behavior change counseling, etc.). Peer outreach workers can collect this individual registration and tracking data, which can be used to record how many key population individuals the program is reaching, condom needs, risk and vulnerability of each key population individual, what services each individual has received, which services the individual is due to receive, individual's location, etc.

The following **Tool #6A: Outreach Enrollment Form** records an individual's demographic information and information on their current behaviors and sexual practices, which allows the peer outreach worker to assess that particular individual's risk for acquiring HIV.

TOOL #6A: OUTREACH ENROLLMENT FORM (FSW/MSM)

(To be completed by staff outreach supervisor or peer outreach worker)

<table>
<tr><td colspan="3">1. Name of Implementing Partner:</td><td colspan="3"></td></tr>
<tr><td colspan="3">2. Date of Enrolment:</td><td colspan="3"></td></tr>
<tr><td colspan="3">3. Name of District/Department:</td><td colspan="3"></td></tr>
<tr><td colspan="3">4. Name of Location:</td><td colspan="3"></td></tr>
<tr><td colspan="3">5. Name of Hotspot:</td><td colspan="3"></td></tr>
<tr><td colspan="3">6. Name of the Staff Outreach Supervisor:</td><td colspan="3"></td></tr>
<tr><td colspan="3">7. Name of the Peer Outreach Worker:</td><td colspan="3"></td></tr>
<tr><td colspan="3">8. Date/Month/Year of Enrolment:</td><td colspan="3"></td></tr>
<tr><td colspan="3">9. Name/alias of the key population individual::</td><td colspan="3"></td></tr>
<tr><td colspan="3">10. Contact Address:</td><td colspan="3"></td></tr>
<tr><td colspan="3">11. Sex:</td><td colspan="3">Male/Female/Transgender</td></tr>
<tr><td colspan="3">12. Nationality:</td><td colspan="3"></td></tr>
<tr><td colspan="3">13. Date of Birth (DD/MM/YY):</td><td colspan="3"></td></tr>
<tr><td colspan="3">14. Program ID:</td><td colspan="3"></td></tr>
<tr><td colspan="3">15. Phone Number:</td><td colspan="3"></td></tr>
<tr><td colspan="3" rowspan="8">16. Where do you MOSTLY operate/conduct sex work/ meet your clients or partners?

CIRCLE ALL THAT APPLY</td><td colspan="3">Name of hot spot (s):</td></tr>
<tr><td colspan="2">1. Bar with Lodging</td><td>2. Bar without Lodging</td></tr>
<tr><td colspan="2">3. Sex Den (Brothels)</td><td>4. Strip Club</td></tr>
<tr><td colspan="2">5. Streets/Highways</td><td>6. Home</td></tr>
<tr><td colspan="2">7. Casino</td><td>8. Beach</td></tr>
<tr><td colspan="2">9. Lodgings/Guesthouse/Rest House/Hotels</td><td>10. Massage Parlors</td></tr>
<tr><td colspan="2">11. Parks</td><td>12. Beer Tavern</td></tr>
<tr><td colspan="2">13. Public Toilets</td><td>14. Others</td></tr>
<tr><td colspan="3">17. Have you been ever been contacted by a peer outreach worker from the HIV prevention program?</td><td colspan="2">Yes</td><td>No</td></tr>
<tr><td colspan="3">18. Have you ever visited any DIC/clinic/wellness center for any services in the last 6 months?</td><td colspan="2">Yes</td><td>No</td></tr>
<tr><td colspan="3">19. If Yes, which DIC did you visit?</td><td colspan="3"></td></tr>
<tr><th colspan="3">ONLY FOR FSWS</th><th colspan="3">ONLY FOR MSM/TG</th></tr>
<tr><td colspan="3">20. How old were you when you started sex work?</td><td colspan="3">At what age did you first have anal sex?</td></tr>
<tr><td colspan="3" rowspan="2">21. How many penetrative acts (anal/vaginal) have you had in the
LAST DAY? ________
LAST WEEK? ________</td><td colspan="3">How many receptive anal sex acts have you had in the
LAST DAY? ________
LAST WEEK? ________</td></tr>
<tr><td colspan="3">How many penetrative anal sex acts have you had in the
LAST DAY? ________
LAST WEEK? ________</td></tr>
<tr><td>22. Did you use a condom in your last penetrative Act?</td><td>Yes</td><td>No</td><td>Did you use a condom in your last receptive/ penetrative anal sex</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="3">Signature: ________________________________
Staff Outreach Supervisor</td><td colspan="3">Signature: ________________________________
Peer Outreach Worker</td></tr>
</table>

KP Master Register

The KP Master Register is a master list of all key population individuals served by the site. **Tool #6C: Master Register (FSW/MSM)** below provides an example of the type of information that should be recorded (and kept up-to-date) for each key population individual, such as names of the key population individual and the peer outreach worker, type of sex worker, age, spot, sex, registration date, etc. Each program should determine the specific data that should be kept on the Master Register for each key population individual.

TOOL #6C: MASTER REGISTER (FSW/MSM)

(To be completed by the monitoring and evaluation officer)

SL. NO.	NAME OF IMPLEMENTING PARTNER	NAME OF DISTRICT	NAME OF LOCATION	NAME OF HOTSPOT	NAME OF STAFF OUTREACH SUPERVISOR	NAME OF PEER OUTREACH WORKER	DATE OF ENROLMENT	NAME OF KP	GENDER	AGE	AGE AT START OF SW/ FIRST ANAL SEX	PROGRAM ID	PHONE NUMBER	TYPOLOGY OF KP
1	2	3	4	5	6	7	8	9	10	11	12	13	14	

4.4.2 Intensive peer-based tracking and regular contacts

Intensive peer-based outreach is the cornerstone of effective key population programs. It is the main way in which the program establishes contact, trust and continued communication, educates key population members about available services, and enrolls them into the program. Key outreach activities include:

- STIs/HIV knowledge – transmission, risks, nature, prevention methods
- Condom promotion – condom demonstration, why they should be used, and where they are available
- Provision of commodities – condoms, lubricant and needle and syringes
- Where and what health/STI/HIV services are available to key populations
- Community mobilization and empowerment
- Talk about the program as a whole, and explain the different outreach services and referrals to testing, care, and treatment services

It may take time and several contacts before an individual fully trusts the program and registers with the program. Once registered, it is important that the program monitor outreach efforts to see if the program is effectively reaching the target population.

The following individual tracking tools can be used to track which outreach services each key population individual is receiving:

- **INDIVIDUAL TRACKING SHEET (TOOL #7A)** (FSW/MSM/TG and PWID): The peer outreach worker fills out this form on a weekly basis and records all interactions with his/her peers on one form. In many programs, peer outreach workers carry some form of a 'daily diary' to record daily interactions with each key population individual. At the end of each week, the peer outreach worker can transfer this information from his/her daily diary to the Individual Tracking Sheet. At the end of the month, the peer outreach worker turns in the Individual Tracking Sheet to the staff outreach supervisor, who combines all of the data from all of the peer outreach worker tracking sheets onto the Outreach Worker Compilation Sheet (Tool #7A).

- **OUTREACH WORKER COMPILATION SHEET (TOOL #7B):** The staff outreach supervisor takes all of the Individual Tracking Sheets (Tool #7) from the peer outreach workers and aggregates the data onto one summary report.

TOOL #7A: INDIVIDUAL TRACKING SHEET/PEER CALENDER (OUTREACH)

(To be completed by peer outreach worker)

Name of ORW: Name of Peer: Quarter Q1 (Oct–Dec), Q2 (Jan–Mar), Q3 (Apr–Jun), Q4 (Jul–Sep)

SL. NO.	PID NO.	SPOTS/HOTSPOTS	NAME/NICK-NAME	TYPE OF KP	AGE	SEX	COMMU-NICATION SESSION (1-1, 1-G)			AT LEAST ONE OF THE FOLLOWING TOPICS DISCUSSED: STI, HIV, HCT, SGBV, STIGMA (YES/NO)	REFERRAL FOR HEALTH SERVICES																		RECEIVED COMMOD-ITIES (NO. AND TYPE OF CONDOM: MALE/ FEMALE/LUBE)						FACED ANY VIOLENCE			ADDRESSED VIOLENCE			REMARK
											STI			HIV TESTING			ART			FP			TB			OTHERS*			C/FC			LUBE									
							M1	M2	M3		M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41
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20																																									

TOOL #7B: ORW COMPILATION SHEET BY PEER ORW SITES

(To be compiled by staff outreach supervisor for his/her area)

SL. NO.	SPOTS/HOTSPOTS	TYPE OF KP	PEER OUTREACH WORKER'S NAME	TOTAL KP REGISTERED	COMMUNICATION SESSION (1-1, 1-G)			REFERRAL FOR HEALTH SERVICES																		RECEIVED COMMODITIES (NO. AND TYPE OF CONDOM: MALE/ FEMALE/LUBE)			ANY CRISIS INCIDENTS FACED			CRISIS INCIDENTS ADDRESSED		
								STI			HIV TESTING			ART			FP			TB			OTHERS*											
					M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	CON-DOMS	FE-MALE CON-DOMS	LUBE	M1	M2	M3	M1	M2	M3
1																																		
2																																		
3																																		
4																																		
5																																		
6																																		
7																																		
8																																		
9																																		

4.4.3 Distribution of condoms (male and female), lubricant, and needles and syringes

Tool #8A: Condom Outlet Register records information on condom outlets, including the type of outlet and how many condoms they distributed during the month. This register can be maintained by the staff who developed the condom outlets. This register should be updated regularly or when a change happens, e.g., a location change, closure, new outlet, etc.

TOOL #8A: CONDOM OUTLET REGISTER

<Implementing partner>

HOTSPOT	NAME/PLACE OF OUTLET HOLDER*	DATE OF INDUCTION IN PROJECT	SEX OF OUTLET HOLDER (M/F/TG)	TYPE OF OUTLET	DATE OF DISCONTINUATION (IF DISCONTINUED)	REASON FOR DISCONTINUATION
1	2	3	4	5	6	7

***Code 1** = Individual outlet holder, **2** = Public place, **3** = Private place, **4** = Vending machine, **5** = Health facility, **6** = Others

The Condom and Lubricant Inventory Register (Tool #8B) informs the program manager on the stock of condoms and lubricant in the program. Based on the available stock, the program manager can place procurement orders for condom and lubricant supplies.

TOOL #8B: CONDOM AND LUBRICANT INVENTORY REGISTER

<Implementing partner>

DATE	OPENING BALANCE CONDOMS & LUBRICANTS		NUMBER RECEIVED				NUMBER DISTRIBUTED				CLOSING BALANCE	
			MOH/DONOR		OTHER SOURCES		PEER OUTREACH WORKER		OUTLETS			
	C	L	C	L	C	L	C	L	C	L	C	L
1	2	3	4	5	6	7	8	9	10	11	12	13

The **Condom and Lubricant Outlet Inventory/ Distribution Register (Tool #8D)** records condom supply movement in the operational area. This helps in monitoring and planning condom promotion activities in the operational area.

4.4.4 Distribution of needles and syringes

TOOL #8C: NEEDLE AND SYRINGE INVENTORY REGISTER

<Implementing partner>

	OPENING BALANCE NEEDLE & SYRINGES		NUMBER RECEIVED				NUMBER DISTRIBUTED								CLOSING BALANCE	
			MINISTRY/ DONOR		OTHER SOURCES		PEER OUTREACH WORKER		DIC		HEALTH FACILITY		OTHERS			
DATE	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17

4.5 MONITORING BIOMEDICAL INTERVENTIONS

4.5.1 Referral to health services

After a peer outreach worker registers a new key population individual and begins providing outreach services, there are two types of primary referrals that a key population individual may need:

1. Referral from outreach into HIV and STI testing
2. Referral from HIV and STI testing into HIV treatment and care and other health services

The program should develop clear guidelines for referral procedures and train all staff on how to refer individuals for these services. Several key population programs have developed methods for tracking these referrals. (Please refer to Section 5 for more information on assessing the quality of these referral points.) See the following example from a program in Ghana to learn how they refer individuals for additional services and track these referrals.

EXAMPLE OF REFERRAL PROCESS AND TRACKING

Ghana – SHARPER

The Ghana – SHARPER program uses official referral slips (**Tool #9C**) that are filled out each time a peer outreach worker refers an enrolled individual for any service. Note that the only identifier on the referral slip is the UIC for the key population individual.

Referral from outreach to HIV and STI testing

1. When initiating a referral from outreach to HIV and STI testing, the peer outreach worker writes all necessary information on the Referral Slip (see the example of a referral slip in Annexure III, Tool #9C) and indicates which services the client has been referred to.
2. The peer outreach worker then gives the form to the client and the peer outreach worker keeps a carbon copy for the program's records.
3. The client then takes the completed referral slip to the referral service facility (e.g., HIV testing center).
4. After the client has received all services, program staff go to each referral clinic or facility periodically to retrieve all of the referral forms.
5. The clinic releases and signs the referral forms back to the program.
6. If the UIC on the paper form released by the clinic matches a UIC on a carbon copy form held by the program, this indicates that the referral from outreach into testing services was successful.
7. If a UIC on a paper form released by the clinic does not match the UIC on a carbon copy form held by the program, this indicates that the referral was not complete.
8. The number of total referrals given by peer outreach workers and the total number of successful referrals are recorded in the site monitoring system. For example, peer outreach workers made 100 referrals during a month, and 85 individuals actually went to the facility for services, which equals an 85% success rate for referrals.

Referral from HIV and STI testing into treatment, care, and support

1. If a client tests positive for HIV or other STIs, then the clinic fills out a referral form to refer the client into testing and care.
2. The clinic submits the carbon copy to the program while giving the paper copy of the referral form to the client.
3. The client then takes the paper copy of the referral form to the ART, treatment, and care facility.
4. After the client has been enrolled in long-term treatment and care, program staff will visit each clinic or facility periodically to retrieve all referral forms.
5. If the UIC on the paper form released by the clinic matches a UIC on a carbon copy form held by the program, this indicates that the referral from testing services into treatment, care, and support was successful.
6. If a UIC on a paper form released by the clinic does not match the UIC on a carbon copy form held by the program, this indicates the referral was not complete.
7. The number of total referrals given by the clinics and the total number of successful referrals into treatment and care are recorded in the site monitoring system.

4.5.2 Key population registration at clinics

It is important that each key population individual who enters the clinic be enrolled in the clinic with specific health and risk assessment indicators so that s/he receives appropriate services based on the diagnosis. Please refer to Annexure III to see examples of the following registration forms for specific key populations (due to the length of the forms, they are not shown here):

- **Tool #9A: MSM/TG Clinic Enrollment Form**
- **Tool #9B: FSW Clinic Enrollment Form**

4.5.3 Provision of high-quality clinical services

Each program should take steps to ensure that key populations receive quality testing, treatment, and care services. The following services are the minimum that a program should offer within the program site area:

Testing

- HIV testing and screening
- STI (gonorrhea, chlamydia, syphilis) testing and screening

Treatment and care

- Corresponding treatments for persons that have tested positive for STIs
- Antiretroviral treatment (or referral into antiretroviral treatment) for individuals that test HIV-positive and are eligible for ART
- Clinical and community care for pre-ART people living with HIV (PLHIV)
- Counseling
  - Given before and after testing
  - Given before enrolling into treatment and continuously throughout treatment
- ART adherence support

However, these are the minimum services that a program should provide — a more comprehensive package is ideal for key populations if available. These testing, treatment, and care services are critical services, which the program should monitor. The following forms show the different types of information that the program should collect on quality of services.

Please refer to Annexure III for recording all of the above-mentioned services in the following multi-page forms (not shown here due to length):

- **Tool #10: FSW/MSM Clinic Visit Form**
- **Tool #10A: KP Individual Tracking Sheet for Clinical Services**

4.5.4 Monitoring key population PLHIV key population provided with services

Once a key population individual begins receiving necessary prevention services, it is important to record and track the progress of the individual through the cascade of HIV services. The **KP PLHIV Tracking Sheet (Tool #11)** allows the program to record service data for each key population individual in one place, which provides an overall picture of the services the individual has received. The tool can be used by each spot to maintain this record. This will help ensure that each key population individual is not missing some of the vital services they should receive.

> This register supports collection of information for PEPFAR indicator CARE_NEW, CARE_CURR,CARE_COM-M,TX_NEW,TX_CURR,TX_RET, CUSTOM INDICATORS (Viral suppression and testing).

TOOL #11: KP PLHIV TRACKING SHEET

(Confidential information; To be completed by designated trained clinical staff)

							DISCLOSED STATUS		ART			CD4 DONE		VIRAL LOAD DONE		
SL. NO.	PID	UIC (PROVIDED BY ART CENTER)	TYPOLOGY	AGE	DATE OF DETECTING HIV POSITIVE	RECEIVED HIV RESULTS	YES/ NO	IF YES, TO WHOM*	DATE OF PRE-ART REGISTRATION	PLACE OF ART REGISTRATION	DATE STARTED ON ART	DATE	LEVELS	DATE	LEVELS	PEER ORW/PEER NAVIGATOR
1																
2																
3																

TOOL #11A: CASE MANAGER/PEER NAVIGATOR – INDIVIDUAL FORM

(PLHIV: MSM-TG-MSW-TGSW-FSW-PWID)

CARE_ COMM: Number of HIV-positive adults and children receiving care and support services outside of the health facility

CBO		CASE MANAGER/PEER NAVIGATOR	
LOCATION/HOTSPOT		CM/PN SIGNATURE	

								CARE AND SUPPORT SERVICES TO HIV POSITIVE KP OUTSIDE HEALTH FACILITIES								
													COMMODITY PROVISION, SPECIFY THE NUMBER/ITEM			
NO.	DATE (D/M/Y)	UIC/ ID/ NICK NAME	AGE	SEX (M/F)	KP TYPE	ON ART (YES/ NO)	PRE-ART (YES/ NO)	SUPPORT FOR RETENTION ON PRE-ART CARE & ART (YES/NO)	SUPPORT FOR ADHERENCE ON ART (YES/NO)	CLINICAL & PSYCHOSOCIAL NEEDS ASSESSMENT (YES/NO)	CLINICAL & PSYCHOSOCIAL REFERRALS (YES/NO)	REFERRAL TO HIV CARE (YES/NO)	ART REFILL (YES/NO)	MALE CONDOMS	FEMALE CONDOMS	BASIC MEDICATIONS, E.G., COTRIMOXAZOLE

4.6 MONITORING STRUCTURAL INTERVENTIONS

4.6.1 Violence prevention and response

Key populations face harassment, violence, and coercion which directly affect their condom negotiation power and their ability to practice health-seeking behaviors. Stigma and discrimination are causative and compounding factors that also affect their ability to seek help. Violence prevention efforts help to build a supportive and safer environment, leading to vulnerability reduction and safer sex practices among key populations by providing crisis support within the shortest possible time. **Tool #12: Crisis Management Register** (p.56) can be used to record any violence or crisis that has happened within the area. This data can help program managers plan advocacy and sensitization activities with various stakeholders to reduce violence and track trends in violence within the community.

