2015

NATIONAL STANDARDS FOR PEER EDUCATION & OUTREACH FOR HIV PREVENTION AND CARE AMONG KEY POPULATION: MOZAMBIQUE
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<td>BCC</td>
<td>Behavior Change Communication</td>
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<td>CBO’s</td>
<td>Community Based Organizations</td>
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<td>CNCS</td>
<td>National AIDS Council</td>
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<td>CROs</td>
<td>Condom Retail Outlets</td>
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<td>CSO</td>
<td>Civil Society Organizations</td>
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<td>DIC</td>
<td>Drop In Center</td>
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<td>DQA</td>
<td>Data quality assurance</td>
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<td>FSW</td>
<td>Female sex workers</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>HCPs</td>
<td>Health Care Providers</td>
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<td>HIV</td>
<td>Human Immuno Deficiency Virus</td>
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<td>HRGs</td>
<td>High Risk Groups</td>
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<td>HTC</td>
<td>HIV Testing and Counseling</td>
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<td>IBBS</td>
<td>Integrated Bio-Behavioral surveys</td>
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<td>IDU</td>
<td>Intravenous drug users</td>
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<td>INS</td>
<td>National Institute of Health</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>KAPs</td>
<td>Knowledge, skills, practice and attitudes</td>
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<td>KPs</td>
<td>Key populations</td>
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<td>LRPss</td>
<td>Legal Resource Persons</td>
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<td>MARPS</td>
<td>The Most at Risk Populations</td>
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<td>MIS</td>
<td>Management Information Systems</td>
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<tr>
<td>MOT</td>
<td>The Modes of Transmission</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NAP+</td>
<td>Networks of People Living with HIV</td>
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<td>NTCP</td>
<td>National Tuberculosis Control Program</td>
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<td>PEN III</td>
<td>National Strategic Plan Against HIV and AIDS for 2010-2014</td>
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<td>PEPFAR</td>
<td>President Emergency Plan for AIDS Relief</td>
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<td>PHE</td>
<td>Peer health educator</td>
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<td>PMTCT</td>
<td>Prevention from Mother to Child HIV Transmission</td>
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<td>QA/QI</td>
<td>Quality assurance/Quality Improvement</td>
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<td>RRS</td>
<td>Rapid Response System</td>
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<td>SGBV</td>
<td>Sexual and Gender Based Violence</td>
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<td>SOPs</td>
<td>Standard operating procedures</td>
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<td>SRH/FP</td>
<td>Sexual and reproductive health/family planning</td>
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<td>STI’s</td>
<td>Sexually Transmitted Infections</td>
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<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
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Mozambique is among the 10 countries with the highest estimated prevalence of HIV in adults at a reproductive age. Evidence shows that when HIV prevalence is high among key population, especially female sex workers and MSM, the epidemic spreads to their clients and partners, and from them to their regular partners/spouses (general population). Mozambique has in place the national target of reducing new HIV infections by half by 2015. As a result, it is imperative to have focused prevention intervention for key populations to achieve the target.

The Bridge Project initiative of transfer of learning through its India Learning network came at a critical moment when Mozambique was deliberating the mechanism of implementing a high quality key populations program. A senior delegation from the government and civil society was given an opportunity to see the Aastha program, successfully implemented in India, as part of the BMGF – Avahan program. The team closely interacted with key India national government senior staff who shared their experiences of the India response for key populations which was based on Avahan experiences.

After communicating with community members in India and witnessing the impact of the program towards the reduction of their vulnerability and risk for contracting HIV, it was felt that similarly in Mozambique national standards need to be developed to scale up prevention activities among key populations. The National Standards and SOPs detailed in this document will be used to implement a key population program with a strong coordination with clinical services team across the country.

It is our belief that this document will guide all implementers and planners to provide quality HIV prevention services to key populations and enable the country to reach its goal of reduced new HIV infections.

Dr. Diogo Milagre
Deputy Executive Secretary
The CNCS, Mozambique acknowledges the significant contributions of all those who were involved in the development of the “National Standards for Peer Education and Outreach for HIV prevention among Key Population: Mozambique” Their dedication and hard work are highly appreciated. This document was drafted under the leadership of CNCS and a specifically set up working group, members of which provided instrumental guidance and technical input. Sincere thanks go to all the members of the working group for their extensive inputs in developing this document: USAID, MoH, FHI 360/Mozambique ROADS and FHI 360/India Bridge Project. Their contributions and participation in various discussions has culminated in the drafting of the SOPs.

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1.1 Country HIV Epidemiology

Mozambique is among the 10 countries with the highest estimated prevalence of HIV in adults at reproductive age. The 2011 surveillance data reveals a slight rise in the HIV prevalence between 2009 and 2011, having risen from 13.7% to 15.8% respectively, with wide variation between regions, with the south being the highest and the north being the lowest. The 2011 surveillance data shows that the HIV prevalence observed in pregnant women in Mozambique is 15.8% and 13.2% among girls between 15-24 years of age (INS, 2013). It has been observed that 84% of the new infections are sourced from sub Saharan Africa. 11% of sub Saharan Africa infections (excluding South Africa) are from Mozambique.

The Modes of Transmission (MOT) study conducted in 2013 estimates at 110,399 new HIV infections in this year amongst adults between the ages of 15-49 years in Mozambique, which represents an incidence rate of 1.1%. The major contributor is the south region with 40% of new infections, followed by the center region with 36% and the north region with 24%.

The MOT reveals new groups opening a new door for the redefinition of these groups, this include: stable heterosexual relations, multiple partners and their partners, MSM and their partners, FSW, Clients of FSW and partners of FSW clients.

The figures shows clearly that almost three fourths of the infections are sourced from FSWs, MSM and multiple partner relationship. The national program has therefore identified these groups as major risk groups to be targeted.

HIV prevalence among FSWs and MSMs

Integrated Bio-Behavioral surveys (IBBS) conducted in 2011 amongst FSW and MSM covering the three major cities in Mozambique; Maputo (capital) Beira and Nampula indicates that the HIV prevalence is three times higher in these populations when compared to the general population. The HIV prevalence among FSWs was 31.2% in Maputo, 23.6% in Beira and 17.8% in Nampula. The prevalence rate when compared between the age groups of 15-24 years and 25 years and more it was four times higher in Maputo, three times higher in Beira and sixtimes higher in this last group. The HIV prevalence among MSM was 8.1% in Maputo, 9.1% in Beira and 3.7% in Nampula. The prevalence rate when compared between the ages groups of 18-24 years and 25 years and more was 14 times higher in Maputo, 11 times higher in Beira and 4 times higher in this last group. This shows that there is a need for targeting Key populations especially FSW and MSM to accelerate the impact on reducing HIV infections.

