Monitoring Guide and Toolkit for HIV Prevention, Diagnosis, Treatment, and Care Programs with Key Populations

APRIL 2020

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LINKAGES
Across the Continuum of HIV Services for Key Populations

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Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CBO	Community-based organization
CSO	Civil society organization
EPOA	Enhanced peer outreach approach
FP	Family planning
FSW	Female sex worker
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
KP	Key population
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
M&E	Monitoring and evaluation
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Nongovernmental organization
ORW	Outreach worker
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
STI	Sexually transmitted infection
TB	Tuberculosis
UIC	Unique identifier code
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

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FHI 360/LINKAGES HEADQUARTERS AND REGIONAL PROGRAMS

Chris Akolo
Hibist Astatke
Dorica Boyee
Michael Cassell
Danielle Darrow de Mora
Robyn Dayton
Melaku Dessie
Meghan DiCarlo
Myriam Hamdallah
Tiffany Lillie
John Macom
Hally Mahler
Tara Miller
Caleb Parker
Navindra Persaud
Virupax Ranebennur

FHI 360/LINKAGES COUNTRY PROGRAMS

Chris Agunga (Kenya)
Ana Diaz (Angola)
Justin Djè (Côte d'Ivoire)
Stanley Kalyati (Malawi)
Frederic Mbuta (Democratic Republic of the Congo)
Jacob Michel (Haiti)
John Ndiritu (South Sudan)
Siti Sulami (Indonesia)
Pradeep Thakur (Nepal)

TECHNICAL PARTNERS

Parinita Bhattacharjee (University of Manitoba)
Judy Chen (USAID)
Nashiva McDavid (USAID)
William Miller (University of North Carolina)
Tisha Wheeler (USAID)
Sabrina Zadrozny (University of North Carolina)
Jinkou Zhao (Global Fund)

EDITOR

James Baer

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PART 1.
PROGRAM MONITORING GUIDE