TOOL #12: CRISIS MANAGEMENT REGISTER

(To be completed by staff outreach supervisor with support from peer outreach worker)

When an incident of harassment takes place for a particular KP member, give the following details:
(Use one form for each incident)

<table>
<tr><td colspan="2">1. Name of the person who experienced crisis:</td></tr>
<tr><td>2. Age:</td><td>3. Sex:</td></tr>
<tr><td>4. Program ID number:</td><td>5. Hot spot:</td></tr>
<tr><td colspan="2">6. Name of peer outreach worker:</td></tr>
<tr><td colspan="2">7. Name of staff outreach supervisor:</td></tr>
<tr><td colspan="2">8. KP affected: ☐ FSW ☐ MSM ☐ TG ☐ PWID</td></tr>
<tr><td colspan="2">9. Date of incident:</td></tr>
<tr><td colspan="2">10. Number of key population members affected in the incident:</td></tr>
<tr><td colspan="2">11. Type of incident: ☐ Harassment ☐ Physical Violence ☐ Sexual Violence ☐ Discrimination ☐ Other (Specify):</td></tr>
<tr><td colspan="2">12. A brief description of the incident (not more than 200 words):</td></tr>
<tr><td colspan="2">13. Who committed the incident? (Tick as applicable)
☐ Community pressure groups
☐ Local leaders
☐ Police
☐ Military
☐ Madams/Pimps/Bar
☐ Bar managers and owners
☐ Local gangs
☐ Fellow employee
☐ Magistrate/Judiciary
☐ Government officials
☐ General community
☐ Family members
☐ Religious groups
☐ Regular partner
☐ Clients
☐ Healthcare provider
☐ Employer
☐ Other (specify)</td></tr>
<tr><td colspan="2">14. Was the incident reported within 24 hours? Yes /No</td></tr>
<tr><td colspan="2">15. Did the individual receive post-violence care within 24 hours? Yes/No</td></tr>
<tr><td colspan="2">16. Type of post-violence service provided?
☐ Rapid HIV testing with referral to care and treatment as appropriate
☐ Post-exposure prophylaxis (PEP)
☐ STI screening and treatment
☐ Emergency contraception
☐ Psychosocial counseling
☐ Legal support
☐ Complaint registration at police station
☐ Child protection services
☐ Others (Specify)</td></tr>
<tr><td colspan="2">17. Role of project Crisis Management Team in addressing the issue (describe in 200 words):</td></tr>
<tr><td colspan="2">18. Follow-up action planned (describe in 200 words):</td></tr>
</table>

4.6.2 Advocacy with power structures

Programs should sensitize gatekeepers and stakeholders in the community while working with key populations, especially sex workers. In the short term, this creates and helps ensure opportunities for continuous access of services by key populations. Long-term benefits include the creation of an enabling environment in which key populations can access services themselves. In this manner, key populations are able to practice healthy behaviors, use health services, enjoy their fundamental rights, and access services without the stigma and discrimination associated with their identity or profession. **Tool #13: Advocacy/Sensitization Register** can be used to monitor and document a program's advocacy activities.

TOOL #13: ADVOCACY/SENSITIZATION REGISTER

(To be completed by staff outreach supervisor)

Implementing partner:		Meeting No:
1. Date:		
2. Activity held at: Hosting spot:	Location/Area:	City/Town:
3. What was the issue discussed?		
4. How was the issue identified?		
5. What was the advocacy objective? (What did you want to achieve?)		
6. Whom did you advocate with?		
☐ Community pressure groups ☐ Local leaders ☐ Police ☐ Military ☐ Madams/Pimps/Bar ☐ Bar managers and owners	☐ Local gangs ☐ Fellow employee ☐ Magistrate/Judiciary ☐ Government officials ☐ General community ☐ Family members	☐ Religious groups ☐ Regular partner ☐ Clients ☐ Healthcare provider ☐ Employer ☐ Other (specify)
7. Number of participants:		
8. Who are the other partners/allies you involved in the activity?		
9. What methods did you use? (e.g., lecture/presentation, individual meeting, group meeting, health services, exhibitions, street plays, other)		
10. What difficulties did you face in addressing the issue?		

11. Follow-up action after the activity:

FOLLOW-UP ACTION POINTS	RESPONSIBLE PERSON	TIMELINE

Name of person who conducted the advocacy:

Signature: ______________________________

4.6.3 Monitoring referrals for non-medical services, including entitlements

Networking and linkages are essential components of any intervention with key populations to ensure they have access to all services they are eligible to receive, without the stigma and discrimination that often prevent them from enjoying all of their rights. These types of services include obtaining government ID and ration cards, insurance and bank accounts, and accessing schemes and entitlement programs for which they are eligible.

The program should maintain the following **Tool #14: Referral Register for Non-medical Services** to document activities in this area. These registers record the types of entitlements and linkages that key population individuals received during the current recording period and where they received them.

TOOL #14: REFERRAL REGISTER

(for non-medical services) (To be completed by staff outreach supervisor)

NAME OF INSTITUTION	PROGRAM ID NUMBER	DATE OF REFERRAL	SERVICES REFERRED FOR	CONTACT PERSON AT THE REFERRED SERVICES	RESULT OF THE REFERRAL

4.6.4 Group formation and community mobilization

Key populations should have a voice, and program activities should promote an enabling environment. This allows key populations to actively participate in the implementation of the prevention program. As a result, many key population individuals over time may become official advocates of the program to other peers. Individuals may want to become peer outreach workers, or form support groups to support each other, or form groups that fight stigma and advocate for increased rights for key populations. It is important to monitor these activities, such as the formation of groups by key populations, and to track their progress in terms of their activities supporting the intervention activities. **Tool #15: Support Group Register** and **Tool #15A: Gend_Norm – Individual Form** can help the program record these activities.

TOOL #15: SUPPORT GROUP REGISTER

(To be completed by staff outreach supervisor)

SECTION I
Group Details

1. Name of Support Group ____

2. Date of Formation of Support Group ______________________________________

SECTION II
Executive Committee of Support Group (if applicable)

Committee Effective from (date) ______ /______ /____________

1. NAME OF OFFICE BEARER	2. POSITION	3. DATE OF ELECTION AS OFFICE BEARER
	President	
	Secretary	
	Treasurer	
	Member	
	Member	

→ *Add more rows if necessary*

SECTION III
Membership Details

1. SR. NO.	2. PROGRAM ID NUMBER	3. MEMBER NAME	4. AGE	5. SEX	6. TYPE OF KP	7. DATE AND YEAR OF JOINING	8. DATE AND YEAR OF DROP OUT

→ *Add more rows if necessary*

SECTION IV
Minutes of the Meetings Held by the Support Group

Attendance Summary

1. SR. NO.	2. PROGRAM ID NUMBER	3. MEMBER NAME	4. AGE	5. SEX	6. TYPE OF KP	7. DATE OF MEETING	8. SIGNATURE

→ *Add more rows if necessary*

MINUTES OF THE MEETING REGISTER

<table>
<tr><td>1. Date of meeting</td><td></td></tr>
<tr><td>2. Hot spot/place</td><td></td></tr>
<tr><td>3. Meeting no.</td><td></td></tr>
<tr><td>4. Time of the meeting</td><td>Start time:
End time:
Total hours:</td></tr>
<tr><td>5. Number of members attending the meeting</td><td></td></tr>
<tr><td colspan="2">6. Summary of topics discussed/activities

Gender Norms:
1. Understand and question existing gender norms
2. Impact of gender norms on lives of key population
3. Link between the gender norms and HIV prevention, treatment, care or support
4. Norms that encourage violence and stigma against KPs
5. Others, specify

Care and Support for PLHIV:
1. Support for retention for pre-ART and ART clients
2. Adherence support if on treatment
3. Basic client assessments with documentation of clinical and psychosocial needs and linkage/referral to other services as appropriate
4. Referral and linkage to health facilities providing comprehensive HIV care
5. Distribution of commodities such as condoms, refill of ART or basic medications such as cotrimoxazole
6. Others, specify</td></tr>
<tr><td colspan="2">7. Curriculum used:

Linkages curriculum
Stepping Stones
Yaari Dosti
Programme H
Tuelimishane
One Man Can
Men as Partners
Others (specify)</td></tr>
<tr><td colspan="2">8. How was the session facilitated, including methodology?</td></tr>
<tr><td colspan="2">9. Outcome or decisions in the meeting:</td></tr>
</table>

TOOL #15A: GEND_NORM – INDIVIDUAL FORM

(MSM-TG-MSW-TGSW-FSW-PWID)
(Compiled from Tool #15)

CBO		REPORTING PERSON	
LOCATION/HOTSPOT		PEER OUTREACH WORKER SIGNATURE	

No	Date (D/M/Y)	UIC/ID/ Nick Name	Age	Sex (M/F)	KP Type	SESSION TYPE		MINIMUM CRITERIA FOR INTERVENTIONS COMPONENTS COMPLETED		
						One on One	Small Group	Use participatory methodology to support understanding and questioning of existing gender norms & reflection on the impact of norms on the lives of KP? (Yes/No)	Make a link between gender norms discussed & HIV/AIDS prevention, care, and support and treatment outcomes (e.g., norms that encourage violence and stigma against KP)? (Yes/No)	Completed minimum of 10 hours intervention? (Yes/No)

5. Periodic Outcome and Quality Monitoring

HIV prevention programs set goals to reduce HIV incidence and prevalence and STI prevalence among key populations. Behavior outcomes should be measured on a regular basis to monitor if the programs are effective and being implemented in an appropriate way.

5.1 POLLING BOOTH SURVEY

Large-scale surveys help in understanding changes in behavior, but they require extended time and significant resources, which are limited in most HIV programs. In addition, because face-to-face interviews and analyses take significant time, the outcomes of such surveys are often too late to be useful in assessing program outcomes and refine the interventions. Furthermore, responses to questions in face-to-face interviews about personal and intimate behaviors are frequently influenced by social desirability bias (i.e., giving answers that the respondent thinks will be viewed favorably by others), which tends to distort the results.

The polling booth survey is a rapid, simple, and easy to administer approach to gather behavioral outcomes on a routine basis. It is also a more suitable method to collect information on an individual's sexual health in a confidential and anonymous manner. Unlike a survey or in-depth interview or focus group discussion, the responses to questions in a polling booth survey are unlinked (an individual respondent is not linked to the response), so the respondent remains anonymous. The method thus increases the sense of confidentiality among the respondents which may reduce the biases in reporting sensitive and personal information.

Broad information areas queried in polling booth surveys

The questions in polling booth surveys usually cover the following 10 aspects of behavior:

1. Condom use in the last sexual intercourse with:
    a. Clients (paying, new, or occasional clients)
    b. Regular clients (paying regular clients)
    c. Lovers (non-paying lovers, who do not live together)
    d. Husbands or co-habiting partner (non-paying, spouse or live-in partner)
2. Sex without condom
3. Condom breakage
4. Barriers for condom use
    a. Partner's choice
    b. Influence of alcohol
    c. Non-availability of condoms
    d. More money for sex without condoms
5. Anal sex
6. Risk perception
7. Experience of violence
8. HIV testing
9. Knowledge on ART
10. Experience of sexual violence in the past one year

Materials required

The following materials are required to conduct polling booth surveys. These should be arranged in advance of the survey:

- Cardboard or privacy dividers to establish the polling booth set-up
- Colored boxes (three types of boxes are used: for example, green, red, and white)
- Stack of cards (each card has a serial number corresponding to a survey question — one card for each question and one stack of cards for each participant)
- A room big enough to seat participants so that their responses to questions cannot be seen by other participants
- A nearby venue (participants, particularly key populations, often refuse to travel long distances from their place of solicitation/recruitment)

Method

- A homogenous group of about 8-15 randomly selected participants are brought to the selected polling booth venue (a large room or space).
- Participants are separated from each other in a polling booth environment, by cardboard or other privacy dividers.
- Each participant is given three boxes (red, green, and white) and a stack of cards.
- Each participant receives a stack of cards, stacked in serial order corresponding to the question numbers.
- The facilitator/researcher/moderator reads the questions aloud one by one.
- A card with the number corresponding to the question asked is put into the green box if the response to the question is YES.
- A card is put into the red box if the response is NO.
- A card is put into the white box if the question is NOT APPLICABLE.
- A card is kept outside these boxes if the participant does not want to respond to that question.

FIGURE 8: Polling Booth Survey Set-up

FIGURE 9: An Example of a Polling Booth Session

Sampling of respondents

The number of polling booth survey sessions in each domain (district/city/town) is determined considering the sample size required and the average number of participants per session. If sub-regions are included in the selected domain, the sample size may be proportionately allocated based on the estimated/contacted number of key population individuals in the sub-regions.

Various approaches can be used to recruit 8-15 respondents for each polling booth survey session. A list of individuals exposed to the intervention often exists with the implementing agency and can be used as a sampling frame. Consider the number of potential non-responses and boost the sample size to accommodate it. It is recommended that 10-15% more key population individuals be selected from the list after stratifying them based on characteristic (age/typology, etc.) and organize them into different lots of equal size so that each lot can be a group of participants for each polling booth session. Once they are organized for each session, share the list with the research team/implementing agency to mobilize them for the respective polling booth session.

Frequency of polling booth surveys

Behaviors often do not change in a very short period; therefore, polling booth surveys are recommended at a reasonable interval, such as once a year.

Survey domain/coverage

The domain for the survey is defined considering the level at which the behaviors are monitored. The smaller the domain, the better the design since the behaviors can be monitored for smaller geographic units. Usually, a district/town can be considered as a domain, and sample sizes are calculated to provide outcomes at a desired power and confidence.

Analysis

At the end of each polling booth session, the responses to each question are tabulated based on the total number of cards that are found in the red, green, and white boxes. The number of participants who responded YES, NO to each question is recorded on the polling booth survey form. The non-responses (those cards kept outside boxes) as well as the NOT APPLICABLE responses are also tabulated on the same form.

The tabulated data are entered on the computer to conduct analysis (usually Microsoft Excel or Access) to assess behaviors.

5.2 PEER COMMUNICATION QUALITY ASSESSMENT

The objective of this tool is to assess and improve the quality of communication sessions between peer outreach workers and peers. To ensure the quality of communication sessions, the staff outreach supervisor can use **Tool #16: Tool for Assessment of Communication by Peer Outreach Worker** on a regular basis to identify gaps and develop plans for capacity building.

This tool measures the quality of communication sessions in several specific areas and provides information on areas of communication that need improvement. It also measures how well peer outreach workers communicate with their peers. In a mature project, this tool is used on a quarterly basis by staff outreach supervisors for the peer outreach workers under their supervision.

This is a participatory tool with scores filled in, in consultation with the peer outreach worker, which generates supportive feedback towards improving outreach. The tool obtains information on five specific areas:

- **GREETING, RAPPORT, AND GROUND-BUILDING:** In a quality communication session, the peer outreach worker welcomes and introduces him/herself to the key population individual, builds rapport with them, and creates a ground for dialogue. It is important not to underestimate the significance of finding a reasonably appropriate space and time to conduct the session, and use appropriate language to ensure retention and proper understanding.
- **TWO-WAY COMMUNICATION/ENSURING UNDERSTANDING:** In a quality communication session, the peer outreach worker must actively listen to the individual's concerns using appropriate methods, while ensuring two-way communication for risk identification and risk reduction of STIs and HIV, and partner treatment.
- **NON-JUDGMENTAL ATTITUDE:** For a good communication session, the peer outreach worker must show empathy and be non-judgmental towards the individual's lifestyle and sexual practices.
- **CONCLUSION/THANKS/NEXT VISIT:** To ensure understanding, at the end of the session the peer outreach worker should conclude the session by summarizing the key messages communicated, thanking the key population individual for his/her time, and setting a date and place for the next session.
- **RECORD-KEEPING:** The last step in the process of conducting a good communication session is to record information from the session accurately on the appropriate forms.

The results are collated and analyzed and shared with the peer outreach worker to evaluate his/her performance as well as overall program performance. This analysis can reveal improvement trends with individual outreach workers as well as at the organizational level.

To collect information for this form, the staff outreach supervisor should observe the peer outreach worker while s/he is conducting a communication session with a peer. The staff outreach supervisor should observe the following points and rank him/her on a 0-5 scale (0 - Not Done, 1 - Needs Improvement, 2 - Average, 3 - Good, 4 - Very good 5 - Excellent).

TOOL #16: TOOL FOR ASSESSMENT OF COMMUNICAITON BY PEER OUTREACH WORKERS

(One-to-one, one-to-group, group meeting)

Date: ____________________ Implementing Partner: ____________________

Hotspot: ____________________ Name of Peer Outreach Worker: ____________________

SR. NO.	QUALITY INDICATORS	SCORE (0-5)	OBSERVATIONS/REMARKS
A	**Greeting, Rapport, & Ground Building**		
1	Peer outreach worker greets the KP(s) with a smile and displays a pleasant and friendly attitude through appropriate body language.		
2	Peer outreach worker displays rapport with the KP(s) and builds the ground appropriately before beginning the session.		
3	Peer outreach worker finds a reasonably appropriate space to carry out the session.		
4	Peer outreach worker has chosen a time convenient to KP(s) to conduct the session.		
5	Peer outreach worker ensures proper visibility and audibility while conducting the session.		
6	Peer outreach worker uses appropriate language with the KP(s) to gain their attention and understanding.		
B	**Two-way Communication/Ensuring Understanding**		
1	Peer outreach worker asks appropriate open-ended and probing questions to KP(s), to establish a dialogue and gain their involvement.		
2	Peer outreach worker encourages KP(s) to speak – ask questions, share opinions – to ensure their understanding and gives enough time for them to respond.		
3	Peer outreach worker actively listens to KP(s) and allows appropriate silence for the KP to speak.		
4	Peer outreach worker is able to facilitate the session in a manner and tone of voice that sustains the interest of KP(s).		
C	**Non-Judgmental Attitude**		
1	Peer outreach worker is non-judgmental towards KP(s)' lifestyle and sexual practices.		
2	Peer outreach worker shows empathy with KP(s)' situation/expression of feelings.		
D	**Conclusion/Thanks/Next Visit**		
1	Peer outreach worker summarizes the session by briefly emphasizing the learning drawn from the material in question.		
2	Peer outreach worker concludes by fixing a date, time, place for the next session and thanks the KP(s) before leaving.		
E	**Record Keeping**		
1	Peer outreach worker records the session and method used as per the prescribed MIS formats.		

5.3 SERVICE QUALITY ASSESSMENT TOOL FOR REFERRAL SERVICE POINTS

When referring key population individuals for services, it is important that those services are delivered in a quality and friendly manner. Program managers can take the following steps to ensure the services are friendly and high quality:

- Conduct continuous advocacy with the manager of the service facility
- Orient and sensitize the staff of the service facility about the needs of key populations
- Assess the quality of services provided at the center at a regular interval

Tool #17: Assessment of Referral Service Point can be used to collect basic information from the referral facility to gauge the quality of services that key population members receive when referred to the facility. This should be repeated once every six months.

TOOL #17: ASSESSMENT OF REFERRAL SERVICE POINT

SR. NO.	OBSERVATION	YES	NO	NOTES
1	Qualified doctor in position			
2	Doctor trained on ARV, STI, Syndromic Case Management (SCM) according to standards country guidelines			
3	Nurse in position			
4	Nurse trained on job responsibility			
5	Counselor in position			
6	Counselor trained on counseling			
7	Staff are approachable, friendly, and non-judgmental			
8	Adequate history-taking and proper clinical examination conducted at the facility			
9	Supervised treatment is provided			
10	Staff explain compliance, condoms, contact tracing, and follow-up			
11	Staff explain drug compliance with respect to ARV, STIs after consultation			
12	Staff maintain confidentiality and proper documentation of client records			
13	Staff explain informed choice for HIV testing (explain benefit and risk of HIV testing)			
	Score = Total no. of (Yes) /13			

6. Using Monitoring Data for Decision-making

This guide has shown how to collect data and establish a monitoring system that provides data on the number of key population individuals being served and the types and quality of the services and commodities they receive from the program. Analyzing these monitoring data enables program staff and peer outreach workers to determine how well the program is performing and how to improve the program.

This section divides analysis of the monitoring data into two levels. The first level of analysis is performed at the spot or micro-level, where peer outreach workers (with the help of staff outreach supervisors) can see how well they are reaching their peers with outreach services and use this data to plan their upcoming outreach activities (e.g., which peers they didn't see last month, which peers are due for HIV testing, how many peers they referred to testing or treatment last month, etc.). The second level of analysis is at the macro level — at the site, regional, or national level — to see how well the program is performing and where improvements are needed.

6.1 USE OF MONITORING DATA AT THE MICRO-LEVEL BY PEER OUTREACH WORKERS

There is always a feeling that "a lot of people" are being reached by the program and that peer outreach workers are working hard at reaching out to people. But how do you define what a "lot" of people is? And how do you know for sure?

For example:

- Program site A reached out to 10,000 key population individuals last month.
- Program site B reached out to 500 key population individuals last month.

Which program do you think performed better? 10,000 people certainly is a lot more than 500. But what if:

- Program site A has 50,000 key population individuals that could be reached by the program.
- Program site B has 500 key population individuals that could be reached by the program.

When the concept of denominator is considered, the complete answer of who is performing better is different. By using percentages, the program can better assess the question: *we are reaching out to a lot of people, but are we reaching out to everyone we possibly can?* In the example above, site B reached out to 100% of the target population, while site A reached out to only 20%. Using the population size estimates in your program site region is a powerful way to determine if the program is reaching out to everyone that it can.