HIV Prevention Programs targeting sex workers have been expanded since 2009 in terms of coverage and range of interventions. Currently, activities are being implemented in the main cities and transport corridors by establishing friendly and discrimination free services for sex workers. These programs are implemented against the umbrella national response program which includes Blood Safety, Prevention from Mother to Child Transmission (PMTCT), HIV Counseling and Testing (HCT), Sexually Transmitted Infections (STI’s), and Knowledge and Behavioural Change Programs. The main target groups include Adolescents and Young People and Most at Risk Populations (MARPs).
1.2 Need for Standards and SOPs

Standard operating procedures (SOPs) and minimum standards will support the design, and implementation of quality of HIV interventions in Mozambique. The SOPs and minimum standards will standardize and quantify the intervention package and define the services and ensure uniformity of terms, definitions and systems.

These SOPs will systematize the strategies described under the HIV and AIDS Response – Strategic Acceleration Plan for Mozambique 2013-2015 and will assist implementers and planners to provide quality services to MARPs and better enable Mozambique to reduce number of new HIV infections in MARPs. The implementing agencies will ensure that services are provided as per the minimum prevention service package as mentioned in this document and safeguard standardization among partners working in their respective areas.

1.3 Minimum Package of services for Key Populations

Experiences in India under Aastha/Avahan Program have shown that Minimum Packages of Services for key population (KPs) are necessary aspects of HIV prevention programming for KPs, to ensure optimum and regular coverage with essential services and quantification of the packages of services could add value for prevention program. This could be done by tracking of essential services to individual KPs to ensure maximum coverage.

The Minimum package of services could include:

- **Outreach:** Peer Health Educator should visit each KP at least once a week and provide services; (e.g. either a Behavior Change Communication (BCC) session, condom, clinical service)
- **BCC:** A quality BCC session should be provided to all KP once a month
- **STI Service:** STI related services/ clinical services should be offered to all KP every quarter
- **HIV Testing and Counseling:** A HTC service should be provided to KP every six months
- **Condoms and lubricants:** Quality condoms and lubricants should be provided every week to KP (based on condom demand)
- **Continuum of care:** All HIV positive KP will be referred and linked for care, support and treatment services
- **Sexual and Gender Based Violence screening:** All KP will be offered and screened for SGBV once in a year
- **Sexual and Reproductive Health:** All KP will be reached with sexual and reproductive health services.
2. Standard Operating Procedures

2.1 Outreach program management

2.1.1 Designing an Intervention

**Context**

Management of peer outreach is a key component of successful programs. This section ensures that planning and implementing successful projects include participatory and informed planning and program design. This SOP presents critical components for effective participatory planning, evidenced-based understanding of the vulnerabilities for KPs and the intervention area characteristics.

**SoP objectives**

- To develop a clear, thorough and realistic implementation plan with an outline of key activities with timelines for implementation and serves as a basis for monitoring and evaluation.
- To identify a budget and needed inputs for components to consider when designing an implementation plan for successful implementation from the beginning.
- To help the implementer to use this as a planning and management tool.

**Procedure**

Designing could be divided into steps namely: Review to develop work plan and Identify the needed resource.

**Review existing data and additional/updated information**

- Define goal and SMART Objectives.
- The data should be gathered through observations and mapping, in-depth interviews, focus groups, and short surveys.
- Define location/geographic scope. At minimum, identify the existing hot spots with concentrated presence of KP.
- Location and types of HIV and reproductive health services; existing resources/other interventions working with KP.
- Locations of potential barriers to implementation (e.g. police stations); and Identify key stakeholders/gatekeepers critical for the achievement of intervention goals and objectives.
- Define microsites within the larger intervention area: The ideal microsite should be concise geographical area that has one or more hot spots with between 30 to 60 enumerated KP, to which one peer educator (PE) will be assigned.
- Identify key characteristics, risks and needs of KP within the intervention area. Use recent behavioral and biological surveillance results as a guide.
- Based participatory assessments develop an activity plan with clear measurable indicators.
- Map out the sequence of activities along a time line helps to ensure your plan is realistic within the given timeframe.
Budgeting and ensuring adequate resources

Based on the work plan and determines the resources needed for the intervention. Consider the following:

Funds Availability

• Cost out all inputs that are unavailable and need to be covered by the project.
• Identify existing available resources, e.g. in-kind contributions or donations from community leaders, stakeholders, and share resources with partners.

Human resources including staffing needs:

- Will you need additional staff (full-time, facilitators, or consultants)
- Will existing or new staff need additional training?
- What duration do you need for each position?
- Cost out staff salaries, benefits, allowances and severance.

Availability of Equipment and Space

- Equipment: Functional/standard equipment that facilitate efficient working environment (e.g. computers, DIC equipment etc.)
- Furniture: Standard office furniture that enhances/promotes effective work such as desks, chairs.
- Communication tools: Access to office communication tools.
- Identify a dedicated space for administrative/management needs.
- Identify space for service delivery which is accessible and acceptable for KPs (Eg. such as the DIC, space for counseling).
- Identify & cost secure space for storing equipment, files.

2.1.2 Mapping and size estimation of KPs at intervention levels

Context

Being able to determine the size of the target is important for planning any prevention activities. When the outreach team starts working in the field it is important for them to generate a data that could be used as a denominator to assess their performance. This section makes an effort to generate a localized population size estimate, which local implementers can use to set targets and to guide their programming.

SoP Objectives

• To estimate size of key population and map groups who have been identified as vulnerable to infection and transmission of HIV and other STIs.
• To identify and map Health Care Providers (HCPs) and facilities and Condom Retail Outlets (CROs) available in close vicinity of the areas where the vulnerable population groups are mapped
• To list CSO/NGOs/CBOs (Community Based Organizations) working within the mapped geographic locations of the selected area and services provided.
• To ensure involvement of the key population.
Procedure

**How to reach key population key informants**

**Step 1:** Identify the key hot spots using the potential key informants from the first section of the list above

**Step 2:** Identify exact site location with more information on the site, including type of key informants available at the sites and the risk behavior of the key population

**Step 3:** Use Delphi method to discuss with the key population key informants to understand the size of the key population at that site, with all the other information requested in the format. Key informants at the site have to be key population themselves. This will help to collect authentic information about the site.

**Material required for mapping**

- Maps of location where mapping exercise is being carried out.
- The only materials needed to conduct the group session are large flipchart papers and marker pens
- Data collator should carry sufficient number of broad mapping forms to fill out (immediately) after each broad mapping session
- Mapping teams should carry letters of introduction so that KPs and others who participate in the mapping exercise understand that the teams’ work is legitimate, as well as to provide contact information if they would like to find out more about the project
- The mapping teams should also carry condoms, lubricant, and referral information to distribute upon request.