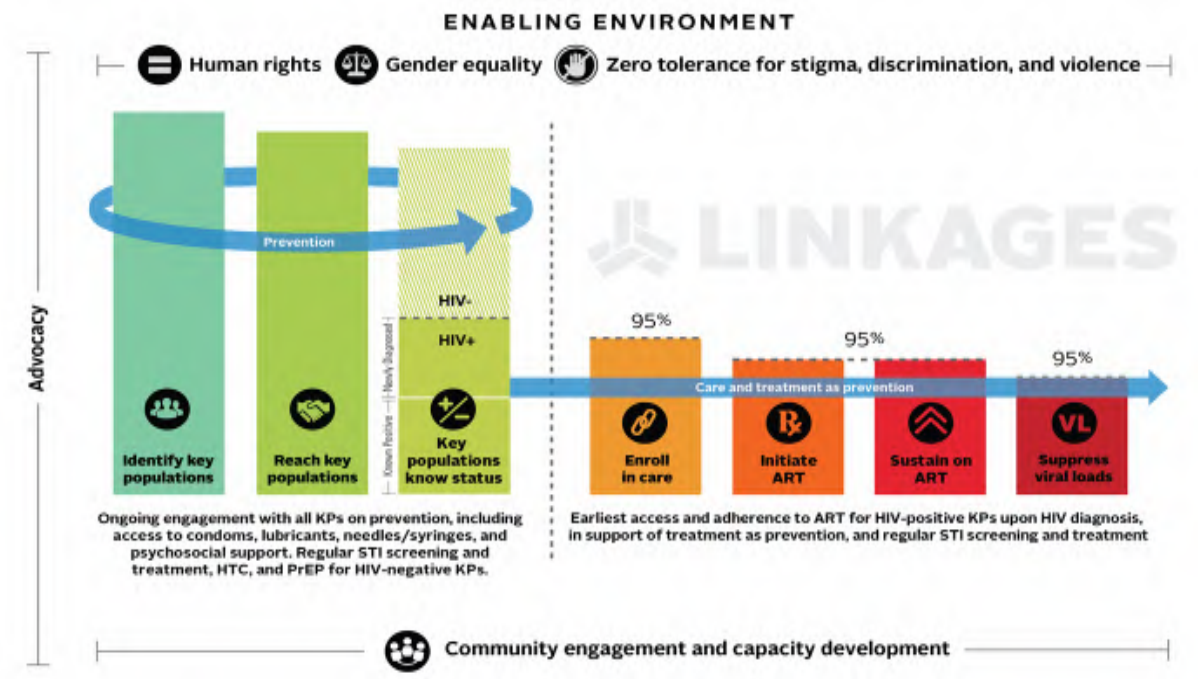
1. Introduction

This guide and toolkit is designed to help governments, civil society organizations (CSOs), and other partners implement and monitor programs for HIV prevention, diagnosis, care, treatment, and viral load testing with key populations (KPs)—sex workers (SWs), gay men and other men who have sex with men (MSM), transgender people, and people who inject drugs (PWID). KPs bear a disproportionate burden of HIV but have much lower access to HIV-related services and other services than members of the general population.[1]

In keeping with the global commitment to end AIDS by 2030, governments and donors have put renewed emphasis on developing programs that target KPs. The LINKAGES project (Linkages across the Continuum of HIV Services for Key Populations Affected by HIV), supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID), aims to accelerate the ability of partner governments, KP-led civil society organizations (CSOs), and private-sector providers to plan, deliver, and optimize comprehensive HIV prevention, care, treatment, and viral load (VL) testing services at scale. The goal is to reduce HIV transmission among KPs and extend the lives of individuals who are HIV positive.

The LINKAGES approach is summarized in the cascade framework that presents services along a continuum of HIV prevention, diagnosis, care, treatment, and VL suppression (Figure 1). The cascade is aligned with the United Nations 95–95–95 objective—that by 2030, 95 percent of all people living with HIV (PLHIV) will know their HIV status, 95 percent of people diagnosed with HIV infection will receive sustained antiretroviral therapy (ART), and 95 percent of people receiving ART will have viral suppression.

Figure 1. LINKAGES Cascade Framework



[1]For a detailed definition of key populations, see Annex 2.

Establishing and maintaining effective programs for KPs requires:

- Detailed and regularly updated estimates of the size and locations of KPs in order to set targets for outreach and determine infrastructure, personnel, and budgets (approaches for estimating the size of KP groups that use the Internet rather than physical locations to connect with sexual partners are discussed in Section 3)
- Individual tracking of KP members to ensure they regularly access high-quality outreach and clinical services
- Regular monitoring of programs to ensure that prevention, testing, treatment, and VL services meet the needs of KPs and are run efficiently. This monitoring includes regular analysis of tracking data by those who deliver services, as well as by their supervisors, and use of data in real time to manage programs and improve performance at scale while maintaining service quality.
- Regular reporting of data to subnational and national program levels as required by the government or other funders
- Ensuring data confidentiality and security at all levels of the program

This guide is designed to help programs with all these requirements. It shows how to establish monitoring systems that can be used to understand and improve performance by program managers, monitoring and evaluation (M&E) advisors, and donors, as well as frontline workers including peer outreach workers, peer navigators,[2] staff outreach supervisors, and program managers.

The toolkit offers a comprehensive range of tools used at the local level to collect and analyze data to establish, manage, and improve the program, to ensure KP individuals receive adequate services, to report on the indicators required by funders, and to demonstrate progress toward the 95–95–95 goals. The tools are designed to ensure that monitoring systems and data will be consistent and compatible, and they can be modified as needed to take into account specific national guidelines and the monitoring systems of government or other partners. The tools are practical and based on the experience of LINKAGES and other KP programs around the world.