Now suppose that the program has collected data as a part of monitoring by peer outreach workers on some basic indicators. The following grid explains how the collected data at the site level could be analyzed.

SL. NO.	SPOTS/ HOTSPOTS	TYPE OF KP	PEER OUTREACH WORKER'S NAME	TOTAL KP REGISTERED	COMMUNICA-TION SESSION (1-1, 1-G)	REFERRAL FOR HEALTH SERVICES						RECEIVED COMMODITIES (NO. AND TYPE OF CONDOM)			ANY CRISIS INCIDENTS FACED	CRISIS INCIDENTS ADDRESSED
						STI	HIV TESTING	ART	FP	TB	OTHERS*	CONDOMS	FEMALE CONDOMS	LUBE		
1	A	FSW	AA	35	30	5	5	1	1	1		1000	50		5	5
2	B	FSW	AB	22	20	4	8	5	4			550	60		1	
3	C	FSW	AC	45	35	20	12	3				1500	5		2	2
4	D	FSW	AD	40	30	10	15	2	7			2000	4		5	5
5	E	FSW	AF	20	12	7	10	1		4		500			1	1
6	F	FSW	AG	25	22	3	5	6				700			6	1
7	G	FSW	AH	50	34	4	8	4	5	3		1500	100		10	4
			TOTAL	**237**	**183**	**53**	**63**	**22**	**17**	**8**	**0**	**7750**	**219**	**0**	**30**	**18**

SL. NO.	SPOTS/ HOTSPOTS	TYPE OF KP	PEER OUTREACH WORKER'S NAME	TOTAL KP REGISTERED	COMMUNICA-TION SESSION (1-1, 1-G)	REFERRAL FOR HEALTH SERVICES						RECEIVED COMMODITIES (NO. AND TYPE OF CONDOM)			ANY CRISIS INCIDENTS FACED	CRISIS INCIDENTS ADDRESSED
						STI	HIV TESTING	ART	FP	TB	OTHERS*	CONDOMS	FEMALE CONDOMS	LUBE		
1	A	FSW	AA	35	86%	14%	14%	3%	3%	3%		1000	50		14%	100%
2	B	FSW	AB	22	91%	18%	36%	23%	18%	0%		550	60		5%	0%
3	C	FSW	AC	45	78%	44%	27%	7%	0%	0%		1500	5		4%	100%
4	D	FSW	AD	40	75%	25%	38%	5%	18%	0%		2000	4		13%	100%
5	E	FSW	AF	20	60%	35%	50%	5%	0%	20%		500			5%	100%
6	F	FSW	AG	25	88%	12%	20%	24%	0%	0%		700			24%	17%
7	G	FSW	AH	50	68%	8%	16%	8%	10%	6%		1500	100		20%	40%
			TOTAL	**237**	**77%**	**22%**	**27%**	**9%**	**7%**	**3%**	**0**	**7750**	**219**	**0**	**13%**	**60%**

The above example shows how to track the performance of the peer outreach workers with respect to some important indicators that could affect the whole program. In the above grid, "**Site A**" performance is low in many indicators (highlighted in green) that should be improved. Some sites may have specific problems, such "**Site G**", which screened only 8% of its registered key population individuals for STIs, which is well below the expected mark.

This level of analysis provides intelligence at the field level to outreach workers to understand and fix problems in the field. This will in turn help to achieve rapid scale-up goals. This also provides an opportunity to identify sites where there are serious problems in implementing the program, especially if there is a continuous pattern over a long period of time.

6.2 USE OF MONITORING DATA AT THE PROGRAM MANAGEMENT LEVEL

It is important for the program manager and the senior management team to have a macro-level analysis of the program. A dashboard is an important tool for tracking progress towards program objectives. It displays key indicators showing progress of activities in various domains of the project. This helps program managers to strategize and modify activities if needed.

The dashboard can be divided into two sections. Section I can be used for management purposes, as shown below:

DASHBOARD INDICATORS	CALCULATION	EXPECTED LEVELS
Staff outreach supervisor to peer outreach worker ratio	Total peer outreach workers/Total staff outreach supervisors	5:1
Peer outreach worker to peer ratio	No. of key population individuals registered/ no. of peer outreach workers in the program	50:1
Proportion of staff posts filled/vacant	No. of staff/total staff to be appointed	100%
Proportion of staff trained in prescribed training curriculum	No. of trained staff/total number of staff	100%
Number of drop-in centers established compared to plan		Yes
Number of project-owned health facilities opened compared to plan		Yes
Number of services linked with prevention and care services compared to plan		Yes

The second section of the dashboard can be for program monitoring, such as the following example:

(Refer to Annexure I for calculation and source data)

INDICATORS	EXPECTED LEVELS	LEVEL OF ANALYSIS
Program Coverage		
Proportion of key population individuals registered (cumulative) in the intervention through outreach compared to estimated key population	90-100%	Hotspot Level, Partner Level & Program Level
Proportion of key population individuals receiving outreach regularly for HIV services every three months	80-90%	Hotspot Level, Partner Level & Program Level
HIV Testing by KPs		
Proportion of KPs tested and received results for HIV	>90%	Hotspot Level, Partner Level & Program Level
HIV CARE for KPs		
Proportion of KPs who are HIV positive that are registered for care	>90%	Hotspot Level, Partner Level & Program Level
Proportion of KPs who are on ARV out of those registered for care	>90%	Hotspot Level, Partner Level & Program Level
Advocacy and Gender-Based Violence among KPs		
Number of KPs who faced violence last month	Monthly trend to be monitored	Hotspot Level, Partner Level & Program Level
Proportion of violence cases that were addressed within 24 hours	>90%	Hotspot Level, Partner Level & Program Level
Mean number of participants per advocacy workshop and meetings with key stakeholders	25-30	Hotspot Level & Program Level

In addition to this, program managers are encouraged to refer to relevant survey reports that are available within the areas as well as at the national level. The information will be an additional support beyond what is being collected as a part of program activities.

Annexures

ANNEXURE I: Calculation of Dashboard Indicators for Monitoring the Program

ANNEXURE II: Data Sources for Core PEPFAR Indicators

ANNEXURE III: Monitoring Tools and Instructions

ANNEXURE IV: Example of a Scope of Work for Validating and Estimating Number of Key Population Individuals at the Spot Level

ANNEXURE I

Calculation of Dashboard Indicators for Monitoring the Program

INDICATORS	NUMERATOR	DENOMINATOR	EXPECTED LEVELS	PM TOOL #	LEVEL OF ANALYSIS
PROGRAM COVERAGE					
Proportion of key population individuals registered (cumulative) in the intervention through outreach compared to estimated key population	Total registered in the program (till date)	Total estimated key population individuals (mapped)	90-100%	Numerator - 6C/6D Denominator – 1A/1B	Hotspot level, Partner Level & Program Level
Proportion of key population individuals receiving outreach regularly for HIV services	Total key population individuals met regularly for HIV services (PEPFAR defn)	Total registered and Active as of today	80-90%	Numerator – 7B Denominator - 6C/6D	Hotspot level, Partner Level & Program Level
HIV TESTING BY KEY POPULATION INDIVIDUALS					
Proportion of key population tested and received results for HIV	Total key population individuals tested for HIV in last three month and received results	Total registered and Active as of today	>90%	Numerator - 10A Denominator - 6C/6D	Hotspot level, Partner Level & Program Level
HIV CARE FOR KEY POPULATION INDIVIDUALS					
Proportion of key population individuals who are HIV positive and are registered for care	Total number of key population individuals who are registered for care	Total number of key population individuals tested positive and received results	>90%	Numerator - 11 Denominator - 10A	Hotspot level, Partner Level & Program Level
Proportion of key population individuals who are on ARV out of those registered for care	Number of key population individuals who are on ART	Total number of key population individuals who are registered for care	>90%	Numerator - 11 Denominator - 11	Hotspot level, Partner Level & Program Level
ADVOCACY AND GENDER BASED VIOLENCE AMONG KEY POPULATION INDIVIDUALS					
Number of key population individuals who faced violence last month			Monthly trend to be monitored	7B, 10A, 12	Hotspot level, Partner Level & Program Level
Proportion of Violence cases that were addressed within 24 hours	Number of key population individuals who received GBV care within 24 hours last month	Number of key population individuals who faced violence last month	>90%	Numerator – 7B, 10A Denominator – 7B,10A	Hotspot level, Partner Level & Program Level
Mean number of participants per advocacy workshop and meetings with key stakeholders	Total number of participants	Total number of advocacy meetings	25-30	13	Hotspot level & Program Level

ANNEXURE II

Data Sources for Core PEPFAR Indicators

PEPFAR OR CUSTOM INDICATOR	INDICTOR DESCRIPTION	MONITORING TOOL #	
		N	D
	REACH KEY POPULATIONS		
KP_PREV	Number of KPs reached with individual and/or small group level HIV preventive interventions	7B	
KP_PREV	Percentage of key populations reached with individual and/or small group-level HIV preventive interventions that are based on evidence and meet the minimum standards required	7B	
KP_PREV	Number of KPs reached with individual and/or small group level HIV preventive interventions	7B	
FPINT_SITE	Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services		
GEND_GBV	Number of people receiving post-Gender Based Violence (GBV) clinical services minimum package	7B & 10	
	TEST KEY POPULATIONS		
HTC_TST	Number of KPs who received HTC services and received their test results	10 & 10A	
Custom Indicator	Proportion of KPs tested for HIV among those reached	10A	1A/1B or 6C/6D*
	DIAGNOSE PLHIV & ENROLL IN CARE		
CARE_NEW	Number of HIV positive KPs newly enrolled in clinical care who received clinical assessment (WHO staging)/CD4 count/viral load at enrolment	11	
CARE_CURR	Number of HIV positive KPs who received clinical assessment (WHO staging)/CD4 count/viral load	11	
CARE_COMM	Number of HIV positive KPs receiving care and support outside of the health facility	11A	
CARE_SITE	Percentage of PEPFAR-supported clinical care sites at which at least 80% of PLHIV received 1) clinical assessment (WHO staging)/CD4 count/viral load, AND 2) TB screening, AND 3) if eligible, cotrimoxazole		
Custom Indicator	Proportion of KPs with HIV currently enrolled in care among those who tested positive	11	10A
	INITIATE ART		
TX_NEW	Number of KPs newly enrolled on ART	11	
	SUSTAIN ON ART		
TX_CURR	Number of KPs currently receiving ART	11	
TX_PVLS	Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/ml)	11	11^
TX_RET	Percentage of KPs with HIV known to be alive and on treatment 12 months after ART initiation	11	

N=numerator D=denominator

* Use Tool 1A/1B if denominator is the overall estimated population of KP members; otherwise use Tool 6C/6D (total KP members registered in the program)

^ Both numerator and denominator are taken from the same register

ANNEXURE III

Monitoring Toolkits and Instructions

TOOL 1: HOTSPOT VALIDATION FORM

Name of NGO/CSO/IA: ____________________				Name of Peer Outreach Worker: ____________________	
Name of hotspot				Hotspot Type*	
Hotspot code				Location	
Department				Commune	
Type of KP	1=FSW, 2=MSM, 3=TG, 4=PWID			Respondent	1=KP, 2=Others, 3=None
Nature of hotspot	1=Active, 2=Inactive				
Date of visit 1 (DD/MM/YY):____ /_____ /________				Date of visit 2 (DD/MM/YY) :____ /_____ /________	

Sl No	SPOT PROFILE	
1	On a usual/typical day, how many KPs work at/visit this hotspot?	Min ☐☐☐ Max ☐☐☐
2	At this hotspot, what time of the day do we find the maximum number of KPs (peak time)? **CIRCLE AS APPLICABLE**	MORNING .... A AFTERNOON .... B EVENING .... C NIGHT .... D ALL 24 hrs .... E
3	At this spot, on which day/s of the week is the number of KPs greater than usual (peak day)? **CIRCLE AS APPLICABLE**	MONDAY .... A TUESDAY .... B WEDNESDAY .... C THURSDAY .... D FRIDAY .... E SATURDAY .... F SUNDAY .... G
4	On a peak day of the week/month, how many KPs work at/visit this hotspot (min – max)?	Low ☐☐☐ High ☐☐☐

Sl No	INFORMATION ON OTHER SPOTS	
5	Do you know any other place like this in this city/village/commune, where KPs work/visit?	Yes ☐ No ☐
S.N	**HOTSPOT NAME/ADDRESS**	**CONTACT**
A		
B		
C		
D		
E		

*__Codes__ for type of hotspot: 1=Bar with lodging, 2= Bar without lodging, 3=Sex den/Brothel, 4=Strip club, 5=Streets/Highways, 6=Home, 7=Casino, 8=Beach, 9=Guest house/Rest house/Hotels/Lodgings, 10=Massage parlor, 11=Parks, 12=Beer tovern, 13=Public toilet, 14=Others______________(Specify)

NAME OF THE TOOL	TOOL 1: HOTSPOT VALIDATION FORM
Who should complete	Peer Outreach Workers
When to complete	While validating the existing/mapped/newly identified hotspot
How often to complete	Periodically (Beginning of every year)

DESCRIPTION TO COMPLETE COLUMNS

TOOL 1: HOTSPOT VALIDATION FORM is used to validate the hotspots identified through programmatic mapping/available.

In each listed spot, a hotspot validation form is filled in, either by interviewing a PRIMARY KEY INFORMANT (KP) or a SECONDARY KEY INFORMANT (someone at the spot who is familiar with it). If a listed spot is not identified or is a duplicate of one of the spots already listed, the first part of the form (IDENTIFICATION) is filled in, providing the reason as INACTIVE or DUPLICATE respectively.

The first part of the form, IDENTIFICATION DETAILS, is used to identify each hotspot by its geographic location.

NAME OF NGO/CSO/IA: Name the program implementing NGO/CSO/implementing agency.

NAME OF PEER OUTREACH WORKER: Write the name of the Peer Outreach Worker who validates the hotspot. If any of the peer outreach workers are from the hotspot or from the locality, they should be assigned to validate the hotspot.

NAME OF HOTSPOT: Write the name of the hotspot and its address clearly, which is being validated. A hotspot is a structure or place where one or more KPs solicit their clients and/or engage in risk behavior.

HOTSPOT TYPE: Write the type of the hotspot here. Use only the code given in the format (as given below). For example, if the hotspot is a bar with lodging, code “1”, if it is a bar without lodging, code “2”, for sex den/brothel code “3”, etc. The different type of spot as defined by the country is used. For an example, the following are the list of hotspots; 1=Bar with lodging, 2=Bar without lodging, 3=Sex den/Brothel, 4=Strip club, 5=Streets/Highways, 6=Home, 7=Casino, 8=Beach, 9=Guest house/Rest house/Hotels/Lodgings, 10=Massage parlor, 11= Parks, 12=Beer tavern, 13=Public toilet, 14=Others.

HOTSPOT CODE: Use a unique hotspot code. Usually, this is unique at the NGO/CSO/IA level. The code should be taken from the original hotspot list (Tool 1A). If a new spot is identified during validation, use a new code beyond those already assigned to the hotspots. The Program Manager and M&E manager/officer of NGO/CSO/IA assign the unique codes.

LOCATION: Write the location of the hotspot. The location is a broad area where the hotspot is located and easily can be identified.

DEPARTMENT: Write the name of the department/district.

COMMUNE/PROVINCE/STATE: Write the name of the commune/province/state.

TYPE OF KP: Write the type of KPs soliciting/engaging in risk in the hotspot. If it is referred as a FSW spot in the hotpot list, use code 1, if MSM use code 2, if TG use code 3 and if PWID use code 4. Use one form for each type of KP. If different types of KP are engaging in risk behaviors at the spot, use additional hotspot validation forms for each KP type.

RESPONDENT: Write who the respondent was for the validation. If one or more KPs are interviewed in the spot to validate, use code 1, if anyone else other than KPs are interviewed, use code 2. If no one is interviewed, use code 3.

NATURE OF HOTSPOT: This field is filled in at the end of the validation. If KPs are engaging in risk behaviors at the hotspot as given by the respondent/s, use code 1 (active spot). If no KPs are engaging in risk behaviors at the spot as reported by the respondent/s, use code 2 (inactive spot).

DATE OF VISIT 1: Write the date of validation. Visit to the spot for the first time to validate is referred here. Use a standard format, DD/MM/YYYY.

DATE OF VISIT 2: Write the date of second visit made to the spot to validate, if made. This is usually used if during the first visit the peer outreach worker could not identify a KP or others to interview and validate the spot: a second visit is made and the date is recorded here in the same format (DD/MM/YYYY). Sometimes, the peer outreach worker may need to make more than 2 visits; if more visits are made, record the last visit date here.

Spot Profile

SL NO 1: On a usual day, how many KP work at /visit this hotspot? This question records the number of KPs visiting the spot on an average or usual day. An average or usual day refers to a day when not the maximum number of KPs visit the spot, but those who regularly come and engage in risk behaviors. TWO boxes, corresponding to LOW and HIGH, are given to record the range of low and high numbers visiting the spot on the usual day, if the respondent gives a range. If the respondent knows the exact number of KPs visiting the spot, record the same number in both LOW and HIGH boxes. If the respondent gives a range, e.g., 10 to 12, record 10 as the LOW and 12 as the HIGH.

SL NO. 2: At this hotspot, what time of the day do we find the maximum number of KPs (Peak Time)? Circle the time when the greatest number of KPs visit the spot on a typical day. There may be more than one peak time, in which case circle all relevant codes.

SL NO 3: At this spot, on which day/s of the week is the number of KPs is more than usual (Peak Day)? Ask the respondent what is the peak day in a week. Peak day refers to a day when a higher number of KPs visit than on other days. A spot may receive the greatest number of KPs on more than one day in a week, in which case, CIRCLE all applicable days. For example, if Saturdays and Sundays are the days on which the greatest number of KPs visit the spot, circle G and A. If the peak day is only one day, circle the corresponding code of the day.

SL NO 4: On a peak day of the week/month, how many KPs work at/visit this hotspot (min – max)? This question is to understand the estimated number of KPs who visit the spot and engage in risk behavior/seek partners or inject drugs on a peak day. For example, if in Q3 the peak day is SATURDAY, Q4 refers to the number of KPs who visit the spot on SATURDAY. Record the range as reported by the respondent. If the respondent knows the exact number of KPs visiting the spot, record the same number in both LOW and HIGH boxes. If the respondent gives a range, e.g. 12 to 15, record 12 as the LOW and 15 as the HIGH.

Information on Other Spots

The information in the grid is to identify a new spot, if any is missed in the mapping data or a new spot has emerged since the list was developed.

SL NO 5: Do you know any other hotspot like this in this city/town/village/ commune, where KPs work/solicit visit? Ask the respondent/s if they know any other spot than the one where they are interviewed. If they know any other spots, CHECK the box, "Yes", otherwise check "No" and thank the respondent.

If the respondent knows any other spot within the city/town/village of interview, write all the spots the respondent knows about. Once all the spots are listed, ask if they know any contact person in the spot. Obtaining contacts in a new spot sometime help validations.

Once the validation is completed, check the name of spots reported by the respondents against the hotspot list used for validation. If the newly reported spot is listed, it is an existing/already identified spot. If the reported spot is not listed the hotspot list, add the name of the spot to the hotspot list, and visit the spot and validate it using a new "Hotspot validation form"

Tool contributing to PEPFAR indicator

denominator for KP_PREV

TOOL #1A: HOTSPOT LIST

<Implementing Partner's Name >

Month/Year: ______________________________ **Type of KP:** FSW ☐ MSM ☐ TG ☐

NAME OF HOTSPOT	HOTSPOT CODE	LOCATION	DISTRICT NAME	TYPE OF HOTSPOT*	EST. NO. (AVG.)	PEAK DAYS	PEAK TIME	PEER OUTREACH WORKER RESPONSIBLE
1	2	3	4	5	6	7	8	9

***Codes** for type of hotspot: 1=Bar with lodging, 2=Bar without lodging, 3=Sex den/Brothel, 4=Strip club, 5=Streets/Highways, 6=Home, 7=Casino, 8=Beach, 9=Guest house/Rest house/Hotels/Lodgings, 10=Massage parlor, 11=Parks, 12=Beer tovern, 13=Public toilet, 14=Others_______________(Specify)

NAME OF THE TOOL	TOOL 1A: HOTSPOT LIST
Who should complete	Program manager/M&E officer
When to complete	Prior to setting up intervention
How often to complete	First hotspot list is the programmatic mapping list. Following the validation, the list is refined, and subsequently updated following every periodic validation (beginning of every year)

DESCRIPTION TO COMPLETE COLUMNS

TOOL 1A: THE HOTSPOT LIST is used to list all of the FSW/MSM/TG hotspots. It provides a complete list of hotspots where interventions can be established. A separate hotspot list is developed for each type of KP. If the same NGO/CSO is implementing programs in multiple locations (city/town/district), a single hotspot list is developed for the implementing organization, and any sub-unit list is extracted from the comprehensive list.