2.1.3 Recruiting Peer Health Educators

**Context**

Recruitment of peer health educators is a very important aspect of prevention programs among KPs. The focus will be to involve individuals with strong leadership skills and are identified by the community members and project staff as peer leaders. These leaders need to be individuals from the same geographical area, community, speak the same language, belong to the same age group and work in the same profession who should also be a currently practicing KP so that he/she has regular access to other KPs, has active linkages and understands the present needs. The outreach staff or program managers identify KPs as peers on the basis of feedback from other KPs.

**SoP Objectives**

- To provide contextual clarity on the strategy for selecting peers from the among the KPs
- To provide information about essential requirements and detailed processes for peer selection.

This will be complemented by SOPs on Peer progression and Micro-plan.
Procedure

Criteria for selection of Peer Health Educators

Criteria should include:

- Representativeness of population, size of social network and degree of respect among peers, availability over period of intervention,
- Commitment to working as a peer educator
- The person should be a team player with voluntary spirit who has a potential for leadership and ability to lead.

Process of Selection

- Should be taken up as an intentional strategy to make the project sustainable and increase community ownership
- Establish a standardized and transparent interview and selection process.
- Standardize and document the interview forms and processes, including establishment of a credible recruitment panel consisting of senior key population members.
- The selection process needs to be documented in writing, made available to all interested parties, and should be implemented fairly.

2.1.4 Training and Capacity Development

Context

Maximum involvement of key population in project activities is very important to ensure the sustainability of the project. Quality training imparted to staff at every stage and level of project implementation will ensure that there is constant upgrading of knowledge of community. Training stages the way for quality performances.

SOP Objectives

- To provide contextual clarity on the strategy for carrying out training needs assessment for the development of need based training manual and programs.
- To provide contextual clarity on the strategy for designing a training for the effective implementation of the project. To provide information about essential requirements and detailed processes for designing a training.
Procedure

Training Needs Assessment

Needs assessment are carried under the following conditions which will help the project conduct specific trainings:

- New Recruitments - Induction and orientation to all new employees.
- If a new activity is included in the project.
- Difference between actual performance and standard performance.
- In case of attitudinal problems among the team members.
- If there is a need expressed by the project team.

There are two aspects of capacity building, the initial group training and subsequent mentoring and refresher

Capacity building through regular group training

- The entry level behavior of the participants is to be documented and studied before designing the training.
- Creativity is an important requirement as the training should to be participatory and it needs to cater to participants who may be illiterate or semi-literate.
- The training material and formats need to be pictorial and easy to use for all the participants.
- The venue should be identified with all the necessary facilities available for trainees.
- The trainer should come prepared and rehearse the sessions before conducting the training. This rehearsal needs to aim at overcoming inhibitions, if any.
- The trainer needs to adopt a participatory approach to ensure involvement of all the participants.
- The training needs to include energizers after every two hours to revive the mood of the participants and also to ensure everyone is attentive during the session.

Capacity building through engaged mentoring

- Engaged mentoring plan is to be made in keeping with the requirements of each type of KP.
- Planning activities and rolling them out by achieving and maintaining speed.
- Training through on site demonstrations and supervision thus creating a cascading effect.
- Supportive supervision through demonstration and re-demonstration of activity to provide on-site training.
- Setting performance standards and stressing on uniformity.
- Developing quality assessment tools and used at the time of supervision to assess performance standards.
- In order to mentor the outreach staff, the process of training the PEs also needs to be demonstrated. The supervisor take over the role of engaged mentoring with the PEs.
2.1.5 Peer Progression and Retention

Context
In order to achieve the vision of community involvement, it is necessary to have a specific strategy to involve the community in program implementation and management. Opportunities for community members to take on leadership and staff roles in the project should be available and advocated. This would lead to the gradual building of capacities of community members and an increased role of the community in defining the project direction, which is crucial for transfer of project activities to the community.

SoP Objectives
- To provide contextual clarity on the strategy for KP progression
- To provide essential requirements and detailed processes of KP progression

Procedure
Initially the PHEs should be identified according to the criteria mentioned above. Once they are identified following should be followed:
- KPs to be inducted and trained to work as community volunteers with minimal responsibilities.
- Outreach workers and project staff will observe performance of community volunteers in the project. Establish a system where peers are provided opportunities to grow within the project activities.
  - The position could be peer supervisors, peer nurse, peer advocate, peer trainer etc. Set up an effective supportive supervision system, with mentoring provided as possible.
  - Ensure that peer educators are well prepared for their new responsibilities with updated knowledge and skills as needed with expansion of respective roles.
  - Supervisors need to manage the group dynamics, encourage team building, promote a safe environment and stay aware of personal relationships.
  - Supervisors should build ownership by involving the peer educators in the decision-making process, sharing supervision and responsibilities with other peer educators.

2.1.6 Community mobilization—Formation of community groups

Context
KPs rarely come together, generally seeing each other as rivals. Being isolated, they tend to get marginalized and vulnerable to abuse, violence, arrests and coercion. It is imperative to bring KPs together to help them recognize and address their problems and use their collective strength to derive solutions and reduce exploitation. Being together also gives them a group identity, leading to increased self-esteem and therefore improved negotiation skills, health seeking behavior and safer sex practices.
SOP Objectives

- To provide contextual clarity on the formation and working of the SHGs.
- To provide essential requirements and detailed processes on the functioning of the SHGs.

Procedure

KP groups could come together and form their own group with clear criteria for being a member of the SHG. The prerequisites could be that all should be KPs only with clear core values of coming together for unity; to solve difficulties; to gain mutual respect for all the KPs. The intention is to have a vision of involving each and every KP into groups for stronger actions.

Each SHG needs to have three leaders: a President, a Secretary and a Treasurer and have monthly meetings

Formation and strengthening of SHGs

- Community events to be organized at the PE site level to bring the KPs together and build rapport.
- During the events, build awareness related to common needs e.g. the need to provide support in times of crises, the need to be self-dependent and the effectiveness of collective action.
- Each PHE to have an SHG which should not exceed 20 KPs.
- Each SHG to democratically elect three leaders during an SHG meeting: President, Secretary and Treasurer.
- The PHE to conduct at least one monthly meeting with their respective SHGs with support from their outreach team.
- Regular exposure visits to police stations, relevant government offices, hospitals, banks to be organized for the SHG members to familiarize them with the personnel and services available.

Procedures for conducting an SHG meeting

Introduction:

- Each meeting to start with an introduction session, where all the members introduce themselves.
- The introduction is to be repeated if there are any new members.
- A song to be sung by the group, too create a feeling of togetherness, cohesiveness and empowerment among the members.