1.1 How to use this guide

This guide and toolkit is designed to be used alongside the *LINKAGES Key Population Program Implementation Guide*, which describes establishing and running programs for each step along the cascade. Part 1 of this guide describes how to establish programs from a monitoring perspective and contains a list of key indicators that can be used to monitor each step of the cascade (see Table 2). Part 2 presents a suite of tools to support data collection, analysis, use, and reporting (summarized in Table 1). Some tools are essential for program implementation, some compile data from the implementation tools to make monitoring easier, and others are used for both implementation and

[2]A peer navigator is a key population member who is trained to help key population members living with HIV to address the practical, medical, and emotional aspects of an HIV diagnosis, similar to the way peer outreach workers work with HIV-negative key population members. Peer navigators are usually HIV positive themselves.

monitoring. Users are encouraged to select only those indicators and corresponding tools consistent with the design and objectives of their own program.[3]

The tools in this guide are not meant to replace existing country systems. Instead, they focus on KPs in order to complement national systems usually designed for the general population. As many national HIV programs already have tools to support data collection for HIV testing, care, treatment, and VL testing, users of this guide are encouraged to use those within their own programs. Sample tools for these clinical services are provided in Part 3, along with additional tools that may be of use. For countries establishing new programs, see Annex 3 for a table showing the lifecycle of a program, and the monitoring indicators and tools relevant to each stage.

In addition to the *LINKAGES Program Implementation Guide*, the program elements and guidance in this publication are compatible with relevant guidance from the World Health Organization (WHO), UNAIDS, PEPFAR, and the Global Fund.[4] This guide differs from these publications in that it focuses primarily on data collection, use, and program management at the site level as the foundation of a monitoring system.

KEY POINTS TO REMEMBER ABOUT THIS GUIDE AND TOOLKIT

This guide is not prescriptive. The recommendations in this guide are the foundations of a strong monitoring system, and they are based on the experience of LINKAGES and of practitioners and experts from other programs and donors. However, programs are not required or expected to implement every detail of every monitoring strategy exactly as presented here.

Flexibility is key. The tools and approaches can be used as they are presented here, but they may also be adapted to suit the contexts of specific countries, e.g., by translating them into local languages, or making them conform to the reporting requirements of national HIV programs. Select only those indicators and corresponding tools relevant to your program.

[3]For programs that have used the previous (2016) edition of this monitoring guide, Annex 1 provides a table showing how the numbering and names of some tools have changed in this version.
[4]WHO. Consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations, 2016 update. Geneva: WHO; 2016. WHO. Tool to set and monitor targets: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2015. UNAIDS, PEPFAR, Global Fund. Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men, and transgender people. Washington (DC): USAID (Measure Evaluation); 2013.

Table 1. Program Monitoring Tools, by LINKAGES Program Area

TOOL NO.	TOOL NAME	FREQUENCY	RESPONSIBILITY	USED FOR IMPLEMENTATION (I) or MONITORING (M)
ENGAGING KEY POPULATIONS IN POPULATION SIZE ESTIMATION, MAPPING, AND PROGRAM PLANNING				
1A	Hot Spot Validation Form	Annually	POW	I
1B	Hot Spot Register	Annually	PM/M&E	M
2	Peer Outreach Worker/Peer Navigator Register	As needed	PM/ORS	M
3	Capacity-Building Register	As needed	PM	M
PEER OUTREACH				
4A	Outreach Enrollment Form	Once	POW/ORS	I
4B	Key Population Register	Weekly	M&E	M
5A	KP Outreach Tracking Sheet (Peer Calendar)	As needed	POW/ORS	I
5B	KP Outreach Compilation Sheet	Monthly	ORS	M
6	Referral Slip (Clinical Services)	As needed	POW/PN	I & M
7	Referral Register for Social-Protection Services	Weekly	ORS/PM	M
8A	Condom and Lubricant/Needle and Syringe Outlet Register	Quarterly	M&E	I
8B	Condom and Lubricant Inventory Register*	Monthly	PM	I
8C	Condom and Lubricant Outlet Inventory/Distribution Register*	As needed	PM	I & M
CLINICAL SERVICES				
9	Clinical Services Compilation Sheet	Monthly	Clinic staff	M
10A	HIV Care and Support Tracking Sheet (Peer Navigator Calendar)	As needed	PN	I & M
10B	HIV Care and Support Compilation Sheet	Monthly	ORS	M
11	HIV Treatment Compilation Sheet	Quarterly	Clinic staff	I
STRUCTURAL INTERVENTIONS				
12	Violence Disclosure and Service Provision Form	As needed	Various	I & M
13	Advocacy/Sensitization Activity Register	As needed	ORS/PM	I & M