The following are the criteria to develop and complete the Hotspot List.

IMPLEMENTING PARTNER: Write the name of the implementing NGO/CSO/partner at the top of the form.

MONTH/YEAR: Write the month and year in which the list is prepared. This refers to the time point when mapping/validations are carried out. This can be referred to to decide when a follow-up validation is to be carried out and a new hotspot list to be developed.

TYPE OF KP: This refers to the type of KP whose hotspots are listed. If the hotspot list is of FSWs, CHECK the box FSW, if it is MSMs CHECK MSMs, TG then CHECK TG and if it is PWID, then CHECK the box PWID. Whichever box is checked, all the hotspots on the list must refer to that type of KP. Do not mix different type of KPs in a single list.

NAME OF HOTSPOT: Write the name and address of the hotspot here. Start with name of the hotspot and then write the address. Address to be clearly written so that using the name and address the hotspot can be easily located.

HOTSPOT CODE: The code uniquely distinguishes each spot. The code should be taken from the Hotspot List (Tool 1).

LOCATION: Write the location of the hotspot. The location is written as mentioned in the hotspot validation form and is a broad area where the hotspot is located and easily can be identified

DISTRICT NAME: Write the name of the district here. In places where the intervention is designed at the city/town level, use city/town, followed by district. In places where other administrative divisions are used than district, use the relevant type of administrative unit.

TYPE OF HOTSPOT: Code the type of hotspot here. Use the given codes only;

1=Bar with lodging, 2=Bar without lodging, 3=Sex den/Brothel, 4=Strip club, 5=Streets/Highways, 6=Home, 7=Casino, 8=Beach, 9=Guest house/Rest house/Hotels/Lodgings, 10=Massage parlor, 11=Parks, 12=Beer tavern, 13=Public toilet, 14=Others

ESTIMATED NUMBER OF KPS (AVG): This refers to the estimated number of KPs in the spot and used is for micro-planning, monitoring and evaluations. Use the average of LOW and HIGH of peak day estimate from the hotspot validation form (Tool 1).

PEAK DAY(S): Write the peak day or days here. Peak day(s) are when higher number of KPs visit the spot compared to other days. A spot may receive maximum KPs on more than one day in a week, therefore write all peak days. Use the same codes as used in Tool 1, i.e. "A" for Monday, "B" for Tuesday, etc.

PEAK TIME: Write the peak time of the spot when the greatest number of KPs visit the spot on a day compared to other times on the same day. The peak time may be multiple time slots, and therefore write all relevant times. Again, use codes as given on the hotspot validation form

(Tool 1), i.e., “A” for morning, “B” for Afternoon, “C” for Evening, “D” for night and “E” for 24 hours.

PEER OUTREACH WORKER RESPONSIBLE: Write the name of the peer outreach worker who is assigned to provide program services at the spot. If the hotspot is a large one visited by many KPs, and more than one peer outreach worker is assigned, write the names of all the peer outreach workers responsible at the hotspot.

Tool contributing to PEPFAR indicator

denominator for KP_PREV
Custom Indicator: Proportion of KPs tested for HIV among those reached

TOOL #1B: HOTSPOT LIST (PWID)

<Implementing Partner's Name >

Month/Year: ___________________________

NAME OF HOTSPOT	HOTSPOT CODE	LOCATION	DEPARTMENT/ DISCTRICT	TYPE OF HOTSPOT*	ESTIMATED NO.		PEAK DAYS	PEAK TIME	PEER OUTREACH WORKER RESPONSIBLE
					MALE	FEMALE			
1	2	3	4	5	6		7	8	9

***Codes** for type of hotspot: 1=Street /Market, 2=Injecting den, 3=Uninhabited building, 4=Parks, 5=Homes, 6= Beach, 7=Casino.

NAME OF THE TOOL	TOOL 1B: HOTSPOT LIST (PWID)
Who should complete	Program manager/M&E officer
When to complete	Prior to setting up intervention
How often to complete	First hotspot list is the programmatic mapping list. Following the validation, the list is refined, and subsequently updated following every periodic validation (beginning of every year)

DESCRIPTION TO COMPLETE COLUMNS

TOOL 1B: HOTSPOT LIST (PWID) is used to list all the PWID hotspots.

The method of completing TOOL 1B is similar to TOOL 1A, except that typology of the hotspot and the estimated PWID at the spot are recorded differently.

The type of spot for PWID uses the following codes; 1=Street/Market, 2=Injecting den, 3=Uninhabited building, 4=Parks, 5=Homes, 6=Beach, 7=Casino.

ESTIMATED NO.: Write the average of LOW and HIGH estimates of Male IDUs and the same of Female IDUs visiting the hotspot on a peak day here.

Tool contributing to PEPFAR indicator

denominator for KP_PREV
Custom Indicator: Proportion of KPs tested for HIV among those reached

TOOL #2: INFRASTRUCTURE STATUS

SL. NO.	TYPE OF INFRASTRUCTURE	DESCRIPTION OF THE INFRASTRUCTURE	PROJECT-OWNED/ REFERRAL POINT	DATE ESTABLISHED	CONTACT DETAILS	REMARKS

NAME OF THE TOOL	TOOL 2: INFRASTRUCTURE STATUS
Who should complete	Program manager
When to complete	At the start of the program and whenever new infrastructure is set up or an existing piece of infrastructure is shut down.
How often to complete	Whenever a new piece of infrastructure is established or the status of an existing piece of infrastructure changes (closed down).

DESCRIPTION TO COMPLETE COLUMNS

TOOL 2: INFRASTRUCTURE STATUS lists the entire infrastructure available with the program. It also also gives the type of infrastructure, date of establishment, contact information, and infrastructure not active now for various reasons.

SL. NO.: This refers to the serial number and starts with 1,2,3, etc.

TYPE OF INFRASTRUCTURE: This refers to the type of infrastructure established. The type can be project offices, clinics, Drop-in-Centers (DIC), etc. Any infrastructure established using project funds or as referral set-up to link KPs to various HIV/STI services is included here.

DESCRIPTION OF THE PROJECT INFRASTRUCTURE: Write the description of the infrastructure, including the address of the establishment.

PROJECT-OWNED/REFERRAL POINT: Write whether the infrastructure is owned by the project or used as a referral point for referring KPs to services. Project-owned infrastructure is infrastructure established with project funding.

DATE ESTABLISHED: Write the date on which the infrastructure is established, using the DD/MM/YY format.

CONTACT DETAILS: Write the key contact person for the project. This need not the head of the establishment, but it is the person whom the project team is constantly interacting with as part of the program. If the establishment is project-owned, write the head of the establishment.

REMARK: Remark is used to write any further information regarding the establishment. For example, if the establishment is not active and closed, then write “Closed” and date on which the establishment become inactive.

Tool may contribute to (non-PEPFAR) monitoring indicators developed by the country program

TOOL #3: STAFF REGISTER

(To be filled by program administrator/program manager)

Contributes to PEPFAR – HRH Indicator

SL. NO.	NAME	POSITION	AGE	GENDER	DATE APPOINTED IN THE PROJECT	CATEGORY STAFF *	NO. OF HOURS WORKING	REMARKS
1	2	3	4	5	6	7	8	9

*Clinical Staff (Worker), Manager, Clinical Support, Social Service, Lay Workers, Others

NAME OF THE TOOL	TOOL 3: STAFF REGISTER
Who should complete	Program Administrator/manager
When to complete	At the start of the program.
How often to complete	Whenever new staff are enrolled or when staff leave the program.

DESCRIPTION TO COMPLETE COLUMNS

TOOL 3: STAFF REGISTER provides the number of staff in the program and their position, age, gender, date of joining, category and number of hours each one working for the program.

SL NO.: This refers to the serial number and start with 1,2,3, etc.

NAME: Write the name of the staff. Write first name followed by second and third name.

POSITION: Write the position of the program staff. If the staff is the project manager, write "Project manager", if he/she is M&E officer, write "M&E officer", etc.

AGE: Write the age in completed years. If the staff is 24 years and 5 months, write 24 years. Similarly, if he/she is 24 years and 11 months, again write 24 years. Write in completed years only.

GENDER: Write the gender of the staff. If the staff is a male, write "M", for female write "F" and for Transgender write "TG".

DATE OF APPOINTMENT IN THE PROJECT: Write the date of joining the program (appointment date) here. Use the DD/MM/YY format when writing the date of joining the program.

CATEGORY OF STAFF: Write the general category of their position in the program. If he/she is the program manager, write "Manager". If the staff is a clinical staff member, write "Clinical staff", if he/she is M&E officer, write "Officer", etc.

NO. OF WORKING HOURS: This refers to the number of hours the staff work for the program per week. If the staff works for 3 hours, write 3. Use completed hours only, that is, if the staff works for 3.5 hours, write 3 only.

REMARK: Write here any further relevant information about the staff. This field can be used if the staff member resigns from the program. In that case, write "Staff resigned" and include "Date of leaving" in DD/MM/YY format.

Tool contributing to PEPFAR indicator

HRH Indicator

TOOL #4: PEER OUTREACH WORKER REGISTER

(To be completed by Program Administrator or Staff Outreach Supervisor)

SL. NO.	NAME	ADDRESS	AGE	GENDER	TYPE OF KP	EDUCATION	DATE OF JOINING THE PROJECT	DATE OF DISCONTINUATION	REASON OF DISCONTINUATION
1	2	3	4	5	6	7	8	9	10

NAME OF THE TOOL	TOOL 4: PEER OUTREACH WORKER REGISTER
Who should complete	Program Administrator/manager/Staff Outreach Supervisor
When to complete	At the start of the program, when the peer outreach workers are recruited.
How often to complete	Whenever a peer outreach worker joins or leaves the project.

DESCRIPTION TO COMPLETE COLUMNS

TOOL 4: PEER OUTREACH WORKER REGISTER provides the number of peer outreach workers in the program and the total number of peer outreach workers recruited who have since left the project.

SL. NO.: This refers to the serial number and starts with 1,2,3, etc.

NAME: Write the name of the peer outreach worker (first name followed by second and third names).

ADDRESS: Write the address of the peer outreach worker. Write the complete address and the phone/mobile number.

AGE: Write the age in completed years. If the peer outreach worker is 24 years and 5 months, write 24 years. Similarly, if he/she is 24 years and 11 months, again write 24 years.

GENDER: Write the gender of the peer outreach worker. If the peer outreach worker is a male, write "M", for female write "F" and for Transgender write "TG".

TYPE OF KP: Write the KP type the peer outreach worker belongs to. If the peer outreach worker is a female sex worker, write "FSW", if MSM write 'MSM" and if a person who injects drugs, write "PWID".

EDUCATION: Education status of the peer outreach worker is recorded here. Write the number of years of education completed. If the peer outreach worker completed 7 years of education write "7". If the peer outreach worker is a graduate, write "15", etc.

DATE OF JOINING THE PROJECT: Write the date on which the peer outreach worker joined the program (appointment date), using the DD/MM/YY format.

DATE OF DISCONTINUATION: If the peer outreach worker has discontinued from the project, write the date they left, using DD/MM/YY format.

REASON FOR DISCONTINUATION: Write the main reason for discontinuation from the project. If the peer outreach worker discontinued because he/she is no longer practicing risk behavior, write "No more a KP". If the peer outreach worker discontinued because he/she is migrating, write "Migrated", etc.

Tool contributing to PEPFAR indicator

HRH Indicator

TOOL #5: CAPACITY-BUILDING REGISTER

(To be completed by Project Administrator/Project Manager)

SL. NO.	DATE		ORGANIZED BY	TRAINING NAME	TYPE AND NUMBER OF PARTICIPANTS					
	FROM	TO			PEER ORW	NO.	STAFF	NO.	OTHERS	NO.
1. Objectives of the training:										
2. Training methodology used:										
3. Training curriculum and material used:										
4. Training process (summary of each day of the training):										
5. Participants' feedback:										

LIST OF PARTICIPANTS				
SL. NO.	NAME	ROLE IN PROJECT	AGE	SEX

NAME OF THE TOOL	TOOL 5: CAPACITY BUILDING REGISTER
Who should complete	Project Administrator/Project Manager
When to complete	At the end of each training session conducted by Project Administrator/Manager
How often to complete	Periodically, whenever capacity-building of staff takes place

DESCRIPTION TO COMPLETE COLUMNS

TOOL 5: CAPACITY-BUILDING REGISTER helps the Program Manager to keep a record of the number of trainings conducted in a given month, topics covered, methodology adopted (training material used), and number of staff trained by their type. This form should also be completed if the NGO did not organize the training itself but staff attended training organized by other NGO/organization.

SL. NO.: Refers to the serial number of the capacity building training conducted in a given month

DATE (FROM/TO): The date or period when training was organized by the NGO or attended by the staff. Mention the start date and end date of the training in DD/MM/YY format.

ORGANIZED BY: The name of the organization that provided the training.

TRAINING NAME: This refers to the type of training conducted by the NGO or attended by the staff during the month. This may include induction training, skill building training, or refresher training.

TYPE OF PARTICIPANTS AND NUMBER: Fill in the total number of staff attended the training by their type.

OBJECTIVES OF THE TRAINING: Write a brief description of the objectives of the training conducted.

Trainings are generally fall into three broad categories: program management (outreach, TI component, MIS, etc.); financial management (audit, preparation of SOE (statement of expenditure), etc.); and clinical management (doctor training, counseling, STI symptoms, etc.)

TRAINING METHODOLOGY USED: Describe the methodology used for the training. The methodology used in the training can be classroom training, participatory training or in the forms of exposure visits.

TRAINING CURRICULUM AND MATERIAL USED: Mention the contents of the training, topics covered and materials used during the capacity-building.

TRAINING PROCESS (SUMMARY OF EACH DAY OF THE TRAINING): Describe the training process, including process adopted for organizing the training, agenda of the each days, and knowledge gained.

PARTICIPANTS' FEEDBACK: Summarize the feedback provided by the participants. Feedback on type of training, methodology used, content, and process should be included.

LIST OF PARTICIPANTS: This records the details of the participants who attended the capacity-building, including name and designation viz. position held by the staff who is participant of the training, their age, and sex.

TOOL #6A: OUTREACH ENROLMENT FORM (FSW/MSM)

(To be completed by Staff Outreach Supervisor or Peer Outreach Worker)

1. Name of Implementing Partner:		
2. Date of Enrollment:		
3. Name of District/Department:		
4. Name of Location:		
5. Name of Hotspot:		
6. Name of the Staff Outreach Worker:		
7. Name of the Peer Outreach Worker:		
8. Date/Month/Year of Enrollment:		
9. Name/Alias of the key population individual:		
10. Contact Address:		
11. Sex:	Male/Female/Transgender	
12. Nationality:		
13. Date of Birth (DD/MM/YY):		
14. Program ID:		
15. Phone number:		
16. Where do you MOSTLY operate/conduct sex work/ meet your clients or partners? **CIRCLE ALL THAT APPLY**	Name of hot spot (s):	
	1. Bar with Lodging	2. Bar without Lodging
	3. Sex Den (Brothels)	4. Strip Club
	5. Streets/Highways	6. Home
	7. Casino	8. Beach
	9. Lodgings/Guesthouse/ Rest House/Hotels	10. Massage Parlors
	11. Parks	12. Beer Tavern
	13. Public Toilets	14. Others
17. Have you been ever been contacted by a peer outreach worker from the HIV prevention program?	Yes	No
18. Have you ever visited any DIC/clinic/wellness center for any services in the last 6 months?	Yes	No
19. If Yes, which DIC did you visit?		

<table>
<tr><th colspan="3">ONLY FOR FSWS</th><th colspan="3">ONLY FOR MSM</th></tr>
<tr><td colspan="3">20. How old were you when you started sex work?</td><td colspan="3">At what age did you first have anal sex?</td></tr>
<tr><td colspan="3" rowspan="2">21. How many penetrative acts (anal/vaginal) have you had in the
LAST DAY? ______________
LAST WEEK? ____________</td><td colspan="3">How many receptive anal sex acts have you had in the
LAST DAY? ___________
LAST WEEK? _________</td></tr>
<tr><td colspan="3">How many penetrative anal sex acts have you had in the
LAST DAY? ___________
LAST WEEK? _________</td></tr>
<tr><td>22. Did you use a condom in your last penetrative act?</td><td>Yes</td><td>No</td><td>Did you use a condom in your last receptive/penetrative anal sex?</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="3">Signature ______________________________________
Staff Outreach Supervisor</td><td colspan="3">Signature ______________________________________
Peer Outreach Worker</td></tr>
</table>

NAME OF THE TOOL	TOOL 6A: OUTREACH ENROLLMENT FORM (FSW/MSM/TG)
Who should complete	Staff Outreach Supervisor/Peer Outreach Worker
When to complete	For each FSW/MSM once during the project period
How often to complete	Whenever a new KP member is identified for inclusion in the program

DESCRIPTION TO COMPLETE COLUMNS

TOOL 6A: OUTREACH ENROLLMENT FORM (FSW/MSM/TG) is used for registering the new KP member in the program. This form contains information about the basic profile of the KP individual and their risk behavior. This serves as the authenticated document of the KP member having enrolled in the program to access services.

NAME OF THE IMPLEMENTING PARTNER: This is the name of the implementing partner/NGO contracted to implement the HIV prevention intervention in a given area or district. The LINKAGES country team will assign a code to uniquely identify each implementing partner, and this can also be entered here.

DATE OF ENROLLMENT: Enter the date when the new KP was enrolled in the program using the DD/MM/YY format.

NAME OF DISTRICT/DEPARTMENT: Refers to the name of district/department where KP usually solicits/operates. Use a two-digit numeric code to uniquely identify the district and enter it here. (Where more than one implementing partner is operating in a single district/department, LINKAGES will assign each partner their unique code.)

NAME OF LOCATION: This depicts the name of area/location where KP is soliciting. Use the same location name as mentioned in the hotspot validation format. Assign a three-digit numeric code to uniquely identify the location within a district.

NAME OF HOTSPOT: Refers to the name of exact pickup/solicitation point within an area as identified during the mapping process. Write the name and address of the hotspot, so that it can be easily identified. Use the three-digit code taken from the Hotspot List (Tool 1A) to uniquely identify the hotspot.

NAME OF THE STAFF OUTREACH SUPERVISOR: Write the name of the staff outreach supervisor who registers the KP in a given hotspot. Assign a two-digit numeric code to uniquely identify the staff outreach supervisor.

NAME OF THE PEER OUTREACH WORKER: Write the name of peer outreach worker who will contact the registered KP during outreach. Assign a three-digit numeric code to uniquely identify the peer outreach worker.

DATE/MONTH/YEAR OF ENROLMENT: The date of enrolment is the first time when the KP was contacted by someone from the program and began to fill in the outreach enrollment form.

NAME/ALIAS OF THE KP: Write the full name of the KP in BLOCK LETTERS. The KP's name should appear in the same way on all other forms.

CONTACT ADDRESS: Write the present address of KP where s/he is residing. Also include any other landmark or information relevant to the contact address such as pin code.

SEX: Write the sex of the KP as reported at the time of enrolment. This should be a non-judgmental record ,i.e., the staff outreach supervisor or the peer outreach worker must record the sex exactly as reported by the KP. Circle "Male", "Female", or "Transgender" as appropriate.

NATIONALITY: Record the nationality of the KP as reported at the time of registration.