Issues taken up by the SHG:

- Last meeting minutes to be read and follow up action to be discussed.
- Discussions about any issue that the SHG wants to take up.
- Information related to project services to be shared
- SHG members, PHE and outreach team to plan and prepare in advance for a session on the issue of discussion.
**Entertainment:**

- Games, songs or other activities as per the interest of the KPs to be conducted in order to facilitate interaction among the members.

**Planning for the next meeting:**

Date, time, place and issues to be discussed to be finalized before the close of the meeting.

### 2.2 Peer Education (Outreach–In-reach)

Peer education is one of the most widely used strategies in intervention projects, as a peer is a KP who has an equal standing and belongs to the same societal group especially based on age, grade or status. Peer involvement is an effective way of reaching out to communities and affecting change in norms. Peers are knowledgeable “insiders”, and their involvement enhances trust and communication. They constitute a credible source of advice and can be powerful role models who can help change social norms. Peer networking and the sharing of information leads to community mobilization around issues of concern. Greater involvement of KPs has been the focus of the many projects, the process of which involves participation of KPs in project implementation.

#### 2.2.1 Micro Planning and Individual Tracking

**Context**

A micro plan is a crucial tool in planning, implementing, monitoring and strategizing service delivery for community outreach interventions. Micro plan is a live tool that facilitates a PE to do individual-level planning and follow up on prevention service uptake based on the individual risk, vulnerability, profiles of KPs and their partners. Micro-planning at each site is done by PHEs. A micro plan gives a visual picture of the site that a PE is managing. It helps to understand the extent to which program services have reached the KPs and also helps to identify and monitor problem areas. To ensure the effective execution of a micro plan, the outreach team prepares a plan by keeping in mind definite responsibilities of individuals involved in project implementation.

**SoP Objectives**

- To provide contextual clarity on the strategy for developing a micro plan for the effective implementation of an outreach program.
- To provide information about essential requirements and detailed processes for the development, implementation and monitoring of a micro plan.

**Procedure**

*An Micro plan is developed in the following manner*

- Geographical area of operation to be defined at the organizational level
- Area demarcation is to be done at the ORW level. The ORW Micro-plan to consist of the areas of the PHEs under him/her.
- PHEs to be capacitated to make their specific area map, enroll and track registered KPs individually.
- Regular collection and action on data.
- PHEs need to be equipped to be able to implement their micro plans.
- The implementation of the micro plan is to be monitored on a weekly basis.
- The implementation of micro plans is to be documented by the PE in the form of individual tracking sheets and weekly reports.
- Data is documented and is tracked through a smooth flow of various interconnected documents. Field data is to emerge from the micro-plan.

**Institutionalization of a Micro Plan**

It is important for the PHEs to be able to develop their micro plans as it capacitates them as site managers and help them own the plan.

*Micro Planning Competition* – in order to institutionalize the concept of micro-planning, holding a competition was found useful. During this competition, each PE develops his/her own micro plan and presents the same to a panel of judges who selects the best micro plan. Each PHE also needs to explain his/her micro-plan, the benefits and how he/she will use it for regular planning and monitoring. This creates healthy competition among the PHEs as well as ensures that the process is ingrained.

An illustration of micro plan by a PHE

![Micro Plan of Peer Heal Educator area.](image)
2.2.2 Communication
   2.2.2.1 Conducting Communication Session

Context
Effective communication sessions with Key Populations are a very necessary strategy in the context of an STI/HIV prevention project as it is necessary to encourage Key Populations to register with the project, avail the services, participate in project activities and ultimately develop health seeking behavior.

SoP Objectives
- To provide contextual clarity on the strategy for conducting communication with the KPs.
- To provide information about essential requirements and detailed processes for planning, conducting and evaluating communication sessions.

Procedure
The process of registering new Key Populations and improving health seeking behavior among them is carried out through communication sessions.

- One to one communication sessions – one PHE to one KP.
- One to group communication sessions – one PHE to group of maximum four to five KPs.

How should a PHE Approach a KP?
- Each PHE to conduct minimum one, one to one session with maximum three Key Populations per day.
- Each one to one session should not exceed more than 20 to 30 minutes.
- Each PHE must conduct at least one, one to group session every day.

What should be done when approaching the KP?
- The PHE to build rapport with the key population before initiating a discussion on STI/HIV.
- The PHE should take prior appointment to fix the session at a time convenient time and place to the Key Populations.
- The PHE to decide on the appropriate communication material or message to be discussed based on the prior session.
- The PHE to use appropriate communication material in an interesting way.
- The PHE to teach every SW three different ways to use a condom correctly with the help of a demonstration and re demonstration on the penis model.
- The PHE to use appropriate language and dialect while communicating with the SW.
- The PHE to listen to the current STI/HIV knowledge of the Key Populations.
- The PHE to address the myths and misconceptions of the Key Populations and initiate a dialogue on risk reduction.
- The PHE to refer Key Populations to other government health institutions to as per their needs as and when required.
2.2.2.2 Communication Packages

Context
The communication packages are to be used to pull the Key Populations towards a positive behavior instead of pushing them or forcing them towards change. The pull factor ensures that the change is internalized and sustainable. The goal is to increase knowledge and skills to adopt positive health seeking behavior. It drives environmental as well as individual change in an effort to create enabling environments that make health-seeking and low-risk behaviors achievable.

SoP Objectives
- To provide contextual clarity on the strategy for developing BCC packages for the effective implementation of the project. To provide information about essential requirements and detailed processes for the development, implementation and monitoring of an engaged mentoring plan.

Procedure
Ensuring the consumer (KP) focus where participation of KPs is a crucial part of the process. This will also take care of current behavior in exchange for another and the marketing mix which goes beyond promotion to designing strategies to make healthy choices. Division of KPs into groups as per their risks and need to plan develop effective Communication packages as follows.

- Division of the KPs into groups depending on their vulnerability and risks. This helps to plan need based communication packages.
- Situational analysis on the availability of existing material and the communication needs of different typologies of KPs.
- An understanding about the areas of interest of the KPs is important. This information can serve as communication hooks which need to be developed with creativity.
- The Communication material needs to generate a dialogue between the PEs and the Key Populations.
- Field testing of the materials is to be done with each typology of KPs to make changes where necessary.

The illustration of segment of KP (FSWs) can be referred in Annexure III.

2.2.3 Condom Promotion: Demonstration and distribution

Context
KPs are exposed to sexual relationships with multiple partners, who could be infected by STIs/HIV and therefore it is imperative for them to use condoms at the time of every encounter. It is important that condoms need to be correctly and consistently used in order to prove as an effective means for prevention. The lack of awareness and proper knowledge about how to use a condom amongst clients compounds their vulnerability. To address this, it is essential to demonstrate the proper use of condoms in all circumstances. It is also important that the condoms should be made available for KPs are the convenient places of their choice. This will help the KPs who want to hide their identity while acquiring condoms.
SoP Objectives

- Steps to be followed while correctly using a condom, thus ensuring protection from STIs/HIV.
- To provide conceptual clarity about the need to establish condom depots involving maximum participation of KPs.