*Note: **POW** = peer outreach worker; **PM** = program manager; **M&E** = monitoring and evaluation officer; **ORS** = outreach supervisor*

**Corresponding tools for needle/syringe exchange programs can be found in Part 3.*

2. Using Data to Establish and Monitor KP Programs

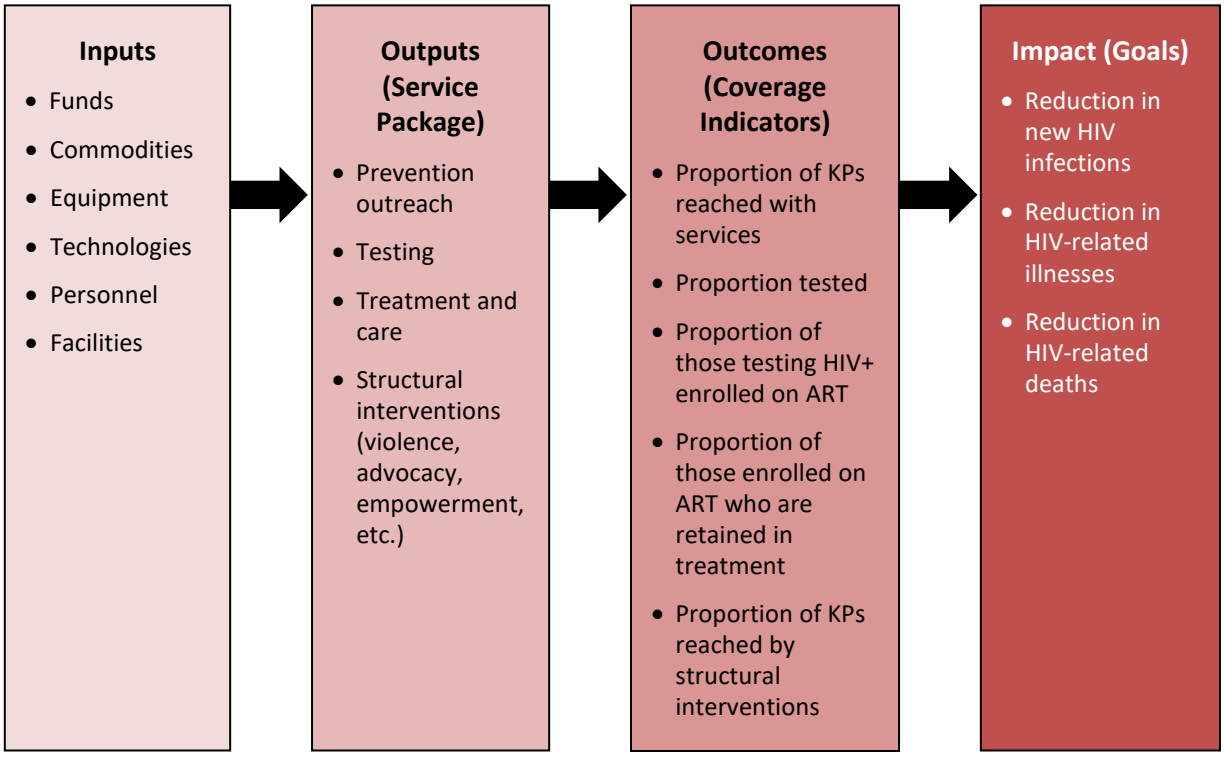
2.1 Establishing goals, objectives, and targets

At the national level, programs must be established with a specific goal in mind, for example, to decrease new HIV infections, HIV-related illnesses, and HIV-related deaths among KPs. Data on the estimated size and location of KPs, HIV infection rates, and access to services will be essential to determining the program's goals and setting related targets.

A logic model can help program planners see how specific inputs (funds, personnel, infrastructure, etc.) and a clearly defined package of services and interventions can lead to measurable outputs that contribute to the program's goals. Outcomes are measured with monitoring indicators and may be designed to align with the 95–95–95 targets. A logic model can serve as the basis for understanding how to use data to measure progress and inform program changes.