DATE OF BIRTH (DD/MM/YYYY): Report the KP's date of birth in DD/MM/YYYY format. To the extent possible, verify the reported date of birth through any supporting document/identify proofs. Mention "Not Available" if the KP does not know or remember their date of birth.

PROGRAMME ID (PID): PID is a 14-digit code to uniquely identify each KP within the program. It is used in cases where a program is not using the unique identifier code (UIC). The PID is the combination of the district code, implementing partner code, location code, hotspot code, and site category code, followed by a four-digit serial

number for the KP. The PID for each KP is generated by the M&E officer at the NGO level while entering the data into the Master Register. Once the PID is generated, it is given to the staff outreach supervisor and peer outreach worker for all further uses.

A PID can be generated as below:

DISTRICT CODE		IMPLEMENTING PARTNER CODE		LOCALITY CODE			HOTSPOT CODE			CATEGORY CODE	KP UNIQUE CODE			
0	1	0	1	0	1	2	0	1	1	F	0	1	1	2
0	1	0	3	0	2	2	0	0	1	T	0	1	2	4

PHONE NUMBER: Write the mobile/landline number on which the KP can be contacted.

WHERE DO YOU MOSTLY OPERATE/CONDUCT SEX WORK/MEET YOUR CLIENTS OR PARTNERS? CIRCLE ALL THAT APPLY: This refers to the type of spot that KPs mostly visit to conduct sex work/meet their clients/engage in risk behaviors. There are 14 types of spots mentioned in the tool. The peer outreach worker should write the "Name of hotspot(s)" that the KP mostly visits, and tick the most appropriate category of the spot as per the responses of the KP. Below are the examples of type of spot:

1=Bar with lodging, 2=Bar without lodging, 3=Sex den/Brothel, 4=Strip club, 5=Streets/Highways, 6=Home, 7=Casino, 8=Beach, 9=Guest house/Rest house/Hotels/Lodgings, 10=Massage parlors, 11= Parks, 12=Beer Tavern, 13=Public toilet, 14=Others.

It the KP mentions more than one spot, record all of them and circle the type(s) of spot.

HAVE YOU BEEN EVER BEEN CONTACTED BY A PEER OUTREACH WORKER FROM THE HIV PREVENTION PROGRAM?: If the KP has ever been contacted by a peer outreach worker from an HIV prevention program, circle code "1- Yes"; otherwise circle code "2- No".

HAVE YOU EVER VISITED ANY DIC/CLINIC/WELLNESS CENTRE FOR ANY SERVICES IN THE LAST 6 MONTHS?: If the KP has ever visited to a DIC/clinic/wellness centre to obtain any services in the last 6 months through any HIV prevention program, circle code "1- Yes"; otherwise circle code "2- No".

IF YES, WHICH DIC DID YOU VISIT?: If the KP has visited the DIC in last 6 months, enter the name and address of the DIC.

HOW OLD WERE YOU WHEN YOU STARTED SEX WORK? (FOR FSW)/AT WHAT AGE DID YOU FIRST HAVE ANAL SEX? (FOR MSM): Mention the age at initiation of sex work (for FSW) or age at first anal sex (for MSM), in completed years. If the KP does not know/remember the age, enter '98'.

ONLY FOR FSW

HOW MANY PENETRATIVE ACTS ANAL/VAGINAL HAVE YOU HAD? LAST DAY?__ / LAST WEEK?__

Record the number of sexual acts (anal/vaginal) which the FSW had with any partner in the last working day and in the last week. If no such sexual act happened either in the last day or in the last week then record "00".

DID YOU USE A CONDOM IN YOUR LAST PENETRATIVE ACT? 1. YES 2. NO.

ONLY FOR MSM:

HOW MANY RECEPTIVE ANAL SEX ACTS HAVE YOU HAD? LAST DAY?_____/ LAST WEEK? ___

Record the number of receptive anal sex acts reported by the MSM in the last day and in the last week. If no such sexual act happened either on the last day or in the last week then record "00".

HOW MANY PENETRATIVE ANAL SEX ACTS HAVE YOU HAD? LAST DAY? ___ / LAST WEEK?___

Record the number of penetrative anal sex acts reported by the MSM in the last day and in the last week. If no such sexual act happened either on the last day or in the last week then record "00".

DID YOU USE A CONDOM IN YOUR LAST RECEPTIVE/PENETRATIVE ANAL SEX? 1. YES 2. NO.

Once the registration has been completed, the staff outreach supervisor or the peer outreach worker should forward this sheet to the M&E officer to record this information in KP Master Register (Tool 6C).

TOOL #6B: OUTREACH ENROLMENT FORM (PWID)

(To be completed by Staff Outreach Supervisor or Peer Outreach Worker)

1. Name of Implementing Partner:		
2. Date of Enrollment:		
3. Name of District/Department:		
4. Name of Location:		
5. Name of Hotspot:		
6. Name of the Staff Outreach Supervisor:		
7. Name of the Peer Outreach Worker:		
8. Date/Month/Year of Enrollment:		
9. Name/alias of the KP:		
10. Contact Address:		
11. Sex:	Male/Female/Transgender	
12. Date of Birth (DD/MM/YY):		
13. Program ID:		
14. Phone number:		
15. Where do you MOSTLY inject drugs/buy your drugs? **CIRCLE ALL THAT APPLY**	Name of hotspot(s):	
	1. Street	2. Home
	3. Market	4. Beach
	5. Uninhabited building	6. Injecting den
	7. Parks	8. Other
16. Have you ever been contacted by a peer from the HIV prevention program?	Yes	No
17. Have you ever visited any DIC/clinic/wellness centre for any services in the last 6 months?	Yes	No
18. If yes, which DIC did you visit?		
19. At what age did you first inject drugs?		
20. On average how many times do you inject PER DAY? ______________ PER WEEK? ____________		

Signature ______________________________________
Staff Outreach Supervisor

Signature ______________________________________
Peer Outreach Worker

NAME OF THE TOOL	TOOL 6B: PWID ENROLLMENT FORM (PWID)
Who should complete	Staff Outreach Supervisor/Peer Outreach Worker
When to complete	For each person who injects drugs (PWID) once during the project period
How often to complete	Whenever a new PWID is identified for the inclusion in the program

DESCRIPTION TO COMPLETE COLUMNS

TOOL 6B: OUTREACH ENROLLMENT FORM (PWID) is used for registering the new PWID in the program. This form contains information about the basic profile of the PWID and their risk behavior. It serves as the authenticated document of the PWID having enrolled in the program to access services.

NAME OF THE IMPLEMENTING PARTNER: This is the name of the implementing partner/NGO contracted to implement the HIV prevention intervention in a given area or district. Use a two-digit code to uniquely identify the implementing partner. The LINKAGES country team will assign a code to uniquely identify each implementing partner, and this can also be entered here.

DATE OF ENROLLMENT: Mention the date when a new PWID ws enrolled in the program. The date of registration should be given in DD/MM/YY format.

NAME OF DISTRICT/DEPARTMENT: Refers to the name of district/department where PWID usually visits for drug use. Use a two-digit numeric code to uniquely identify the district and enter it here. (Where more than one implementing partner is operating in a single district/department, LINKAGES will assign each partner their unique code.)

NAME OF LOCATION: This depicts the name of area/location where PWID visit for injecting drugs. Use the same location name as mentioned in the hotspot validation format. Assign a three-digit code to uniquely identify the location within a district.

NAME OF HOTSPOT: Refers to the name of exact drug injecting point within an area as identified during the mapping process. Write the name and address of the hotspot so that it can be easily identified. Assign a three-digit numeric code to uniquely identify the location within a district.

NAME OF THE STAFF OUTREACH SUPERVISOR: Write the name of the staff outreach supervisor who registers the PWID in a given hotspot. Assign a two-digit numeric code to uniquely identify the staff outreach supervisor.

NAME OF THE PEER OUTREACH WORKER: Write the name of the peer outreach worker who will contact the registered PWID during outreach. Assign a three-digit numeric code to uniquely identify the peer outreach worker.

DATE/MONTH/YEAR OF ENROLMENT: The date of enrolment is the first time when PWID was contacted by someone from the program and began to fill in the outreach enrollment form.

NAME/ALIAS OF THE PWID: Write the full name of the PWID in BLOCK LETTERS. The PWID's name should appear in the same way on all other forms.

CONTACT ADDRESS: Write the present address of PWID where s/he is residing. Also include any other landmark or information relevant to the contact address such as pin code.

SEX: Write the sex of the PWID as reported at the time of enrolment. This should be a non-judgmental record, i.e., the staff outreach supervisor or the peer outreach worker must record the sex exactly as reported by the PWID. Circle "Male", "Female", or "Transgender" as appropriate.

DATE OF BIRTH (DD/MM/YYYY): Report the PWID's date of birth in DD/MM/YYYY format. To the extent possible, verify the reported date of birth through any supporting document/identify proofs. Mention "Not Available" if PWID doesn't know or remember their date of birth.

PROGRAMME ID (PID): PID is a 14-digit code to uniquely identify each PWID within the program. It is used in cases where a program is not using the unique identifier code (UIC). The PID is the combination of the district code, implementing partner code, location code, hotspot code, and site category code, followed by a four-digit serial number for the PWID. The PID for each PWID is generated by the M&E officer at the NGO level while entering the data into the Master Register. Once the PID is generated, it is given to the staff outreach supervisor and peer outreach worker for all further uses.

A PID can be generated as below:

DISTRICT CODE		IMPLEMENTING PARTNER CODE		LOCALITY CODE			HOTSPOT CODE			CATEGORY CODE	KP UNIQUE CODE			
0	1	0	1	0	1	2	0	1	1	F	0	1	1	2
0	1	0	3	0	2	2	0	0	1	T	0	1	2	4

PHONE NUMBER: Write the mobile/landline number on which the PWID can be contacted.

WHERE DO YOU MOSTLY INJECT DRUGS/BUY YOUR DRUGS? CIRCLE ALL THAT APPLY: This refers to the name and type of spot where the PWID mostly injects or purchases drugs. There are 8 types of spots mentioned in the tool. The peer educator should write the "Name of hotspot(s)" that the PWID mostly visits to purchase or inject drugs, and tick the most appropriate category of the spot as per the responses of the PWID. Below are the examples of type of spot:
1=Street, 2=Home, 3=Market, 4=Beach, 5=Uninhabited building, 6=Injecting Den, 7=Parks, 8=Others.

If the PWID mentions more than one spot, record all of them and circle the type(s) of spot.

HAVE YOU BEEN EVER BEEN CONTACTED BY A PEER OUTREACH WORKER FROM THE HIV PREVENTION PROGRAM?: If the PWID has ever been contacted by a peer outreach worker from an HIV prevention program, circle code "1- Yes"; otherwise circle code "2- No".

HAVE YOU EVER VISITED ANY DIC/CLINIC/ WELLNESS CENTRE FOR ANY SERVICES IN THE LAST 6 MONTHS?: If the PWID has ever visited to a DIC/clinic/wellness centre to obtain any services in the last 6 months through any HIV prevention program, circle code "1- Yes"; otherwise circle code "2- No".

IF YES, WHICH DIC DID YOU VISIT?: If the PWID has visited the DIC in the last 6 months, write the name and address of the DIC.

AT WHAT AGE DID YOU FIRST INJECT DRUGS?: Write the age when the PWID started injecting drugs. If the PWID does not know or remember the age, enter '98'.

ON AVERAGE HOW MANY TIMES DO YOU INJECT? PER DAY_______/ PER WEEK____: Record how many times the PWID injects drugs per day and per week on an average basis.

Once the registration has been completed, the staff outreach supervisor or the peer outreach worker should forward this sheet to the M&E officer to record this information in PWID Master Register (Tool 6D).

TOOL #6C: MASTER REGISTER (FSW/MSM)

(To be completed by the Monitoring and Evaluation Officer)

SL. NO	NAME OF IMPLEMENTING PARTNER	NAME OF DISTRICT	NAME OF LOCATION	NAME OF HOTSPOT	NAME OF STAFF OUTREACH SUPERVISOR	NAME OF PEER OUTREACH WORKER	DATE OF ENROLMENT	NAME OF KP	GENDER	AGE	AGE AT START OF SW/ FIRST ANAL SEX	PROGRAM ID	PHONE NUMBER	TYPOLOGY OF KP
1	2	3	4	5	6	7	8	9	10	11	12	13	14	

NAME OF THE TOOL	TOOL 6C: MASTER REGISTER (FSW/MSM)
Who should complete	Monitoring and Evaluation Officer
When to complete	When the implementing partner has an updated list of KP members registered with the program
How often to complete	Periodically, mostly on a weekly basis or when new registration happens

DESCRIPTION TO COMPLETE COLUMNS

TOOL 6C: MASTER REGISTER (FSW/MSM) is a compilation of information about all the registered KPs. It provides easy access to information about the KPs, e.g., the number registered with the program and their classification by hotspot/area/site or typology.

The M&E officer should maintain this register in Excel and update it as required. The information for the Master Register comes directly from Tool 6A (except for the serial number).

SL. NO.: The implementing partner NGO should list all KPs registered in the program serially. When new KPs are registered, the serial number should continue from the previous highest number. If a KP discontinues their participation in the program for any reason, their serial number should not change or be used for any other KP.

Tool contributing to PEPFAR indicator

numerator for KP_PREV

TOOL #6D: MASTER REGISTER (PWID)

(To be completed by the Monitoring and Evaluation Officer)

SL. NO.	NAME OF IMPLEMENTING PARTNER	NAME OF DISTRICT	NAME OF LOCATION	NAME OF HOTSPOT	NAME OF STAFF OUTREACH SUPERVISOR	NAME OF PEER OUTREACH WORKER	DATE OF ENROLLMENT	NAME OF KP	GENDER	AGE	PROGRAM ID	PHONE NUMBER	TYPOLOGY OF KP
	1	2	3	4	5	6	7	8	9	10	11	13	

NAME OF THE TOOL	TOOL 6D: PWID MASTER REGISTER
Who should complete	Monitoring and Evaluation Officer
When to complete	When the implementing partner has an updated list of PWID registered with the program
How often to complete	Periodically, mostly on a weekly basis or when new registration happens

DESCRIPTION TO COMPLETE COLUMNS

TOOL 6D: MASTER REGISTER (PWID) is a compilation of information about all the registered PWIDs. It provides easy access to information about the PWID, e.g. the number registered with the program and their classification by hotspot/area/site or typology.

The M&E officer should maintain this register in Excel and update it as required. The information for the Master Register comes directly from Tool 6B (except for the serial number).

SL. NO.: The implementing partner NGO should list all PWID registered in the program serially. When new PWID are registered, the serial number should continue from the previous highest number. If a PWID discontinues their participation in the program for any reason, their serial number should not change or be used for any other PWID.

Tool contributing to PEPFAR indicator

numerator for KP_PREV

TOOL #7A: INDIVIDUAL TRACKING SHEET/PEER CALENDER (OUTREACH)

(To be completed by Peer Outreach Worker)

Name of ORW: Name of Peer: Quarter Q1 (Oct–Dec), Q2 (Jan–Mar), Q3 (Apr–Jun), Q4 (Jul–Sep)

SL. NO.	PID NO.	SPOTS/HOTSPOTS	NAME/ NICKNAME	TYPE OF KP	AGE	SEX	COMMU-NICATION SESSION (1-1, 1-G)			AT LEAST ONE OF THE FOLLOWING TOPICS DISCUSSED: STI, HIV, HCT, SGBV, STIGMA (YES/NO)	REFERRAL FOR HEALTH SERVICES																	RECEIVED COMMODITIES (NO. AND TYPE OF CON-DOM: MALE/ FEMALE/LUBE)						FACED ANY VIOLENCE			ADDRESSED VIOLENCE			REMARK
											STI			HIV TESTING			ART			FP			TB			OTHERS*			C/FC			LUBE									
							M1	M2	M3		M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41
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NAME OF THE TOOL	7A: INDIVIDUAL TRACKING SHEET/PEER CALENDER (OUTREACH)
Who should complete	Peer Outreach Worker with the help of Staff Outreach Supervisor
When to complete	Whenever peer outreach worker provides services to KP members
How often to complete	Daily updated when services are provided

DESCRIPTION TO COMPLETE COLUMNS

TOOL 7A: INDIVIDUAL TRACKING SHEET/PEER CALENDAR (OUTREACH) is the most important tool for outreach activities. On it the peer outreach worker records all the services that he/she provides to KPs at the hotspot. Each of the services including communication, referral, testing, and violence is be recorded on a daily basis. This information is then compiled by site to aggregate to the project level

NAME OF STAFF OUTREACH SUPERVISOR: Enter the name of the staff outreach supervisor who is mentoring the peer outreach worker.

NAME OF PEER OUTREACH WORKER: Name of the peer outreach worker at the hotspot

QUARTER: Individual tracking is maintained for a particular quarter. Indicate by ticking which quarter is being recorded. Q1 (Oct - Dec) Q2 (Jan - March) Q3 (April -June) Q4 (July-Sept)

SL. NO.: Serial number of the KP on this form.

PID NO.: Program Identification number provided for the KPs when registered in the program.

SPOTS/HOTSPOTS: Enter the name of the hotspot the KP belongs to.

NAME/NICKNAME: Record the name/alias of the KP who is registered in the program.

TYPE OF KP: Type of KPs should be entered using the typologies mentioned in the enrollment form Tool 6A.

AGE: Record the age of the KP in completed years.

SEX: Record the sex of the KP (M, F or TG)

COMMUNICATION SESSION (1-1, 1-G): 1-1=one-to-one. 1-G=one-to-group. The date on which the session was conducted should be recorded here in this column.

AT LEAST ONE OF THE FOLLOWING TOPICS DISCUSSED STI, HIV, HCT, SGBV, STIGMA (YES/NO): If any of the mentioned topic are covered, enter "Yes" to indicated they were covered in the session.

REFERRAL FOR HEALTH SERVICES: If a KP is referred for any of the services such as STI, HIV Testing, ART, FP, TB, or other health problems, the referral should be recorded here. A KP may be referred to multiple services during the quarter.

RECEIVED COMMODITIES (NO. AND TYPE OF CONDOM (MALE-FEMALE/LUBE): KPs are provided with condoms, lubricants and needles/syringes (in the case of PWID). The number of these commodities distributed should be recorded here.

FACED ANY VIOLENCE: If any of the KPs face violence then the peer educators should record that a particular KP faced violence. This could be form partner, law enforcement agencies, other power structures within her area etc.

ADDRESSED VIOLENCE: If KPs have been helped to resolve the violence crisis then it should be recorded here.

REMARK: Any remarks, including follow-up dates for a particular KP, should be recorded here.

Tool contributing to PEPFAR indicator

KP_PREV

TOOL #7B: ORW COMPILATION SHEET BY PEER OUTREACH WORKER SITES

(To be compiled by staff outreach supervisor for his/her area)

SL. NO.	SPOTS/HOTSPOTS	TYPE OF KP	PEER OUTREACH WORKER'S NAME	TOTAL KP REGISTERED	COMMUNICATION SESSION (1-1, 1-G)			REFERRAL FOR HEALTH SERVICES																		RECEIVED COMMODITIES (NO. AND TYPE OF CONDOM: MALE/FEMALE/LUBE)			ANY CRISIS INCIDENTS FACED			CRISIS INCIDENTS ADDRESSED		
								STI			HIV TESTING			ART			FP			TB			OTHERS*											
					M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	M1	M2	M3	CONDOMS	FEMALE CONDOMS	LUBE	M1	M2	M3	M1	M2	M3
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5																																		
6																																		
7																																		
8																																		
9																																		

NAME OF THE TOOL	TOOL 7B: ORW COMPILATION SHEET BY PEER OUTREACH WORKER SITES
Who should complete	Staff Outreach Supervisor
When to complete	At the end of every month
How often to complete	Preferably weekly, and should be completed by the end of the month

DESCRIPTION TO COMPLETE COLUMNS

TOOL 7B: ORW COMPILATION SHEET BY SITES is a compilation tool for all the peer outreach workers being mentored by a staff outreach supervisor. It indicates the performance by site in each staff outreach supervisor's area. A separate line should be completed for each hotspot. If a hotspot is served by more than one peer outreach worker, a separate line should be completed for each peer outreach worker at the hotspot.

SL. NO.: Serial number.