Procedure

Requisites

PHE who will conduct the session will have the following in place:

- Penis model.
- Adequate supply of condoms.
- Flavoured condoms if doing the oral condom demonstration.
- Adequate light.
- Private surroundings.

Demonstration

- The condom demonstration will be done using a penis model. The methods could be normal, oral and blind folded.
- All Methods can be shown on separate occasions or together.
- Each method to be followed by a reverse demonstration, where the KPs themselves re-demonstrate the method. The outreach team member to provide support and clarify doubts.

Condom distribution mechanism

Participation of KPs is crucial in identifying condom depots, in keeping with their safety issues with the police and also to protect their professional identity. Condom depots can be manned or un-manned. Following steps should be followed for developing condom depots

- The condom depots to be established on the basis of the preference expressed by KPs. The KPs to decide the places and people they would prefer as condom depots.
- It is necessary to build rapport and establish relationships with potential individual/s who serve as condom depots or managers and to explain the purpose of setting up condom depots.
- The condom depot to be visited by the PHE on a daily basis to check on the stock.
- If there are opportunities to place condoms where KPs are comfortable pick up the condom PHE can develop un-manned condom outlets like public toilets etc.
2.2.4 Partner Coordination for providing clinical services for KPS

Context
This is an important section as it ensures strong coordination mechanism between various departments of the MoH and the peer health educators who have the confidence of key population to deliver services. A strong coordination mechanism among various stakeholders and service providers will ensure cost effectiveness with no duplication or resources and efforts. Information sharing between partners at all levels strengthens the evidence base, reinforces KP monitoring systems and generates strategic information to improve programs.

SOP Objectives
- To provide guidelines to coordinate among different stakeholders and service providers to KPs

Procedure
At the national, provincial and district levels, local coordination in partnership with the CNCS representative ensures that all relevant stakeholders from all sectors, including development partners and the private sector, are engaged at the appropriate levels.

Define roles and responsibilities of the different partners.
- Identify different agencies needed for the smooth functioning of an intervention.
- Provide coordination guidelines among these agencies.
- Form the group (total membership of the group, national, provincial and districts to be decided).
- Nominate leaders.

Partner coordination
Provincial/District level
- Participation should be decided by the provincial coordinating body of CNCS at provincial level.
- The participants could include governmental institutions, MoH, transportation entities, NGOs, and provincial representatives of the participants at the national level as applicable.
- Provincial level or district level implementers should be invited to participate.
- The meetings should focus on the implementation of the MARP NSP at the Provincial level and the level of program implementation as well as achievements by stakeholders and implementers. It should provide a platform for stakeholder to present their achievements.
- Quarterly meetings are recommended. However, these meetings can be linked to other meetings for HIV coordination at the provincial level. It should be ensured that KP interventions are fully discussed.
Intervention level

Outreach coordination

Regular meetings between the various staff of the project and the outreach teams are required to ensure coordination between them. These coordination meetings will help

- To improve the quality and coverage of services and also help implementers
- To review progress, innovate on their strategies and rethink their resource allocations.
- Participants: The intervention team including the managers and other category of staff including counselor, PHE, outreach workers where each site is represented by either the field staff or the PHE. The Project manager should also participate initially till the system is smooth.
- Frequency: Coordination meetings should be held at least once a month. Time and date should be fixed for the same time each month if possible.
- Location: In the DIC, health facility or any other convenient location/site for PHEs or Key population.
- Purpose of the Meeting:
  o To discuss the outcome of the referrals made to the clinics out the project area.
  o To discuss if the service delivery site is strategically positioned to meet the needs of key populations.
  o To discuss follow up of key populations e.g. to provide treatment, to monitor compliance with treatment, to monitor progress of disease, to follow up on referrals made.
  o To answer queries coming up in the field that cannot be answered by the outreach staff.
  o To provide feedback to clinic as well as the outreach teams to improve services.
  o Acceptability and effectiveness of counseling messages.
  o To strategize for the forthcoming weeks to improve coverage and quality of services.

Preparation for the meeting:

- Important decision of the previous meeting should be documented and circulated to members well before the next meeting and set the agenda for the meeting in advance.
- Before the meeting, teams should analyze their performance for the previous month and come prepared with data.
- Designate an individual to ensure registration of participants and take minutes.
- Matters arising from the previous meeting should be discussed first and this followed by discussion of the agenda of the day.
- At the end of the meeting, indicate the task that need to be done, who is responsible and timelines for actionable points.
- Special situations should be referred to appropriate service provider.
2.2.5 Creating Support System for Key Population

2.2.5.1 Networking and linkages

Context
Networking and linkages are an essential component of any intervention with KPs as they provide synergies for the project to build upon; from a point of challenge to advantage to a point of strength. Networking involves forming formal and informal partnerships and ties with various stakeholders with different/mutual areas of interest and/or benefits. Any one project cannot provide every service needed/wanted by the beneficiaries. Therefore, networking and establishing linkages with stakeholders’ brings the community closer to services needed that go beyond the scope of the project. It also supports the facilitation of the creation of an enabling environment, in which KPs would be able to practice healthy behaviors and utilize health services, making these processes sustainable. The networks work independently and together to ensure that KPs enjoy their fundamental rights and avail services without the stigma and discrimination associated with their profession. This also include skill building, IGA, support services for other medical emergencies etc. to the KPs, as per their needs, through linkages and networks.

SoP Objectives
- To provide contextual clarity on the networking efforts needed with stakeholders while working with KPs.
- To provide essential requirements of networking and detailed processes for establishing linkages.

Procedures
The steps that could be followed for creating networks for KPs.
- Discuss the networking strategy with key community members and staff.
- Create a team of KPs and local experts responsible for the planning and implementation of the strategy.
- Assess the needs of the community, through group discussions to find the needs of the community within and outside the scope of the project.
- Conduct mapping of potential linkages, to enable access to need-based services not being provided by the project that are available within project area and outside project area.
- Develop a system for initiation and strengthening of linkages with stakeholders.
- Develop a relationship building system to facilitate regular exchange of views and updates to ensure continuous support and access of services to the Key Population.
- Review strategy on a periodic basis – decide the time period of the review with the team.

Networking at Government facility level
- List all the Health post, Government hospitals, ART Centers, NTCP, local women welfare Committee within the vicinity with following information
- Identify the local Government functionaries and facilities as per the needs assessment (services not being provided by the project).
• Build rapport with local Government representatives and those in charge of services of the area.
• On a regular basis, the project staff to visit the offices of the functionaries to build rapport and give them information about the project and the role they can play in the implementation.
• Invite them to participate in community and project events and acknowledge them.