Figure 2 shows the components of a logic model. Specific targets (not shown here) are set in order to meet the goals of the national program, informed by existing or newly gathered data. The service package is designed to make it possible to achieve the targets, and indicators are established to measure progress toward them.

Figure 2. Logic model for an HIV program with KPs



Goals are often broken down into a set of more detailed objectives. Effective objectives have specific, realistic, and measurable results and time frames, with accountability assigned to specific organizations or individuals. Targets can then be set for each objective. Clear goals and objectives are important because they lead to better monitoring systems and set standards for using data to improve performance.

The same process of setting objectives and targets can be done at the local level by each implementing partner. Typically, these objectives and targets closely follow those of the national program or funder, but they also reflect the local context, e.g., the type and number of KP individuals, or the ease or difficulty of outreach due to geographical constraints or the attitude of law enforcement officers. Whether goals, objectives, and targets are defined in national guidelines or set at the local level, they should be shaped by input from KP communities.

In addition to the program targets, during the initial stage of planning it is also important to set program quality standards. These could include:

- Ratios for staffing, e.g., the number of peer outreach workers per staff outreach supervisor (see also Section 8)
- Ratios for infrastructure, e.g., the number of KP individuals per clinic or drop-in center
- Standards for service delivery, e.g., the number of times a year a KP individual will be offered screening for sexually transmitted infections (STIs)

At each level of the program, well-defined targets and quality standards set a benchmark for interpreting data and help the program maintain focus as activities change over time. Standard operating procedures (SOPs) can help ensure that targets and standards continue to be met as the program is scaled up. The continual use of monitoring data underpins and informs everything — objectives, targets, standards, and SOPs.

2.2 Monitoring indicators

Table 2 lists key monitoring indicators recommended for an HIV prevention, diagnosis, treatment, and viral load testing program for KPs. It provides a description of each indicator and shows:

- Suggested disaggregations for data (e.g., by KP type, demographics)
- Which indicators contribute to indicators required for reporting to LINKAGES or PEPFAR
- Which tools supply the data for the indicator (see Table 1 for the list of tools)
- Frequency of reporting

This list should be amended to meet each program's needs, but it is important that all implementing partners across a program collect data for a minimum, agreed-upon set of indicators, as dictated by the program objectives. The national program must oversee implementing partners and monitor sites to ensure indicators and definitions are understood and used consistently.

Data collection for these indicators may be carried out at the hot spot level or the implementing partner level, and by different staff at each level. The frequency of data collection also varies: some indicators may be collected on a one-time basis at the beginning of the project, while others are collected weekly, monthly, semi-annually, or yearly, depending upon the needs of the program.

Table 2. Program Monitoring Indicators, by LINKAGES Program Area

No.	PEPFAR or LINKAGES indicator	Indicator	*Disaggregation**	Data collect-ion tool
ENGAGING KPS IN POPULATION SIZE ESTIMATION, MAPPING, AND PROGRAM PLANNING				
1	**Estimation of KP size**			
1.1	Estimated number of KP individuals in the country program geographic area		• *KP* • *Subnational geographic/ administrative unit*	1B
1.2	Number of KP individuals to be covered annually *(according to contract for financial year)*		• *Key subpopulation***	1B
2	**Mapping of hot spots**			
2.1	Number of mapped hot spots in country program geographic area where outreach is to be done for KP individuals		• *KP* • *Physical venue* • *Internet-based (virtual)*	1B
3	**Program planning**			
3.1	Number of peer outreach workers needed *(calculated from ratio of KP individuals to peer outreach workers, as recommended by LINKAGES)*		• *Key subpopulation***	1B
3.2	Number of staff outreach supervisors needed *(calculated from ratio of peer outreach workers to staff outreach supervisors, as recommended by LINKAGES)*		• *KP*	1B
PEER OUTREACH AND PREVENTION ACTIVITIES				
4	**Enrollment and outreach**			
4.1	Number of KP individuals registered (enrolled) by the project during the reporting period		• *Registered through face-to-face contact* • *Registered through online contact*	4B
4.2	KP_PREV	Number of KP individuals reached with individual and/or small-group-level HIV prevention interventions designed for the target population during the reporting period		5B
4.3	Average number of contacts per KP individual with peer outreach workers during the reporting period			5B
4.4	PP_PREV	Number of priority population individuals reached with standardized, evidence-based interventions designed to promote the adoption of HIV prevention behaviors and service uptake during the reporting period		5B
4.5	Number of KP individuals referred to social-protection services during the reporting period			7
5	**Distribution of condoms, lubricant, and needles**			
5.1	Number of male/female condoms/lubricant/needles distributed by program to KP individuals during the reporting period		• *Male condoms* • *Female condoms* • *Lubricant* • *Needles/syringes*	5B 8C Part 3, Tool C
5.2	Number of interventions reporting stock-outs of condoms/lubricant during reporting period			
5.3	Number of used needles/syringes returned by PWID to the program during the reporting period			