SPOTS/HOTSPOTS: Name of the hotspot the key population belongs to should be entered here

TYPE OF KP: Type of KPs should be entered, using typologies mentioned in enrollment form Tool 6A.

NAME OF PEER OUTREACH WORKER: Name of the peer outreach worker at that hotspot

TOTAL KPS REGISTERED: Enter the total number of KPs registered at the hotspot.

COMMUNICATION SESSION (1-1, 1-G): Total number of KPs that have received a communication session from a peer outreach worker at each hotspot. 1-1=one-to-one. 1-G=one-to-group.

REFERRAL FOR HEALTH SERVICES: Compilation of all the individual KPs at each hotspot that have been referred by peer educators for any of the following services: STI, HIV Testing, ART, FP, TB, other health problems.

RECEIVED COMMODITIES: Record the number of commodities that were provided at each hotspot. This includes condoms, lubricant, and needles/syringes (for PWID).

FACED ANY VIOLENCE: Total number of individual KPs who faced violence is listed here.

ADDRESSED VIOLENCE: Record how many KPs received help to resolve violence/crisis for each of the hotspots.

Tool contributing to PEPFAR indicator

KP_PREV

GEND_GBV (Number of KPs receiving post-GBV care)

TOOL #8A: CONDOM OUTLET REGISTER

<Implementing partner>

HOTSPOT	NAME/PLACE OF OUTLET HOLDER*	DATE OF INDUCTION IN PROJECT	GENDER OF OUTLET HOLDER (M/F/TG)	TYPE OF OUTLET	DATE OF DISCONTINUATION (IF DISCONTINUED)	REASON FOR DISCONTINUATION
1	2	3	4	5	6	7

Code 1 = Individual outlet holder, 2=Public place, 3=Private place, 4=Vending machine, 5=Health Facility, 6= Others

NAME OF THE TOOL	TOOL 8A: CONDOM OUTLET REGISTER
Who should complete	Monitoring and Evaluation Officer
When to complete	Initially one time
How often to complete	Updated six monthly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 8A: CONDOM OUTLET REGISTER is updated whenever an outlet is inducted into the program. It shows the distribution and type of condom outlets established by the program.

HOTSPOT: Name of the hotspot where the outset is located.

NAME/PLACE OF OUTLET HOLDER*: Name of the outlet holder.

DATE OF INDUCTION IN PROJECT: Record the date of induction of the outlet.

GENDER OF OUTLET HOLDER (M/F/TG): Record the gender of the outlet holder.

TYPE OF OUTLET: Record the type of outlet (as listed at the bottom of the table).

DATE OF DISCONTINUATION (IF DISCONTINUED): Record the date of discontinuation, if discontinued.

REASON FOR DISCONTINUATION: Record the reason for discontinuation.

Tool may contribute to (non-PEPFAR) monitoring indicators developed by the country program

TOOL #8B: CONDOM AND LUBRICANT INVENTORY REGISTER

<Implementing partner>

DATE	OPENING BALANCE CONDOMS & LUBRICANTS		NUMBER RECEIVED				NUMBER DISTRIBUTED				CLOSING BALANCE	
			MOH/DONOR		OTHER SOURCES		PEER OUTREACH WORKER		OUTLETS			
	C	L	C	L	C	L	C	L	C	L	C	L
1	2	3	4	5	6	7	8	9	10	11	12	13

NAME OF THE TOOL	TOOL 8B: CONDOM AND LUBRICANT INVENTORY REGISTER
Who should complete	Program Manager
When to complete	To be maintained regularly
How often to complete	Update Monthly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 8B: CONDOM AND LUBRICANT INVENTORY REGISTER helps the program manager track the stock levels of condoms and lubricant in the program. Based on the available stock, the program manager can place future procurement orders.

DATE: Date of recording the inventory.

OPENING BALANCE CONDOMS & LUBRICANT: Record the opening balance as the number of condoms and lubricants in stock at the beginning of the accounting period.

NUMBER RECEIVED: Record the quantity received from sources such as MoH/Donor or Other Sources.

NUMBER DISTRIBUTED: Record the number of condoms or lubricants given either to peer outreach workers or to a specific outlet, in the respective column.

CLOSING BALANCE: The closing balance is calculated as the opening balance, plus the number received, minus the number distributed. This can be checked against the quantities remaining in stock at the end of the accounting period.

Tool may contribute to (non-PEPFAR) monitoring indicators developed by the country program

TOOL #8C: NEEDLE & SYRINGE INVENTORY REGISTER

<Implementing partner>

	OPENING BALANCE NEEDLE & SYRINGES		NUMBER RECEIVED				NUMBER DISTRIBUTED								CLOSING BALANCE	
			MINISTRY/ DONOR		OTHER SOURCES		PEER OUTREACH WORKER		DIC		HEALTH FACILITY		OTHERS			
DATE	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2	KIT 1	KIT 2
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17

NAME OF THE TOOL	TOOL 8C: NEEDLE & SYRINGE INVENTORY REGISTER
Who should complete	Program Manager
When to complete	To be maintained regularly
How often to complete	Updated Monthly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 8C: NEEDLE & SYRINGE INVENTORY REGISTER helps the program manager track the stock levels of needles and syringes in the program. Based on the available stock, the program manager can place future procurement orders

DATE: Date of recording the inventory.

OPENING BALANCE NEEDLES & SYRINGES: Record the opening balance as the number of needles and syringes in stock at the beginning of the accounting period.

NUMBER RECEIVED: Record the quantity received from sources such as MoH/Donor or Other Sources

NUMBER DISTRIBUTED: Record the number of needles and syringes given either to peer outreach workers, drop-in centers, health facilities or other in the respective column.

CLOSING BALANCE: The closing balance is calculated as the opening balance, plus the number received, minus the number distributed. This can be checked against the quantities remaining in stock at the end of the accounting period.

Tool may contribute to (non-PEPFAR) monitoring indicators developed by the country program

TOOL #8D: CONDOM/LUBRICANT OUTLET INVENTORY/DISTRIBUTION REGISTER

<Outreach worker>

DATE	HOTSPOT/LOCATION	TYPE OF OUTLET/ DEPOT*	BALANCE/ STOCK		SUPPLY		CLOSING BALANCE		DISTRIBUTED	
			C	L	C	L	C	L	C	L

***Code** 1=Individual outlet holder, 2=Public place, 3=Private place, 4=Health Facility, 5=Others

NAME OF THE TOOL	TOOL 8D: CONDOM/LUBRICANT OUTLET INVENTORY/DISTRIBUTION REGISTER
Who should complete	Program Manager
When to complete	When outlet is supplied with commodities
How often to complete	Updated regularly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 8D: CONDOM/LUBE OUTLET INVENTORY/ DISTRIBUTION REGISTER guides the program on the distribution pattern of condoms/lubricant to and from various outlets

DATE: Date of recording distribution to the outlet.

HOTSPOT/LOCATION: Hotspot where the outlet is located.

TYPE OF OUTLET/DEPOT*: Type of outlet or condom depot.

*Code 1=Individual outlet holder, 2=Public place, 3=Private place, 4=Health Facility, 5=Others

BALANCE/STOCK: Record the balance of stock at the outlet.

SUPPLY: Record how much stock was supplied to the outlet (condoms and lubricant separately).

CLOSING BALANCE: Record the closing balance of stock after the supply was given to the outlet.

DISTRIBUTED: Record number of condoms and lubricants distributed by the outlet.

Tool may contribute to (non-PEPFAR) monitoring indicators developed by the country program

TOOL #8E: NEEDLE/SYRINGE OUTLET INVENTORY/DISTRIBUTION REGISTER

<Outreach worker>

DATE	NAME/OUTLET/FACILITY	TYPE OF OUTLET/ FACILITY*	BALANCE/ STOCK	SUPPLY	CLOSING BALANCE	TOTAL DISTRIBUTED

***Code** 1=Individual, 2=DIC, 3=Health Facility, 4=Others

NAME OF THE TOOL	TOOL 8E: NEEDLE/SYRINGE OUTLET INVENTORY/DISTRIBUTION REGISTER
Who should complete	Program Manager
When to complete	When outlet is supplied with commodities
How often to complete	Updated regularly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 8E: NEEDLE/SYRINGE INVENTORY REGISTER guides the program on the distribution pattern of condom/lube to and from various outlets/centres

DATE: Date of recording the distribution to the outlet.

NAME/OUTLET/FACILITY: Record the name of the place where the outlet is located.

TYPE OF OUTLET/FACILITY*: Type of outlet or condom depot.

*Code 1=Individual, 2=DIC, 3=Health Facility, 4=Others

BALANCE/STOCK: Record the balance of stock at the outlet.

SUPPLY: Record how much stock was supplied to the outlet.

CLOSING BALANCE: Record the closing balance of stock after the supply was given to the outlet.

DISTRIBUTED: Record number of needle/syringes distributed by the outlet.

Tool may contribute to (non-PEPFAR) monitoring indicators developed by the country program

TOOL #9A: MSM/TG CLINIC ENROLMENT FORM

Name of Implementing Partner: ______________________________ Date:____ /_____ /_______

District: ____________________ Location: ______________________ Hotspot: __________________

Staff Outreach Supervisor: ______________________ Peer Outreach Worker: ________________________

Name of KP: ______________________________ Sex: ☐ Female ☐ Male ☐ TG

Date of Birth: ____ /____ /________ Program ID: ____

Contact Address: ____

Phone Number: ____

1	How old were you on your last birthday? (Age in completed years)		
2	Where do you MOSTLY cruise/meet your clients or partners? **CIRCLE ALL THAT APPLY**	**Name of hotspot (s):**	
		☐ Bar with lodging	☐ Bar without lodging
		☐ Sex den (brothels)	☐ Strip club
		☐ Streets/highways	☐ Home
		☐ Casino	☐ Beach
		☐ Lodgings/guesthouse/ Rest house/hotels	☐ Massage parlors
		☐ Parks	☐ Beer tavern
		☐ Public toilets	☐ Others
3	On average how many penetrative sex acts (anal) do you have?	Per day	Per week
4	Have you ever visited any DIC/clinic/wellness centre for any services in the last 6 months?	Yes	No
5	If Yes, which DIC did you visit?		
6	Have you been contacted by a peer outreach worker from the HIV prevention program?	Yes	No

	SEXUALLY TRANSMITTED INFECTIONS	
7	In the past 6 months have you ever had any of these symptoms? **PLEASE READ ALL**	☐ Genital/anal ulcer disease ☐ Foul smelling penile/anal discharge ☐ Painless growth in anal/penile area ☐ Itch in genital/anal area ☐ Rash in genital/anal area ☐ Bubo ☐ Dysuria ☐ LAP ☐ Others
8	Where did you receive treatment for the above mentioned symptoms you had in the past 6 months?	☐ Pharmacy ☐ Private doctor ☐ Government clinic ☐ Herbalist ☐ NGO/ program clinic ☐ Other ______________________ ☐ Did not receive treatment

SEXUAL HISTORY AND RISK ASSESSMENT				
9	At what age did you first have sexual intercourse?			
10	In the past 3 months have you had sex with another man?	☐ Yes	☐ No	
11	In the past ONE WEEK, how many male partners did you have?			
12	What type of sex do you have in most sexual encounters?	☐ Anal penetrative ☐ Anal receptive ☐ Oral ☐ Other ___		
13	Did you ever receive cash or goods in exchange for sex with a man?	☐ Yes	☐ No	
14	If yes, at what age did you start sex work? **(only for MSW)**			
15	In the past ONE WEEK, from how many men did you receive cash or goods in exchange for sex? **(only for MSW)**			
16	In the past ONE WEEK, how many men did not pay you cash or goods in exchange for sex? **(only for MSW)**			
17	Did you use a condom last time you had sex?	☐ Yes	☐ No	
18	Did you use lubricant last time you had anal sex?	☐ Yes	☐ No	
19	During the past one month how often have you consumed drinks containing alcohol?	☐ Never ☐ Most days	☐ Sometimes ☐ Every day	
20	Have you ever used/consumed a drug for non-medical purpose?	EVER	LAST MONTH	LAST WEEK
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

SEXUAL AND GENDER-BASED VIOLENCE			
21	In the last 3 months have you ever experienced violence?	☐ Yes	☐ No
22	If yes, which type? **Tick all mentioned**	☐ Harassment ☐ Physical violence ☐ Sexual violence ☐ Discrimination ☐ Other	
23	Who perpetrated the violence?	☐ Community pressure groups ☐ Local leaders ☐ Police ☐ Military ☐ Pimps ☐ Bar managers and owners ☐ Local gangs ☐ Fellow employee ☐ Magistrate/judiciary	☐ Government officials ☐ General community ☐ Family members ☐ Religious groups ☐ Regular partner ☐ Clients ☐ Health care provider ☐ Employer ☐ Other (Specify) ___
24	Did you seek help?	☐ Yes	☐ No
25	If yes, where did you seek the help? **MARK ALL MENTIONED**	☐ Medical/hospital ☐ Legal/police ☐ Family ☐ Peers ☐ Friends ☐ Religious leader ☐ Chief/village elder ☐ Other ___	

TOOL #9A: MSM/TG CLINIC ENROLLMENT FORM *continued*

HIV TESTING AND COUNSELING			
26	Have you ever been tested for HIV?	☐ Yes	☐ No (Skip to question 33)
27	If yes, how long ago?	☐ Within 3 months ☐ Within 6 months ☐ Within 1 year ☐ Above 1 year	
28	If yes, would you like to share your test result with me?	☐ Tested positive ☐ Tested negative ☐ Results unknown ☐ I do not want to share	
29	If positive, have you disclosed your HIV status to anyone?	☐ Yes	☐ No
30	If Yes, to whom?	☐ Boyfriend ☐ Regular client ☐ Friend/relative	
31	If positive are you receiving HIV care?	☐ Yes (specify duration) If yes, duration ________________________	☐ No
32	If receiving care, which facility is giving you care (address of the facility)?		
33	Could we contact you by phone (including SMS) for services related to STI/FP/HIV testing/HIV care/GBV or other services?	☐ Yes	☐ No
34	Could we contact you through your peer outreach worker /staff outreach supervisor for services related to STI//HIV testing/HIV care/GBV or other services?	☐ Yes Signature/thumb print of the KP______________________	☐ No
35	Name of Service Provider:	Signature____ Date____________________	

NAME OF THE TOOL	TOOL 9A: MSM/TG CLINIC ENROLLMENT FORM
Who should complete	Clinic Staff
When to complete	When the MSM comes to the clinic for the first time for services
How often to complete	Daily

DESCRIPTION TO COMPLETE COLUMNS

TOOL 9A: MSM/TG CLINIC ENROLLMENT FORM is used for each MSM when they visit the clinic for the first time for clinical services. It captures all the basic history of the KP to plan their future clinical management.

BASIC BACKGROUND INFORMATION ABOUT KP: In the first section, basic demographic information should be asked and recorded.

BEHAVIOR OF KP: Questions 1-6 are recorded to understand the risk behavior of the KP which may influence chances of acquiring the HIV infection.

SEXUALLY TRANSMITTED INFECTIONS: Questions 7-8 record the past STI history of the KP.

SEXUAL HISTORY AND RISK ASSESSMENT: Questions 9-20 record the sexual history and past risk behavior of the KP. This will help the clinician to counsel and treat the KP accordingly.

SEXUAL AND GENDER-BASED VIOLENCE: Questions 21-25 record the sexual and gender-based violence experienced by the KP in the past.

HIV TESTING AND COUNSELING: Questions 26-32 record whether the KP has ever been tested for HIV and counseled, and the results if the KP is willing to share. If HIV positive, it also seeks information about the care currently received by the KP.

CONSENT FOR CONTACTING: Questions 33-35 seeks consent from the KP to be contacted by the peer outreach workers and other clinical staff for services.

All the columns in this form are self-explanatory.

TOOL #9B: FSW CLINIC ENROLLMENT FORM

Name of Implementing Partner: ______________________________ Date:____ /____ /________

District: ______________________ Location: ______________________ Hotspot: ______________________

Staff Outreach Worker: ____________________________ Peer Outreach Worker: ____________________________

Name of KP: ________________________________

Date of Birth: ____ /____ /________ Program ID: ____

Contact Address: ____

Phone Number: ____

1	How old were you on your last birthday? (Age in completed years)		
2	Where do you MOSTLY solicit/meet your clients or partners? **CIRCLE ALL THAT APPLY**	**Name of hotspot (s):**	
		☐ Bar with lodging	☐ Bar without lodging
		☐ Sex den (brothels)	☐ Strip club
		☐ Streets/highways	☐ Home
		☐ Casino	☐ Beach
		☐ Lodgings/guesthouse/ Rest house/hotels	☐ Massage parlors
		☐ Parks	☐ Beer tavern
		☐ Public toilets	☐ Others
3	On average how many penetrative sex acts (vaginal/anal) do you have?	Per day	Per week
4	Have you ever visited any DIC/clinic/wellness centre for any services in the last 6 months?	☐ Yes	☐ No
5	If Yes, which DIC did you visit?		
6	Have you been contacted by a peer outreach worker from the HIV prevention program?	☐ Yes	☐ No

	REPRODUCTIVE HEALTH		
7	How many pregnancies have you had in your lifetime including abortions?		
8	Are you currently pregnant?	☐ Yes	☐ No
9	Are you visiting a health facility for antenatal care?	☐ Yes	☐ No
10	How many children do you have now?		
11	Are you currently using any method to prevent pregnancy?	☐ Pill ☐ Injection ☐ Implant ☐ IUD ☐ Condom ☐ BTL ☐ Other ______________________ ☐ None	

TOOL #9B: FSW CLINIC ENROLLMENT FORM *continued*

SEXUALLY TRANSMITTED INFECTIONS		
12	In the past 6 months have you ever had any of these symptoms? **PLEASE READ ALL**	☐ Genital/anal ulcer disease ☐ Foul smelling vaginal/anal discharge ☐ Painless growth in anal/vaginal area ☐ Itch in genital/anal area ☐ Rash in genital/anal area ☐ Bubo ☐ Dysuria ☐ LAP ☐ Others ______
13	Where did you receive treatment for the above mentioned symptoms you had in the past 6 months?	☐ Pharmacy ☐ Private doctor ☐ Government clinic ☐ Herbalist ☐ NGO/program clinic ☐ Other ______ ☐ Did not recieve treatment

SEXUAL HISTORY AND RISK ASSESSMENT				
14	At what age did you first have sexual intercourse?			
15	Did you ever receive cash or goods in exchange of sex with a man?	☐ Yes	☐ No	
16	If yes, at what age did you start sex work?			
17	In the past ONE WEEK, from how many men did you receive cash or goods in exchange for sex?			
18	In the past ONE WEEK, how many men did not pay you cash or goods in exchange for sex?			
19	Did you use a condom last time you had sex with a client?	☐ Yes	☐ No	
20	Did you use lubricant last time you had sex?	☐ Yes	☐ No	
21	During the past one month how often have you consumed drinks containing alcohol?	☐ Never ☐ Most days	☐ Sometimes ☐ Every day	
22	Have you ever used/consumed a drug for non-medical purpose?	EVER	LAST MONTH	LAST WEEK
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

SEXUAL AND GENDER-BASED VIOLENCE			
23	In the last 3 months have you ever experienced violence?	☐ Yes	☐ No
24	If yes, which type? **Tick all mentioned**	☐ Harassment ☐ Sexual violence ☐ Other	☐ Physical violence ☐ Discrimination
25	Who perpetrated the violence?	☐ Community pressure groups ☐ Local leaders ☐ Police ☐ Military ☐ Madams/pimps ☐ Bar managers and owners ☐ Local gangs ☐ Fellow employee ☐ Magistrate/judiciary	☐ Government officials ☐ General community ☐ Family members ☐ Religious groups ☐ Regular partner ☐ Clients ☐ Healthcare provider ☐ Employer ☐ Other (Specify) ______
26	Did you seek help?	☐ Yes	☐ No
27	If yes, where did you seek the help? **MARK ALL MENTIONED**	☐ Chief/village elder ☐ Friends ☐ Peers ☐ Religious leader	☐ Family ☐ Legal/police ☐ Medical/hospital ☐ Other (Specify) ______

TOOL #9B: FSW CLINIC ENROLLMENT FORM *continued*

HIV TESTING AND COUNSELING			
28	Have you ever tested for HIV?	☐ Yes	☐ No (Skip to question 35)
29	If yes, how long ago?	☐ Within 3 months ☐ Within 6 months ☐ Within 1 year ☐ Above 1 year	
30	If yes, would you like to share your test result with me?	☐ Tested positive ☐ Tested negative ☐ Results unknown ☐ I do not want to share	
31	If positive, have you disclosed your HIV status to anyone?	☐ Yes	☐ No
32	If yes to whom?	☐ Boyfriend ☐ Regular client ☐ Friend/relative ☐ Other ___	
33	If positive are you receiving HIV care?	☐ Yes (specify duration) If yes, duration: ___	☐ No
34	If receiving care, which facility is giving you care (address of the facility)?		
35	Could we contact you by phone (including SMS) for services related to STI/FP/HIV testing/HIV Care/GBV or other services?	☐ Yes	☐ No
36	Could we contact you through your peer outreach worker /staff outreach supervisor for services related to STI/FP/HIV testing/HIV Care/GBV or other services?	☐ Yes Signature/thumb print of the KP ___	☐ No
37	Name of Service Provider:	Signature ___ Date ___	

NAME OF THE TOOL	TOOL 9B: FSW CLINIC ENROLLMENT FORM
Who should complete	Clinic Staff
When to complete	When the FSW comes to the clinic for the first time for services
How often to complete	Daily

DESCRIPTION TO COMPLETE COLUMNS

TOOL 9B: FSW CLINIC ENROLLMENT FORM is used for each FSW when they visit the clinic for the first time for clinical services. It captures all the basic history of the KP to plan their future clinical management.