Networking at the Local level
• Map all the local hospitals and health care providers, local NGOs, Women Welfare Associations, forums and community based groups.
• Regular visits to the identified hospitals and health centers to build rapport with health care providers During the visits the PHEs need to talk to the health care providers’ about project activities to make environment conducive for KPs to access services.
• In partnership with the hospital/health care center, have a specified space in their premises for a staff member. This is to create an enabling environment in which KPs would be able to practice healthy behaviors and utilize health services, without stigma and discrimination.
• Staff/key community members responsible for the linkages, to accompany KPs in need of services.
• Staff/community members to visit the CSOs, forums and community based groups on a regular basis to develop contact and strengthen the same.
• Visits to be made initially on a monthly basis. This can be reduced to once in a quarter as the relationship strengthens.

2.2.5.2 Sensitization of Stakeholders

Context
In the context of KPs, sensitization efforts with the gatekeepers and key stakeholders need a specific strategy, keeping in mind community dynamics and local conditions. Sensitization of gatekeepers and stakeholders while working with Key Population is a crucial activity. In the short term, it creates opportunities for continuous access to the Key Population for the provision of services. Long term benefits would be the creation of an enabling environment in which Key Population can access services themselves. These activities need to be conducted on a regular basis and should focus on building community linkages.

SoP Objectives
- To provide contextual clarity on the sensitization efforts needed with stakeholders and gatekeepers while working with KPs.
- To provide essential requirements and detailed processes on the content and implementation of a sensitization strategy.
Procedures

Following are the steps for building of a supportive environment, leading to vulnerability reduction and safer sex practices amongst Key Population:

- Discuss the strategy with key community members and staff
- Conduct stakeholder mapping (including listing and categorization)
  - Gate Keepers: Individuals with whom rapport is needed to identify Key Population as well as gain and maintain access to Key Population. These are individuals who have direct and regular contact with the Key Population and are instrumental while conducting project activities.
  - Key Stakeholders: individuals with whom rapport is needed to identify Key Population and create an enabling and supportive environment, thereby making services accessible to the Key Population. These are individuals who have direct and regular contact with the Key Population and are instrumental while conducting project activities.
  - Other stakeholders: individuals with whom rapport is needed to create an enabling and supportive environment. These are individuals who are on the periphery but have contact with the Key Population. These individuals are supportive while conducting project activities e.g. provide space to conduct health camps, serve as condom depots etc. These individuals are also potential/existing clients of the Key Population.
- Identify areas where support is needed from the stakeholders
- Develop a system for initiation of contact with stakeholders, maintaining contact and monitoring of the same
- Develop a format for conducting a sensitization program (including frequency, content, resource persons etc)
- Make project services such as condom distribution, HIV/AIDS and STI testing, health check-ups etc available for them.
- Review strategy on a periodic basis – decide the time period with the team

Sensitization of Stakeholders

- Identify the list stakeholder in the area
- Analyze the role played by each Stakeholder in the program
- Enlist in what way the stakeholder can contribute to the project activities
- Highlight the potential threats that could be expected from the stakeholders with strategy to convert the threats to support
- Conduct monthly visits and meetings to give project updates and seek support to resolve problems (if any).
- Invite them to participate in community and project events and acknowledge their contributions to the project.
2.2.5.3 Addressing GBV through Rapid Response System

Context
Key Population faces harassment, violence and coercion which directly affect their condom negotiation power and health seeking behaviours. Stigma and discrimination is a causative and compounding factor that also affects their ability to seek help. To address this problem, a system based on community and project action is suggested in this section. This system has wide scope for Key Population to take direct initiative and enable them to handle issues of harassment and violence by police, goons, family members, clients and other stakeholders; of various situations faced by Key Population.

SoP Objectives
- To provide contextual clarity on the working of the Rapid Response System (RRS) with Key Population
- To provide essential requirements and detailed processes on the functioning of the RRS

Procedures
Creation of a supportive environment
- The project should aim to form a strong micro plan site-level Task Force Committees (TFCs)
- These committees should have all the information regarding Linkages developed between projects and various stakeholders
- The committees to ensure their understanding of the project objectives and establish the Key Population direct interface with the stakeholders.
- Legal awareness to be regularly generated to Key Population through community-level legal literacy sessions.
- The project could identify two Legal Resource Persons (LRPs) as consultants, who would conduct legal literacy sessions with the community and advises the Key Population on legal issues.
- A Legal literacy module should be developed by the project in the local language. The module should have information related to the rights of the individual and all laws related that have any bearing on them.

When a crisis incident takes place, the KPs to approach the following individuals/groups in the suggested order:

**First loop of support - Community members:**
1. The Key population in crisis to contact other Key Population for immediate support
2. The Key Population in crisis or other Key Population to contact the TFC members for immediate support.
3. The KP in crisis or other Key Population to contact to contact PHE, and/or SHG for immediate support
Second loop of support – Staff of the project:

1. The KPs in crisis or the other individual/s intimated to contact the project staff for support.
2. The KPs in crisis or the other individual/s intimated to contact the project staff for support.

Third loop of support - External support:

1. The Key Population in crisis or the other individual/s intimated to contact the Legal Resource Person for support

The loops of support as mentioned above are from the point of sustainability of the community systems. If the community members are not available or feel that they need additional assistance; then staff members and lastly the LRPs are to be contacted. This will ensure that assistance reaches the Key population from some source or the other even if some people fail to act in time or appropriately. This can be implemented flexibly as per the prevailing local situation.

Instant support is to be provided by those contacted, within 30 minutes from the time of intimation. The PHE to follow up with the key population within 24 hours to ensure the quality of support and provide guidance, if necessary

2.2.6 Drop in center for peer education – In-reach

Context

The Drop in center (DIC) as a concept is to attract the KPs to a place which would be considered safe and could be used for the facilitation of project related activities. This place needs to be easily accessible with all the necessary facilities to conduct project activities in a non-threatening, clean and friendly environment for the community. It needs to be community centric and orientated to meet the project objectives. The DIC has to be a ‘one stop’ center to address various needs of the KPs with flexibility in its implementation. This calls for creativity, innovation and needs to be strategized in keeping with the requirements of the KPs to make the DIC functional and meaningful. A good DIC should be able to cater to the felt needs of the KPs by providing the services directly or as a referral centers.

SoP Objectives

- To provide contextual clarity on the strategy for setting up and running a DIC for the effective implementation of an outreach program.
- To provide information about essential requirements and detailed processes for setting up and running a DIC.
Procedure

While setting up a DIC it is important to consider the requirements of each typology with sensitive towards hidden population who are spread across the area of operation.