No.	PEPFAR or LINKAGES indicator	Indicator	*Disaggregation**	Data collect-ion tool
CLINICAL SERVICES				
6	**Referral/provision of HIV testing services**			
6.1	HTS_LINK	Number of KP individuals successfully referred to or navigated to an HIV testing site		6
6.2	HTS_TST	Number of KP individuals tested for HIV who received their results during the reporting period		6 9
6.3	HTS_TST_POS	Number of KP individuals testing positive for HIV during the reporting period among those tested and received results		9
6.4	HTS_SELF	Number of individual HIV self-test kits distributed		9
7	**Referral/provision of HIV care, treatment, and viral load testing services**			
7.1	TX_NEW	Number of KP individuals newly initiated on ART during the reporting period		11
7.2	TX_LINK_NEW	Number of HIV-positive KP individuals navigated by LINKAGES to a service delivery point not operated by LINKAGES and newly initiated on ART during the reporting period		10B
7.3	TX_LINK_RETURN	Number of HIV-positive KP individuals previously lost to follow-up or who stopped treatment, who are navigated by LINKAGES to a service delivery point not operated by LINKAGES and re-enrolled in ART during the reporting period		10B
7.4	TX_CURR	Number of KP individuals currently receiving ART during the reporting period		11
7.5	TX_PVLS	Percentage of KP individuals with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months whose viral load is suppressed (<1000 copies/ml)		11
7.6	COMM_SUPP_RET	Number of KP individuals receiving care and support services outside of the health facility (e.g., ART adherence counseling, psychosocial support, assistance accessing services, etc.) during the reporting period		10B
7.7	TX_RET	Percentage of KP individuals still on treatment 12 months after initiation of ART		11
7.8	GEND_GBV	Number of KP individuals provided with post-exposure prophylaxis (PEP) during the reporting period	• *Post-rape care* • *Other reasons*	9 12
8	**Referral/provision of STI services**			
8.1	STI_SCREEN	Number of KP individuals screened for STIs using a national algorithm during the reporting period		9
8.2	STI_DIAG	Number of KP individuals diagnosed with an STI during the reporting period		9
8.3	STI_TREAT	Number of KP individuals treated for an STI during the reporting period		9
9	**Referral to/provision of related services (PrEP, TB, hepatitis, reproductive health, overdose, abscesses, etc.)**			
9.1	PREP_NEW	Number of individuals who have been newly enrolled on PrEP to prevent HIV infection during the reporting period		9
9.2	Number of KP individuals screened for TB during the reporting period			9
9.3	Number of KP individuals referred to TB centers during the reporting period			9