BASIC BACKGROUND INFORMATION ABOUT KP: In the first section, basic demographic information should be asked and recorded.

BEHAVIOR OF KP: Questions 1-6 are recorded to understand the risk behaviou of the KP which may influence chances of acquiring the HIV infection.

REPRODUCTIVE HEALTH: Questions 7-11 record the reproductive health history of the FSW. This helps the doctors to assess her reproductive health and provide services accordingly.

SEXUALLY TRANSMITTED INFECTIONS: Questions 12-13 record the past STI history of the KP.

SEXUAL HISTORY AND RISK ASSESSMENT: Questions 14-22 record the sexual history and past behavior of the KP. This will help the clinician to counsel and treat the KP accordingly.

SEXUAL AND GENDER-BASED VIOLENCE: Questions 23-27 record the sexual and gender-based violence experienced by the KP in the past.

HIV TESTING AND COUNSELING: Questions 28-34 record whether the KP has ever been tested for HIV and counseled, and the results if the KP is willing to share. If HIV positive, it also seeks information about the care currently received by the KP.

CONSENT FOR CONTACTING: Questions 35-37 seeks consent from the KP to be contact by the peer outreach worker and other clinical staff for services.

All the columns in this form are self-explanatory.

TOOL #9C: REFERRAL SLIPS

(SLIP FOR FACILITY/ REFERRAL CENTER) NAME AND ADDRESS OF CSO/NGO	
Slip Number:	
Client PID No.	
Referred to which type of facility:	
Name of the facility:	
Address of the facility	
* Referred by (Name):	
Date of referral:	
Reason for referral:	STI/HCT/ART/FP/TB/Others
Name of the Accompanying Person (if any):	
SLIP FOR NGO/IMPLEMENTING PARTNER NAME AND ADDRESS OF CSO/NGO	
Slip Number:	
Client PID No.	
Referred to which type of facility:	
Name of the facility:	
Address of the facility	
* Referred by (Name):	
Date of referral:	
Reason for referral:	STI/HCT/ART/FP/TB/Others
Name of the Accompanying Person (if any):	
SLIP FOR THE CLIENT NAME AND ADDRESS OF CSO/NGO	
Slip Number:	
Client PID No.	
Referred to which type of facility:	
Name of the facility:	
Address of the facility	
* Referred by (Name):	
Date of referral:	
Reason for referral:	STI/HCT/ART/FP/TB/Others
Name of the accompanying person (if any):	

NAME OF THE TOOL	TOOL 9C: REFERRAL SLIPS
Who should complete	Clinic Staff
When to complete	When a KP is referred for any services outside the CSO/NGO system
How often to complete	Daily

DESCRIPTION TO COMPLETE COLUMNS

TOOL 9C: REFERRAL SLIPS should be prepared in triplicate and below should be followed to keep the record of the referral made to other facilities

SLIP 1: to be retained at the referral centre
SLIP 2: to be collected by the program manager/counsellor of the NGO/CSO from the referral centre at the end of every reporting month
SLIP 3: to be given by the referral centre back to the client after providing services for which the client was referred

SLIP NUMBER: This number is a continuous serial number maintained by the implementing partner.

CLIENT PID NO.: Record the program identification number

REFERRED TO WHICH TYPE OF FACILITY: The KPs should know where they have been referred and what type of facility it is. Write the type of referral facility KP is referred to.

NAME OF THE FACILITY: Name of the facility should be written here.

ADDRESS OF THE FACILITY: The address of the facility in this section will help the KPs to find the facility.

REFERRED BY (NAME): Write the position of the person who referred the KP. This may be the staff outreach supervisor, the peer outreach worker, counselor, antenatal health-care worker, or Project Manager.

DATE OF REFERRAL: Record the date of referral using the format DD-MM-YY.

REASON FOR REFERRAL: Write the reason for referring the KPs to the said facility, e.g. STI, HTS, FP, other ailments, etc.

NAME OF THE ACCOMPANYING PERSON (IF ANY): Write the name of the person accompanying the KP to the referral point.

TOOL #10: FSW/MSM CLINIC VISIT FORM

(To be completed by Clinic Staff)

GENERAL PATIENT INFORMATION				
Client Name	Age		UIC/PID	
Date/Month/Year ____ / ____ /________	Gender	M/F/TG	District	
Phone No.	**Name of Hotspot**			
Reason for Visit (Multiple Possible)	☐ Symptomatic ☐ Asymptomatic ☐ Quarterly Screening			
New Client?	☐ Yes ☐ No	Presenting Complaints: ____________________		
Referred by:	☐ Peer ORW/ORW ☐ Self ☐ Partner ☐ Others			
Any clinical exam performed?	☐ Yes ☐ No	If yes, state findings: ____________________		

STI SYNDROME AND TREATMENT			
SYNDROME	**X**	**TREATMENT**	**X**
1. GUD		Pack 1 (Benz Pcn + Azithromycin)	
2. Cervicitis		Pack 2 (Azithromycin + Cefixime)	
3. PPT			
4. ARD			
5. UD (male)			
6. Vaginitis		Pack 3 (Metronidazole) Add 3b (Clotrimazole)	
7. Vaginitis + Candida			
8. PID		Pack 4 (Cefixime + Doxy14 + Metro14)	

FAMILY PLANNING AND OTHER SERVICES			
SERVICES	**X**	**SERVICES**	**X**
Family Planning		Gender-based violence	
Risk Reduction Counseling		HIV care and treatment	
Condom Demonstration/Education		Post-abortion care	
PEP		Linkage to psychosocial support	
Condoms Given ☐ Male	No. __________	Lubricant given	No. __________
☐ Female	No. __________		

HIV TESTING AND COUNSELING SERVICES					
REPORTED STATUS	**COUNSELED**	**TESTED**	**RECEIVED RESULTS**	**TESTING RESULTS**	**ART THERAPY**
☐ Positive	☐ Yes	☐ Yes	☐ Yes	☐ Positive	☐ Provided here
☐ Negative	☐ No	☐ No	☐ No	☐ Negative	☐ Gets elsewhere
☐ Unknown				☐ Indeterminate	☐ Referred

REFERRAL SERVICES		
Client referred for laboratory tests	☐ Yes ☐ No	If yes, where:
Client referred to other health facilities	☐ Yes ☐ No	If yes, which facility:

CLINICIAN'S COMMENTS

SUMMARY						
CONDITIONS	SCREENED		TREATED		REFERRED	
	Yes	No	Yes	No	Yes	No
STI						
TB						
Hepatitis B						
Alcohol & Drug Abuse						
Cervical Cancer						
Abscess						
FP						
Others (Specify)						
Next Appointment Date:			Reason:			
Clinicians Name:			Signature______________________ Date _____ /______ /_________			

NAME OF THE TOOL	TOOL 10: FSW/MSM CLINIC VISIT FORM
Who should complete	Clinic Staff – Preferably Clinician
When to complete	Every time KP comes for clinic services
How often to complete	Daily

DESCRIPTION TO COMPLETE COLUMNS

TOOL 10: FSW/MSM CLINIC FORM is completed by the clinical staff for each KP each time they visit the clinic. The information is collected to know the history and current complaints which helps the doctor to diagnose and treat illnesses, especially STI, HIV, TB, etc. or to provide services including FP, HTS, etc.

GENERAL PATIENT INFORMATION: This section records the general background information about the KP who is visiting clinic for services.

STI SYNDROME AND TREATMENT: This section records the STI syndromes as reported by the KP and relevant treatment provided by the clinician.

FAMILY PLANNING AND OTHER SERVICES: This section records all the family planning services and other related services provided (if KP needs).

HIV TESTING AND COUNSELING SERVICES: This section records the HIV testing received by the KP at the clinic. The information includes whether tested, received results, and the HIV status.

CLINICIAN COMMENTS: The clinician writes his/her overall comment about the KP and findings from the current visit.

SUMMARY: This section records a summary of the information that has been provided during the KP's visit.

Tool contributing to PEPFAR indicator

GEND_GBV (Number of KPs receiving post-GBV care)

HTC_TST (Number of KPs who received HTC services and received their test results)

Tool may also contribute to (non-PEPFAR) monitoring indicators developed by the country program (STIs, FP)

TOOL #10A: KP INDIVIDUAL TRACKING SHEET FOR CLINICAL SERVICES

(To be completed at clinic by the designated clinic staff)

NAME OF STAFF OUTREACH SUPERVISOR	
QUARTER	☐ Q1 (Oct – Dec) ☐ Q2 (Jan – March) ☐ Q3 (April – June) ☐ Q4 (July – Sept)

1. SL NO.	2. PID NO.	3. SPOTS/ HOT-SPOTS	4. NICK-NAME	5. TYPE OF KP	6. AGE	HEALTH SERVICES																								ANY GBV INCIDENTS FACED			FOLLOW-UP FOR CLINIC		
						STI						HTC						FP						OTHERS*											
						M1		M2		M3		M1		M2		M3		M1		M2		M3		M1		M2		M3							
						S	Tx	S	Tx	S	Tx	T	R	T	R	T	R	S	P	S	P	S	P	S	T	S	T	S	T						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
1																																			
2																																			
3																																			
4																																			
5																																			

Type of KP: 1. FSW 2. MSM 3. TG 4. PWID

STI: S = Screened, Tx = Treated

HTC: T = Tested, R = Received Results

FP: S = Screened, P = Provide FP Methods

Others: *TB, S = Screened, T = Treated

GBV incidents: 1. Harassment 2. Physical Violence 3. Sexual Violence 4. Discrimination 5. Others

NAME OF THE TOOL	TOOL 10A: KP INDIVIDUAL TRACKING SHEET FOR CLINICAL SERVICES
Who should complete	Clinic Staff
When to complete	This should be completed by the clinic staff to provide a summary by peer outreach worker and hotspot.
How often to complete	Daily but compiled quarterly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 10A: KP INDIVIDUAL TRACKING SHEET FOR CLINICAL SERVICES is compiled from the information recorded in Tool 10. This will help the clinic and outreach staff understand the performance of each peer outreach worker at a site with regard to clinical services, including HIV testing.

Tool contributing to PEPFAR indicator

HTC_TST (Number of KPs who received HTC services and received their test results)
CUSTOM INDICATORS;
1.4 (Proportion of KPs tested for HIV among those reached)
1.10 (Proportion of KPs with HIV currently enrolled in care among those who tested positive)
PROGRAMMATIC INDICATORS
Number of key population clients screened for family planning need;

TOOL #11: KP PLHIV TRACKING SHEET

(Confidential Information) To be completed by designated trained clinical staff.

This format will support collection of information for PEPFAR indicator

SL. NO.	PID	UIC (Provided by ART Center)	TYPOLOGY	AGE	DATE OF DETECTING HIV POSITIVE	RECEIVED HIV RESULTS	DISCLOSED STATUS		ART			CD4 DONE		VIRAL LOAD DONE		PEER ORW/PEER NAVIGATOR
							YES/ NO	IF YES, TO WHOM*	DATE OF PRE-ART REGISTRATION	PLACE OF ART REGISTRATION	DATE STARTED ON ART	DATE	LEVELS	DATE	LEVELS	
1																
2																
3																

NAME OF THE TOOL	TOOL 11: KP PLHIV TRACKING SHEET
Who should complete	Clinic Staff
When to complete	All the PLHIV data collected from various sources and compiled in this regularly
How often to complete	Daily

DESCRIPTION TO COMPLETE COLUMNS

TOOL 11: KP PLHIV TRACKING SHEET captures important information on each of the PLHIV KPs identified in the program. This will help to calculate many of the indicators that are part of the HIV cascade. Information is collected from various sources, including government ART centres, testing centres and other clinic records where KP PLHIV seek services.

SL. NO: record the serial number of the PLHIV.

PID: This is the Program ID that has been provided by the program.

UID (PROVIDED BY ART CENTER): Record the UIC that has been provided by the ART center after registration of PLHIV KP.

TYPOLOGY: Typology of KP should be recorded here in this column, i.e. MSM, FSW, PWID or TG

AGE: Current age of the KP PLHIV should be recorded, in complete years.

DATE OF DETECTING HIV POSITIVE: Record the date when the KP was identified as HIV positive..

RECEIVED HIV RESULTS: Whether the KP has received the Result (Yes or No)

DISCLOSED STATUS: It is up to the KP to whom (if anyone) they wish to disclose their HIV status. Record if disclosure has happened (yes or no). If they have disclosed, record who knows the status, e.g., peer outreach worker, staff outreach supervisor, relative, counselor, etc.

INFORMATION ABOUT ART: Record the date of pre-ART registration, place of ART registration, and/or date started on ART.

CD4 STATUS: Record whenever the CD4 count is conducted, with date and levels of CD4 count.

VIRAL LOAD STATUS: Record whenever a viral load test is conducted with date and level of viral load.

PEER NAVIGATOR: Record the name of the peer navigator who is assigned to follow up a particular PLHIV KP.

Tool contributing to PEPFAR indicator

CARE_NEW (Number of HIV positive KPs newly enrolled in clinical care who received clinical assessment (WHO staging)/ CD4 count/viral load at enrolment)
CARE_CURR (Number of HIV positive KPs who received clinical assessment (WHO staging)/CD4 count/viral load)
Custom Indicator (Proportion of KPs with HIV currently enrolled in care among those who tested positive)
TX_NEW (Number of KPs newly enrolled on ART)
TX_CURR (Number of KPs currently receiving ART)
Custom Indicator (Proportion of KPs currently receiving ART among those currently enrolled in care)
TX_RET (Percentage of KPs with HIV known to be alive and on treatment 12 months after ART initiation)

TOOL #11A: CASE MANAGER/PEER NAVIGATOR – INDIVIDUAL FORM

(PLHIV: MSM-TG-MSW-TGSW-FSW-PWID)

CBO	
LOCATION/HOTSPOT	
CASE MANAGER/PEER NAVIGATOR	
CM/PN SIGNATURE	

								CARE AND SUPPORT SERVICES TO HIV POSITIVE KP OUTSIDE HEALTH FACILITIES								
													COMMODITY PROVISION, SPECIFY THE NUMBER/ITEM			
NO.	DATE (D/M/Y)	UIC/ID/ NICK-NAME	AGE	SEX (M/F)	KP TYPE	ON ART (YES/ NO)	PRE-ART (YES/ NO)	SUPPORT FOR RETENTION ON PRE-ART CARE & ART (YES/NO)	SUPPORT FOR ADHERENCE ON ART (YES/NO)	CLINICAL & PSYCHOSOCIAL NEEDS ASSESSMENT (YES/NO)	CLINICAL & PSYCHOSOCIAL REFERRALS (YES/NO)	REFERRAL TO COMPREHENSIVE HIV CARE (YES/NO)	ART REFILL (YES/NO)	MALE CONDOMS	FEMALE CONDOMS	BASIC MEDICATIONS, E.G., COTRIMOXAZOLE
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17

NAME OF THE TOOL	TOOL 11A: CASE MANAGER/PEER NAVIGATOR – INDIVIDUAL FORM
Who should complete	Peer Navigator
When to complete	This form should be completed when the Peer Navigator provides care services in the field
How often to complete	Daily

DESCRIPTION TO COMPLETE COLUMNS

TOOL 11A: KP PLHIV TRACKING SHEET FOR COMMUNITY CARE collects information on the number of KP PLHIV receiving care and support services outside of the health facility through peer navigators.

COLUMNS 1-8: record information from Tool 11. This includes the background characteristics of the PLHIV KP.

COLUMNS 9-17: record the services provided by the peer navigator in the field and outside clinical services. The services are recorded in the form of "yes" or "no" for each KP. Care and support services for KP PLHIV include:

Support for retention on pre-ART care & ART

- **Support for adherence on ART**
- **Clinical & psychosocial needs assessment**
- **Clinical & psychosocial referrals**
- **Referral to comprehensive HIV care**

Commodity provision (specify the number/item)

- **ART refill**
- **Male condoms**
- **Female condoms**
- **Basic medications (e.g., cotrimoxazole)**

Tool contributing to PEPFAR indicator

CARE_ COMM
(Number of HIV positive KPs receiving care and support outside of the health facility)

TOOL #12: CRISIS MANAGEMENT REGISTER

(To be completed by staff outreach supervisor with support from peer outreach worker)

This format will support collection of information for PEPFAR indicator GEND_GBV: Gender Based Violence (GBV) Care: Number of people receiving post-GBV care

When an incident of harassment takes place for a particular KP member, give the following details:
(Use one form for each incident)

1. Name of the person who experienced crisis:	
2. Age:	3. Sex:
4. Program ID number:	5. Hot spot:
6. Name of peer outreach worker:	
7. Name of staff outreach supervisor:	
8. KP affected: ☐ FSW ☐ MSM ☐ TG ☐ PWID	
9. Date of incident:	
10. Number of key population members affected in the incident:	
11. Type of incident: ☐ Harassment ☐ Physical Violence ☐ Sexual Violence ☐ Discrimination ☐ Other (Specify):	
12. A brief description of the incident (not more than 200 words):	
13. Who committed the incident? (Tick as applicable) ☐ Community pressure groups ☐ Local leaders ☐ Police ☐ Military ☐ Madams/Pimps/Bar ☐ Bar managers and owners ☐ Local gangs ☐ Fellow employee ☐ Magistrate/Judiciary ☐ Government officials ☐ General community ☐ Family members ☐ Religious groups ☐ Regular partner ☐ Clients ☐ Healthcare provider ☐ Employer ☐ Other (specify)	
14. Was the incident reported within 24 hours? Yes /No	
15. Did the individual receive post-violence care within 24 hours? Yes/No	
16. Type of post-violence service provided? ☐ Rapid HIV testing with referral to care and treatment as appropriate ☐ Post-exposure prophylaxis (PEP) ☐ STI screening and treatment ☐ Emergency contraception ☐ Psychosocial counseling ☐ Legal support ☐ Complaint registration at police station ☐ Child protection services ☐ Others (Specify)	
17. Role of project Crisis Management Team in addressing the issue (describe in 200 words):	
18. Follow-up action planned (describe in 200 words):	

NAME OF THE TOOL	TOOL 12: CRISIS MANAGEMENT REGISTER
Who should complete	Staff Outreach Supervisor
When to complete	Whenever a crisis incident happens in the field, it should be recorded and the record kept at the program office
How often to complete	Regularly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 12: CRISIS MANAGEMENT REGISTER is completed whenever a crisis incident happens in the community. Once the staff outreach supervisor learns about the crisis he/she should collect and record all relevant information, including where it happened, the name of the peer outreach worker at the hotspot, which key population member(s) was affected by the incident, and the date. The form also records the type of incident, e.g., harassment, physical violence, sexual violence, discrimination.

A brief description of the incident along with identification of the person who committed the incident.