Setting up the DIC:

- The KPs are to be involved at every level in setting up the DIC including choosing the location, painting/renovating and the planning of activities.
- A specific name and logo could be also designed in consultation with KPs
- Set up a committee of Key Population to manage the Drop in Center.
- The DIC is to be a safe, non-threatening environment with no stigma attached.
- The DIC to be clean, neat and tidy with basic facilities such as regular supply of clean drinking water, clean toilet, fans, safe environment etc.
- Keeping in mind the limitations of space, the organization needs to be innovative.
- Entertainment, participatory equipment and tools to be kept in the DIC for facilitating sessions with the community.

Promoting the DIC in the community:

- Identify ways to let key populations know about the service and events. This could include materials disseminated by peer health educators, through SMS or social media. Ensure promotion is conducted in a way which is discreet and targeted towards only key populations.
- Ensure that the promotion of the DIC is consistent and integrated in the other activities/interventions.
- DIC can also be promoted by different partners such as social services of hospital, STI/HTC clinics, hotline, and any other services that are included in the ‘referral system” and specific entertainment venues.
- Review the promotion/communication strategy every year based on the feedback from monitoring.
- Develop a weekly or monthly agenda to plan DIC services.
- Mobilize the communities/groups to use and support the services at the DIC. Undertake intensive community mobilization and promotional activities to increase the demand of services.

Some illustrative activities at the DIC could be as follows:

- Organizing community get together including events, festivals and other activities
- Skill building exercises including Skill development activities in the form of vocational training (eg. Beauty and grooming courses, nutrition)
- Income generation activities
- Infotainment Games and participatory action techniques to disseminate key messages like condom use along with distribution.
- Providing strong medical referral services, especially STI and other health problems including immunization.
- Providing comprehensive counseling including general health, family matters, relationship, nutrition, child care, education and any other felt need of the KPs.
- Organizing meetings viz., core group, Legal resource person etc.
- Legal aid including legal counseling
- Conducting training programs
- Education / tuition classes for children of KPs
- Self-help group development and meetings
- Meetings with other stake holders
- Referral to other services that matter to KPs
- Support group meetings including Nutritional support and positive prevention counseling to PLHIV KPs
- Any other activity as per the needs of the community

2.3 Monitoring and QA/QI

A well-developed Monitoring and quality assurance and improvement systems will ensure robust data collection mechanisms as well as helps in improving the overall quality of programs through systematic gathering of standardized, quality data and a strong feedback mechanism. Institutionalizing effective QA/QI systems helps to achieve efficient, cost-effective, quality program results, and helps to detect and address gaps in HIV service quality measured against established national standards in a timely manner. This section is trying to address the above through two segments including management information systems, data quality assessments.

In the context of and KP programs, the NSP for MARPs 2010-2014 provides the framework needed to produce data for making decisions on KP interventions. The most of indicators are from, Global AIDS Response Progress Report (GARPR), UNAIDS and President Emergency Plan for AIDS Relief (PEPFAR) according to KP category.

2.3.1 Management Information Systems

Context

A strong Management Information Systems (MIS) is a basis for robust health information system, skilled personnel, standardized tools and processes to collect, collate, analyze, disseminate and use information. Instituting an effective MIS is a prerequisite for ensuring quality data at all levels of program intervention. The available quality data contributes to making informed decision to improve programming. For purposes of uniformity and comparability between interventions, there is the need to have in place a standardized format to be used by all agencies to prepare status reports on KP interventions.

SoP Objectives

- To provide contextual clarity on how to develop formats to collect information for all the indicators
- To provide inputs on developing formats separate for the peer health educators who may not be able to read and write
Procedure

Establish MIS

- Indicators
  - Develop data entry and management system/dashboard.
  - Pilot test the system (Dashboard) and make necessary adjustments.
  - Build consensus on core indicators for MIS dashboard.
  - Indicators for KP programming can be found in Annexure IV.
  - Further information on the indicators is available in the National MARPS Strategic Plan 2010-2014.

- Define levels of data reporting
- Define the data reporting flow between the different levels
- Ensure all levels have the tools required to collect and collate data at their level

Develop/ update tools and distribution. Use the standardized data collection and collation tools

- MIS tools could include
  - Individual Tracking Sheet
  - PE daily activity sheet
  - Referral forms
  - DIC attendance reporting forms
  - Summary report data collection forms
  - Counseling and testing referral forms
  - Self Help Support register

It is important that all the staff should be trained to use these tools in the field including report compilation.

2.3.2 Quality Assurance and Quality Improvement

Context

Quality Assurance (QA) could is nothing but using all the standard operating procedures consistently as a basis for assessing performance. It includes all the actions taken to improve program performance of the project activities. Results from QA monitoring lead to the quality improvement (QI) process. This is a means of establishing and using a client-focused, problem-solving approach to test and implement solutions to problems that affect quality. It is a continuous process that identifies gaps in the expected delivery of services and then lessens these gaps not only to meet KPs needs and expectations, but to exceed them and attain exceptional levels of performance. This section describes the steps required in integrating quality improvement into designing and implementing program for KP.
SoP Objectives

- To provide contextual clarity on how to go about conducting the Data Quality Assurance and Quality Improvement

Procedure

Managers should set up a system where they can work with PHEs to improve program. Following steps could be taken up for improving the programs

Quality Assessment

QA is an important activity of any HIV prevention program with following benefits:

- Routine quality assurance (DQA) exercises ensure that collected and reported data are accurate, reliable, consistent and timely.
- QA is a participatory process involving program staff and or external assessors to verify the extent to which the reported data reflects the actual situations and their underlying M&E systems.
- Evidenced- based decision making depends further on a strong feedback system according planned activities.
- Provides an opportunity to regularly assess progress (monitoring) and improve activities through a reflection on challenges – what worked, what didn’t and to reassess resource and capacity building needs.
- Establishing and implementing effective feedback mechanisms keeps service providers motivated when they see the results of their actions; maintains the interest and support of stakeholders and donors; provides information for program managers to re-strategize

Data Quality Assessment

Prepare for DQA assessments.

- Form DQA Team(s) comprising of at least two people, an M&E and program person with clear terms of reference.
- Develop tools for data collection, verification and reporting on the DQA conducted. Adapt to the specific situation if necessary.
- Train the DQA Team and how to implement DQA.
- Identify indicators of greatest importance to the impact of the program with specific time period.
- Select sites to visit, agree on criteria for site selection with randomness.
- Notify selected sites with advance without being too early for rectifying errors.

Implement DQA.