No.	PEPFAR or LINKAGES indicator	Indicator	*Disaggregation**	Data collect-ion tool
9.4	Number of female KP individuals of reproductive age (15-49) provided with family planning services during the reporting period			9
9.5	Number of PWID treated for abscesses during the reporting period			9
10	**Recruitment and training of intervention team**			
10.1	Number of staff		• *Program services (doctor, nurse, counselor, etc.)* • *Management* • *M&E* • *Administrative*	Staff register
10.2	Number of staff/peer outreach workers/ peer supervisors who received initial training		• *Initial training* • *Follow-up/further training*	3
10.3	Number of outreach personnel who discontinued working in the last month		• *Staff outreach supervisors* • *Peer outreach workers* • *Peer navigators*	Staff register 2
KP EMPOWERMENT AND ENGAGEMENT IN PROGRAMS				
11	**Engagement of key populations in outreach and services**			
11.1	Number of peer outreach workers currently doing outreach work		• *Key population*	2
11.2	Number of project-supported drop-in centers		• *Key population*	***
STRUCTURAL INTERVENTIONS				
12	**Provision of violence response services**			
12.1	GBV_REPORT_COMM	Number of KP individuals who report to program staff or outreach workers, outside of clinical facilities, that they have experienced violence during the reporting period		12
12.2	Number of incidents of violence reported during the reporting period *(since a key population individual may report multiple incidents)*			12
12.3	GEND_GBV	Number of KP individuals receiving post-gender-based-violence clinical care based on the minimum package		12
13	**Sensitization/advocacy with power structures**			
13.1	Number of individuals reached by sensitization/advocacy workshops during the reporting period			13
14	**Establishment of offices and services (direct or through linkages)**			
14.1	Number of project-supported health facilities providing HIV testing and at least one of the following: STI services, HIV care, CD4 count, viral load testing, family planning services, TB screening			***

* *Note: For disaggregation of PEPFAR and LINKAGES indicators, consult the relevant Performance Indicator Reference Sheets. Disaggregations are shown for indicators that are not listed on those sheets.*

** *Note: Key subpopulation refers to the subcategory of a KP, e.g., street-based sex worker, brothel-based sex worker, etc.*

*** *Management indicator that has no dedicated tool.*

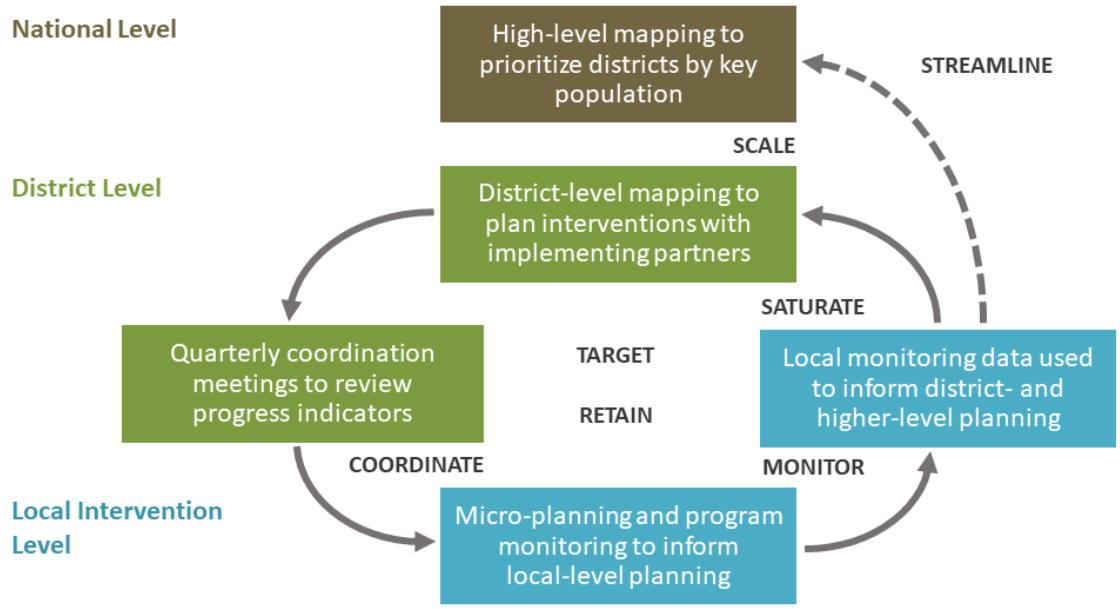
All categories of indicators are equally important to effective programming, as shown in Figure 3.