It is important to record whether the crisis was reported and resolved within 24 hours.

Also record type of response service provided including:

- Rapid HIV testing with referral to care and treatment as appropriate
- Post exposure prophylaxis (PEP)
- STI screening and treatment
- Emergency contraception
- Psychosocial counseling
- Legal support
- Complaint registration at police station
- Child protection services
- Others, specify

Record the role played by the project Crisis Management Team in addressing the issue, with a follow-up action plan

All the columns in the form are self-explanatory.

TOOL #13: ADVOCACY/SENSITIZATION REGISTER

(To be completed by staff outreach supervisor)

Implementing partner:		Meeting No:
1. Date:		
2. Activity held at: Hosting spot:	Location/Area:	City/Town:
3. What was the issue discussed?		
4. How was the issue identified?		
5. What was the advocacy objective? (What did you want to achieve?)		
6. Whom did you advocate with? ☐ Community pressure groups ☐ Local leaders ☐ Police ☐ Military ☐ Madams/Pimps/Bar ☐ Bar managers and owners	☐ Local gangs ☐ Fellow employee ☐ Magistrate/Judiciary ☐ Government officials ☐ General community ☐ Family members	☐ Religious groups ☐ Regular partner ☐ Clients ☐ Healthcare provider ☐ Employer ☐ Other (specify)
7. Number of participants:		
8. Who are the other partners/allies you involved in the activity?		
9. What methods did you use? (e.g., lecture/presentation, individual meeting, group meeting, health services, exhibitions, street plays, other)		
10. What difficulties did you face in addressing the issue?		

11. Follow-up action after the activity:

FOLLOW-UP ACTION POINTS	RESPONSIBLE PERSON	TIMELINE

Name of person who conducted the advocacy:

Signature: ______________________________

NAME OF THE TOOL	TOOL 13: ADVOCACY/SENSITIZATION REGISTER
Who should complete	Staff Outreach Supervisor
When to complete	Whenever an advocacy or sensitization session is conducted with stakeholders
How often to complete	Regularly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 13: ADVOCACY/SENSITIZATION REGISTER is completed when an advocacy activity is held in the area where KPs operate. It is important to have a definite objective for the meeting and methods used for sensitizing stakeholders. It is also important to record if there are any difficulties faced during the advocacy/sensitization session. The activity should be closed with definite action items with timelines and responsibility.

All the columns in the form are self-explanatory.

TOOL #14: REFERRAL REGISTER (FOR NON-MEDICAL SERVICES)

(To be completed by Staff Outreach Supervisor)

NAME OF INSTITUTION	PROGRAM ID NUMBER	DATE OF REFERRAL	SERVICES REFERRED FOR	CONTACT PERSON AT THE REFERRED SERVICES	RESULT OF THE REFERRAL

NAME OF THE TOOL	TOOL 14: REFERRAL REGISTER (FOR NON MEDICAL SERVICES)
Who should complete	Staff Outreach Supervisor
When to complete	Regularly
How often to complete	Regularly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 14: REFERRAL REGISTER (FOR NON-MEDICAL SERVICES) is maintained to know whether the project is meeting other needs of KPs beyond health. This information helps the program manager to plan activities around KPs' interests so that their health-seeking behavior increases as they develop increased confidence in the project activities.

NAME OF INSTITUTION: Record the name of the institution the KP was referred to.

PROGRAM ID NUMBER: Record the KP's program ID number in this column.

DATE OF REFERRAL: Note the date of referral in this column.

SERVICES REFERRED TO: List the type of service the KP was referred to.

CONTACT PERSON IN THE REFERRED SERVICES: Record the contact whom the KP was asked to meet.

RESULT OF THE REFERRAL: Record whether the referral was successful or needs further follow-up.

TOOL #15: SUPPORT GROUP REGISTER

(To be completed by Staff Outreach Supervisor)

SECTION I
Group Details

1. Name of Support Group ____

2. Date of Formation of Support Group ____________________________________

SECTION II
Executive Committee of Support Group (if applicable)

Committee Effective from (date) __________ /__________ /________________

1. NAME OF OFFICE BEARER	2. POSITION	3. DATE OF ELECTION AS OFFICE BEARER
	President	
	Secretary	
	Treasurer	
	Member	
	Member	

→ *Add more rows if necessary*

SECTION III
Membership Details

SR. NO.	PROGRAM ID NUMBER	MEMBER NAME	AGE	SEX	TYPE OF KP	DATE AND YEAR OF JOINING	DATE AND YEAR OF DROP OUT
1	2	3	4	5	6	7	8

→ *Add more rows if necessary*

SECTION IV
Minutes of the Meetings Held by the Support Group

Attendance Summary

SR. NO.	PROGRAM ID NUMBER	MEMBER NAME	AGE	SEX	TYPE OF KP	DATE OF MEETING	SIGNATURE
1	2	3	4	5	6	7	8

→ *Add more rows if necessary*

MINUTES OF THE MEETING REGISTER

<table>
<tr><td>1. Date of meeting</td><td></td></tr>
<tr><td>2. Hot spot/place</td><td></td></tr>
<tr><td>3. Meeting no.</td><td></td></tr>
<tr><td>4. Time of the meeting</td><td>Start time:
End time:
Total hours:</td></tr>
<tr><td>5. Number of members attending the meeting</td><td></td></tr>
<tr><td colspan="2">6. Summary of topics discussed/activities

Gender Norms:
1. Understand and question existing gender norms
2. Impact of gender norms on lives of key population
3. Link between the gender norms and HIV prevention, treatment, care or support
4. Norms that encourage violence and stigma against KPs
5. Others, specify

Care and Support for PLHIV:
1. Support for retention for pre-ART and ART clients
2. Adherence support if on treatment
3. Basic client assessments with documentation of clinical and psychosocial needs and linkage/referral to other services as appropriate
4. Referral and linkage to health facilities providing comprehensive HIV care
5. Distribution of commodities such as condoms, refill of ART or basic medications such as cotrimoxazole
6. Others, specify</td></tr>
<tr><td colspan="2">7. Curriculum used:

Linkages curriculum
Stepping Stones
Yaari Dosti
Programme H
Tuelimishane
One Man Can
Men as Partners
Others (specify)</td></tr>
<tr><td colspan="2">8. How was the session facilitated, including methodology?</td></tr>
<tr><td colspan="2">9. Outcome or decisions in the meeting:</td></tr>
</table>

NAME OF THE TOOL	TOOL 15: SUPPORT GROUP REGISTER
Who should complete	Staff Outreach Supervisor
When to complete	Whenever a group is formed for KPs and starts functioning regularly.
How often to complete	Regularly

DESCRIPTION TO COMPLETE COLUMNS

SECTION I: GROUP DETAILS: This section records the group name and the date it is formed.

SECTION II: EXECUTIVE COMMITTEE OF SUPPORT GROUP: This section should have all the managing committee who are the leadership team for the support group. This should have a system of rotation to provide chance to every member of the group to lead the support group. This section records name of the office bearer, positions, and date of electing the office bearer.

SECTION III: MEMBERSHIP DETAILS: This section records information about each member of the group.

SECTION IV: MINUTES OF THE MEETINGS HELD BY THE SUPPORT GROUP: Minutes of the meetings held by the Support Group: This section records details of the meetings conducted by the support group, including the number of members attending the meeting, and a summary of topics discussed or other activities.

Also record specific topics covered under Gender Norms, including:

- Understand and question existing gender norms
- Impact of gender norms on lives of key population
- Link between the gender norms and HIV prevention, treatment, care or support
- Norms that encourage violence and stigma against KPs
- Others, specify

Record the curriculum used during the session, e.g.:

- Linkages curriculum
- Stepping Stones
- Yaari Dosti
- Programme H
- Tuelimishane
- One Man Can
- Men as Partners

Include how the session was facilitated, including methodology, and any outcomes of the meeting.

Tool contributing to PEPFAR indicator

This format will support collection of information for PEPFAR indicator GEND_NORM

TOOL #15A: GEND_NORM – INDIVIDUAL FORM

(MSM-TG-MSW-TGSW-FSW-PWID)
(Compiled from Tool #15)

CBO				REPORTING PERSON						
LOCATION/HOTSPOT				PEER OUTREACH WORKER SIGNATURE						
						SESSION TYPE		MINIMUM CRITERIA FOR INTERVENTIONS COMPONENTS COMPLETED		
No	Date (D/M/Y)	UIC /ID/ Nick Name	Age	Sex (M/F)	KP Type	One on One	Small Group	Use participatory methodology to support understanding and questioning of existing gender norms & reflection on the impact of norms on the lives of KP? (Yes/No)	Make a link between gender norms discussed & HIV/AIDS prevention, care and support and treatment outcomes (e.g., Norms that encourage violence and stigma against KP)? (Yes/No)	Completed minimum of 10 hours intervention? (Yes/No)

NAME OF THE TOOL	TOOL 15A: GEND_NORM – INDIVIDUAL FORM
Who should complete	Monitoring and Evaluation officer
When to complete	Whenever a training on gender norms is conducted for KP members
How often to complete	Regularly

DESCRIPTION TO COMPLETE COLUMNS

Based on meetings conducted by the support groups and members attending the meeting (Tool 15) a compilation of the data can be done for the following issues:

Minimum criteria for interventions components completed:

- Use participatory methodology to support understanding and questioning of existing gender norms & reflection on the impact of norms on the lives of KP? (Yes/No)
- Make a link between gender norms discussed & HIV/AIDS prevention, care and support and treatment outcomes (e.g. Norms that encourage violence and stigma against KP)? (Yes/No)
- Completed minimum of 10 hours intervention (Yes/No)

These data can generate information for the PEPFAR Gender norm indicator.

Tool contributing to PEPFAR indicator:

GEND_NORM: Number of individuals completing an intervention pertaining to gender norms within the context of HIV/AIDS, that meets minimum criteria.

TOOL #16: TOOL FOR ASSESSMENT OF COMMUNICAITON BY PEER OUTREACH WORKERS

(One-to-one, one-to-group, group meeting)

Date: ______________________ Implementing Partner: ______________________

Hotspot: ______________________ Name of Peer Outreach Worker: ______________________

SL. NO	QUALITY INDICATORS	SCORE (0-5)	OBSERVATIONS/REMARKS
A	**Greeting, Rapport & Ground-Building**		
1	Peer outreach worker greets the KP(s) with a smile and displays a pleasant and friendly attitude through appropriate body language		
2	Peer outreach worker displays rapport with the KP(s) and builds the ground appropriately before beginning the session.		
3	Peer outreach worker finds a reasonably appropriate space to carry out the session.		
4	Peer outreach worker has chosen a time convenient to KP(s) to conduct the session.		
5	Peer outreach worker ensures proper visibility and audibility while conducting the session.		
6	Peer outreach worker uses appropriate language with the KP(s) to gain their attention and understanding.		
B	**Two-way Communication/Ensuring Understanding**		
1	Peer outreach worker asks appropriate open-ended and probing questions to KP/s, to establish a dialogue and gain their involvement.		
2	Peer outreach worker encourages KP(s) to speak – ask questions, share opinions - to ensure their understanding and gives enough time for them to respond.		
3	Peer outreach worker actively listens to KP(s) and allows appropriate silence for the KP to speak.		
4	Peer outreach worker is able to facilitate the session in a manner and tone of voice that sustains the interest of KP(s).		
C	**Non-Judgmental Attitude**		
1	Peer outreach worker is non-judgmental towards KP(s)' lifestyle and sexual practices.		
2	Peer outreach worker shows empathy with KP(s)' situation/ expression of feelings.		
D	**Conclusion/Thanks/Next Visit**		
1	Peer outreach worker summarizes the session by briefly emphasizing the learning drawn from the material in question.		
2	Peer outreach worker concludes by fixing a date, time, place for the next session and thanks the KP(s) before leaving.		
E	**Record Keeping**		
1	Peer outreach worker records the session and method used as per the prescribed MIS formats.		

NAME OF THE TOOL	TOOL 16: TOOL FOR ASSESSMENT OF COMMUNICATION BY PEER OUTREACH WORKERS
Who should complete	Staff outreach worker
When to complete	Upon doing assessment of the peer outreach worker
How often to complete	Six monthly/Yearly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 16: ASSESSMENT OF COMMUNICATION BY PEER OUTREACH WORKERS is used to assess the quality of communication of a peer outreach worker at their hotspot. It should be conducted for each peer outreach worker every six months to assess their performance level and identify training needs to deliver high-quality services. To administer this tool the staff outreach supervisor should observe the peer outreach worker while s/he is conducting a communication session with a peer. The staff outreach supervisor should observe the following points and rank him/her on a 0-5 scale. (0- Not Done, 1- Needs Improvement, 2- Average, 3- Good, 4- Very Good, 5- Excellent)

GREETING, RAPPORT AND GROUND-BUILDING: In a high-quality communication session, the peer outreach worker welcomes and introduces him/herself to the key population individual, builds rapport with them, and creates a ground for dialogue. It is important not to underestimate the significance of finding a reasonably appropriate space and time to conduct the session, and use appropriate language to ensure retention and proper understanding.

TWO-WAY COMMUNICATION/ENSURING UNDERSTANDING: In a quality communication session, the peer outreach worker must actively listen to the individual's concerns using appropriate methods, while ensuring two-way communication for risk identification and risk reduction of STIs and HIV, and partner treatment.

NON-JUDGMENTAL ATTITUDE: For a good communication session, the peer outreach worker must show empathy and be non-judgmental towards the individual's lifestyle and sexual practices.

CONCLUSION/THANKS/NEXT VISIT: To ensure understanding, at the end of the session the peer outreach worker should conclude the session by summarizing the key messages communicated, thanking the KP for his/her time, and setting a date and place for the next session.

RECORD-KEEPING: The last step in the process of conducting a good communication session is to record information from the session accurately on the appropriate forms.

TOOL #17: ASSESSMENT OF REFERRAL SERVICE POINT

SR. NO.	OBSERVATION	YES	NO	NOTES
1	Qualified doctor in position			
2	Doctor trained on ARV, STI, Syndromic Case Management (SCM) according to standards country guidelines			
3	Nurse in position			
4	Nurse trained on job responsibility			
5	Counselor in position			
6	Counselor trained on counseling			
7	Staff are approachable, friendly and non-judgmental			
8	Adequate history-taking and proper clinical examination conducted at the facility			
9	Supervised treatment is provided			
10	Staff explain compliance, condoms, contact tracing and follow-up			
11	Explain drug compliance with respect to ARV, STIs after consultation			
12	Staff maintain confidentiality and proper documentation client records			
13	Staff explain informed choice for HIV testing (explain benefit and risk of HIV testing)			
	Score = Total no. of (Yes) / 13			

NAME OF THE TOOL	TOOL 17: ASSESSMENT OF REFERRAL SERVICE POINT
Who should complete	Program Manager
When to complete	To know the quality of referral centre where KPs are referred.
How often to complete	Six monthly/yearly

DESCRIPTION TO COMPLETE COLUMNS

TOOL 17: ASSESSMENT OF REFERRAL SERVICE POINT is designed to assess the quality of referral centers where KPs are being referred. The assessment parameters include qualified doctor, nurse and other clinical staff; training of the staff for STI, ARV and other health-related issues; approach of the staff towards KPs in treatment, and provision of information. Depending on the findings, implementing partners can plan sensitization and advocacy with the referral centers.

All the parameters are self-explanatory to complete.

ANNEXURE IV

Sample Scope of Work for Validating and Estimating Number of Key Population Individuals at the Spot Level

This scope of work covers the validation of mapping information with respect to locations and different key population groups at the location, and the collection of information that can be used to plan interventions among the identified groups. Apart from describing the locations of key populations, information should gathered on the available STI and HIV resources in the area, vulnerability to HIV (in terms of number of partners and condom usage), the extent of STIs, and the networks of sex workers and clients.

The areas of information to be explored in the assessment are listed below.

1. Mapping Readiness Assessment to assess acceptability of mapping to key populations
2. Locations/spots with approximate number of key population members
3. Description of area (geographical boundaries, demographics, socio-economic status and information about local business, industry and residential areas, history of local police action towards the commercial sex industry)
4. Available resources in the area? (NGOs providing key population members interventions or health services, social services, HIV prevention, condom promotion and distribution, and care and support; available private, public, and NGO services (such as STI services, HIV testing services [HTS], care and support, condom outlets)
5. Type of risk taken by key population members in the area
   - a. Where do the key population operate (soliciting/ pick-up sites, sites where they have sex)?
   - b. Where do they live?
   - c. Profile of the population, e.g. their ethnicity/ language, average age, literacy level
   - d. What is the estimated number of key population members (gross estimate for project planning purposes)?
   - e. What is their work situation (for sex workers: who are the intermediaries such as brothel-owners, pimps; how do they access clients, amount and type of fees, who determines the fee, number of clients per day, usual sex acts)?
   - f. Are there sex worker collectives, support groups or networks in the area? (Are sex workers members of sex workers' collective — why or why not? Do they see any benefit in the collectives?)
6. Who are their clients/partners (number of clients per day; profile of clients — occupational group, etc.; working or living places)?
7. STI services (Where do key population members and clients seek health care? Why do they prefer to seek care in these facilities? If they do not want to go to the government facilities, what are the reasons? How can government STI services be improved?)
8. What are the current STI case management practices (clinical, syndromic, laboratory diagnosis)?

9. Condom usage (Where do they get/buy condoms? Who provides condoms? How much do they cost? Do they use condoms, and what are the barriers to condom use?)

10. What are their sources of information about HIV?

11. Are HTS available, and are they willing to go for HIV testing? Why or why not?

12. Are there NGOs doing targeted interventions to key populations in the identified locations and NGOs wanting to move into these locations?

13. Where would be the closest possible reference clinic/hospital/lab?

14. Maps of locations with key landmarks

Methodology

The specific protocol for programmatic mapping will vary by country as it is adapted to national and local program needs. The protocol should include these essential components:

1. Mapping Readiness Assessment to obtain information necessary to adapt the data collection tools and to determine whether mapping is acceptable to the key population communities

2. Meaningful engagement of key populations throughout the process

3. Clear identification of the program implementation area including its specific boundaries and zones within the area that will be used to ensure that the entire area is mapped

4. Meaningful and appropriate definitions of each key population and sub-groups

5. Determination of whether each key population will be mapped separately or whether mapping of several groups can be implemented concurrently

6. Protocols to assess bias in data collected

7. Protocols for data quality, data entry, data storage, data sharing, and maintenance of data confidentiality, including confidentiality of spot names and locations

8. Adapted data collection forms and informed consent documents and Fact Sheets for participants

9. Commitment to systematic and complete mapping of all spots in each zone in each program implementation area

10. Respect for all persons

11. Training materials for data collectors, supervisors and data entry personnel

12. Analysis plan including table shells, maps, graphs

13. Specific method to be used for size estimation, including assumptions of method and how bias will be measured

14. List of coverage indicators that will be estimated

15. Budget for planning, implementation, analysis, and dissemination of results

An illustrative protocol is currently under development through a collaboration between UNAIDS, Global Fund, WHO, the University of Manitoba and MEASURE Evaluation (funded by USAID) at the University of North Carolina. A workbook describing the major elements of the protocol is available now.

The assessment involves recruitment of consultants (investigators and community consultants), contacting NGOs, and conducting interviews and small group discussions with target group respondents in the field.

Time frame

Two to three weeks and on a continuous basis.

Recruitment of community consultants

Community consultants are needed to help carry out the fieldwork. Their role is to get access to the community in general, and to key population members in particular. Community consultants should be identified with the help of local NGOs. They may already be working with existing HIV projects.

Data collection process is sequential and includes the following steps

1. Community consultations and in-depth interviews as part of a Mapping Readiness Assessment

2. Community Informant interviews with persons knowledgeable about the program implementation area, such as taxi drivers, to identify spots and obtain a comprehensive list of spots in each zone in the area

3. ***Spot Visits:*** "Seeing is believing" is the driving principle of spot visits. Spot visits are essential to meet respondents and see what STI and HIV resources are available in the community (e.g., HTS, ART, STI clinics). All spots should be visited. During the spot visit characteristics of the spot are obtained, including the number of key population members visiting the spot and whether the spot is currently receiving outreach services.

4. Interviews with key population members at the spot during the spot visit