- Conduct briefing site meeting to orient the site staff on the purpose of the DQA.
- Review source and secondary documents, these include relevant data collection tools and reporting or summarizing formats.
- Onsite verification of data for the selected indicators with recalculation of indicators with primary source.
• Undertake root cause analysis to identify the specific sources of identified errors including calculation errors, transcription errors etc.
• Develop an action plan and follow up: these are longer term measures taken to prevent the specified errors from recurring e.g. mentoring, TA, training, improved supervision and distribution of guidelines.

Quality Improvement
Analysis and follow up
• Identify explicit improvement aim and objectives.
• Prioritize recommendations and develop a work plan.
• Findings from sites should be collated and the verification team should agree on recommendations.
• Prioritize the most important and prepare a work plan with activities, responsibilities and timelines.
• Develop a report indicating methodology, collective findings, and recommendations with onsite briefing for program staff.
• Follow up with sites to ensure necessary corrections are made.
• Organize quarterly program review meetings.
• Conduct site visits to verify reports presented at program review meetings and to ascertain the quality of services provided at different sites.
• Communicate achievements and shortfalls to all staff involved.
• Develop action plans to ensure that findings and shortfalls from assessments are addressed.
Annexure I - Client flow in the prevention and care intervention

MOZAMBIQUE CLIENT FLOW ALGORITHM
Annexure II: Illustrative example of Sex worker segments

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>DEFINITIONS (Behavioral and Clinical characteristics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New FSW</td>
<td>▪ New in project (site or profession) in the month.</td>
</tr>
<tr>
<td></td>
<td>▪ Should be registered with in a one month</td>
</tr>
<tr>
<td>Low Risk</td>
<td><strong>Behavioral:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Known to have a low client volume (5 or less than 5 clients in a week)</td>
</tr>
<tr>
<td></td>
<td>▪ Uses condoms regularly with all clients.</td>
</tr>
<tr>
<td></td>
<td>▪ Reporting regular condom use with clients, when offered more money</td>
</tr>
<tr>
<td></td>
<td>▪ Sometimes falters in using condoms with regular partner/lover boy.</td>
</tr>
<tr>
<td></td>
<td>▪ Takes her health as a priority and lives a healthy lifestyle (includes eating habits, no addictions, and so on).</td>
</tr>
<tr>
<td></td>
<td>▪ Reporting no incidences of GVB.</td>
</tr>
<tr>
<td></td>
<td><strong>Clinical:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Is asymptomatic currently and has not shown any symptoms in the last three clinic visits.</td>
</tr>
<tr>
<td></td>
<td>▪ Visits clinic regularly (at least four times in the last six months).</td>
</tr>
<tr>
<td></td>
<td>▪ Gets herself tested for HIV once in every six months.</td>
</tr>
<tr>
<td>High Risk</td>
<td><strong>Behavioral:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Reporting low condom use with lovers/regular /nonpaying partner (as shared with the peer educator)</td>
</tr>
<tr>
<td></td>
<td>▪ Reporting low condom use with clients, when offered more money</td>
</tr>
<tr>
<td></td>
<td>▪ FSW new to the profession (1 month)</td>
</tr>
<tr>
<td></td>
<td>▪ Working in the local drinking establishments</td>
</tr>
<tr>
<td></td>
<td>▪ Known to have a high client volume</td>
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<tr>
<td></td>
<td>▪ Known to have substance abuse issues (alcohol, drugs) – as shared with the peer educator</td>
</tr>
<tr>
<td></td>
<td>▪ Known to indulge in sexual practices other than vaginal sex (as shared with the peer educator)</td>
</tr>
<tr>
<td></td>
<td><strong>Clinical:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Has repeated STIs, same or different</td>
</tr>
<tr>
<td></td>
<td>▪ Reported an STI after a previous asymptomatic visit</td>
</tr>
<tr>
<td></td>
<td>▪ HIV positive</td>
</tr>
<tr>
<td>PLHIV</td>
<td><strong>Clinical:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Is detected HIV Positive and has disclosed her/ his status to PE.</td>
</tr>
<tr>
<td>Ambassador</td>
<td><strong>Behavioral:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Has attended SHG meetings for the last six months consecutively.</td>
</tr>
<tr>
<td></td>
<td>▪ Uses condoms regularly with all clients, lover and regular partners.</td>
</tr>
<tr>
<td></td>
<td>▪ Takes her health as a priority and lives a healthy lifestyle (includes eating habits, no addictions, and so on).</td>
</tr>
<tr>
<td></td>
<td>▪ Reporting no incidences of GVB.</td>
</tr>
<tr>
<td></td>
<td><strong>Clinical:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Has been asymptomatic for the last six months consecutively.</td>
</tr>
<tr>
<td></td>
<td>▪ Visits clinic regularly (at least four times in the last six months).</td>
</tr>
<tr>
<td></td>
<td>▪ Gets herself tested for HIV once in every six months.</td>
</tr>
</tbody>
</table>
### Annexure III: Dash Board Indicators

The table below is the suggested list of indicators that could be measured based on the minimum package of services for key Population

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Suggested level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Individual KPS that are registered with the program out of the mapped</td>
<td>100%</td>
<td>Ongoing</td>
</tr>
<tr>
<td>% of Individual KPs reached by Peer Health Educator every month with at least two services;</td>
<td>80%</td>
<td>Monthly</td>
</tr>
<tr>
<td>% of KPs provided with a quality BCC session in a month</td>
<td>100%</td>
<td>Monthly</td>
</tr>
<tr>
<td>% of Individual KPS that were referred for any clinical service every quarter</td>
<td>100%</td>
<td>Quarterly</td>
</tr>
<tr>
<td>% of Individual KPs provided HIV Testing and Counseling every six months</td>
<td>50%</td>
<td>Half yearly</td>
</tr>
<tr>
<td>% of Individual KPs provided with Condoms and lubricants every month</td>
<td>100%</td>
<td>Monthly</td>
</tr>
<tr>
<td>% of Individual PLHIV KPs provided with Continuum of care by referring to health facilities</td>
<td>100%</td>
<td>Ongoing*</td>
</tr>
<tr>
<td>% of Individual KPs screened for Sexual and Gender Based Violence every month</td>
<td>100%</td>
<td>Yearly</td>
</tr>
<tr>
<td>% of Individual KPS that were provided with Sexual and Reproductive Health services every month.</td>
<td>100%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

*any given point of time this this is cumulative figure among those who are in program.*
# Annexure IV: Illustrative Individual Tracking Sheet

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>ID No.</th>
<th>Area</th>
<th>Nickname of KP</th>
<th>Contact</th>
<th>1:1 BCC Sessions</th>
<th>1:G BCC Sessions</th>
<th>Referred KPS for clinical services</th>
<th>Received condoms</th>
<th>Attended SHG meeting</th>
<th>Month - GBV incidences faced</th>
<th>Who is the perpetrator</th>
<th>Follow up for clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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