Figure 3. Indicator Categories for Monitoring Key Populations Programs

2.2 Data sources

While program targets will be informed by initial programmatic mapping and population size estimation data (see Section 3), they may need to be adjusted (at both local and national levels) to take account of monitoring data once programs are established and operating. This is because the number of KP individuals needing services may increase as programs become known and trusted by them, or may vary because of social, political, or economic changes. This highlights the importance of sourcing and using monitoring data at multiple program levels. Figure 4 illustrates how monitoring data can be used throughout the program, from frontline workers to the national level.

Figure 4. Use of Monitoring Data within the Program



Since KP individuals are likely to access services along the cascade from a number of service delivery points owned or operated by different stakeholders, comprehensive monitoring of KP programs will require collecting data from all these facilities. For instance, prevention and other outreach activities are usually conducted by community-based organizations (CBOs) within both physical and virtual spaces. Testing for HIV, on the other hand, when it is not HIV self-testing, is usually provided through a combination of fixed and mobile services operated both by governments and community-based nongovernmental organizations (NGOs). Clinical services and treatment are almost always provided at fixed health facilities, although WHO guidance also encourages community-based initiation and dispensation of ART as part of differentiated service delivery. Persons developing monitoring systems for KPs should understand and map the places where each service is provided, know what tools are used for capturing and reporting service data, and who is the owner of that data.

2.3 Confidentiality and other ethical considerations

Designing and managing a program with KPs requires gathering and storing personal information (demographic, behavioral, and medical) on individuals, as well as information on locations where sex work or drug injecting takes place, or where transgender people and MSM meet. Data that identify individuals or locations must be handled with strict confidentiality and protected from access by anyone without authorization. Individuals, groups, or organizations may cause harm to KP individuals if confidential information is exposed. Unique identifier codes (UICs) can help to maintain client anonymity (see Section 2.4).

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

- In all circumstances, the information contained in client records must be kept confidential (i.e., it must not be communicated to third parties).

- Client information can 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 must be kept in a secure place, and only project staff with direct client responsibilities may have access to the records. (This means that paper records must be kept under lock and key, and digital records must be password-protected.)
- A confidential accountability system must be established 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 individuals is obtained by outsiders with the risk of harm to those or other KP individuals.
- All program staff members, peer outreach workers, and peer navigators must read and sign an oath of confidentiality, which is to be stored in the personnel files. A code of conduct for peer outreach workers and peer navigators may also be used. See Annex 2 for examples.

Nondiscrimination and confidentiality are cornerstones of high-quality prevention, care, treatment, and VL testing services. All outreach, treatments, procedures, testing, and counseling—whether performed by medical staff or by other staff or workers—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 nondiscrimination in service delivery:

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

Data that are shared for monitoring purposes at the subnational or national level, or with third parties such as government bodies, should be aggregated, without personal identifiers. Data confidentiality and security policies should be included in subcontracts with other organizations.

2.4 Unique identifier codes (UICs)

Many national programs and LINKAGES countries (and others) are developing and using unique identifier codes (UICs) for programs with KPs. The KP individual is assigned a UIC when they enroll in the program, and they use it whenever they access services, ideally across all providers and partners. In some instances UICs are the national ID numbers that are issued by governments. In other cases they are comprised of a series of alphanumeric characters unique to the individual that do not change over time. For example, a UIC could be constructed using the following:

- First two letters of mother's first name
- First two letters of father's first name
- Gender of the individual (1 for male, 2 for female, 3 for transgender)
- Last two digits of year of birth

So a female born in 1965 with a mother named Susan and a father named Peter would have a UIC of SuPe265.

Any program that wants to develop a UIC system should first check whether a national ID or health UIC system already exists.

UICs support the confidentiality of information about KP individuals and can also enhance the quality of monitoring data and improve data analysis and decision-making. The advantages of using UICs for KPs include:

- Uniquely identifies each individual receiving services without disclosing personal information about them
- Largely eliminates the risk of duplication when counting KP individuals receiving services
- Makes it easier to identify new individuals engaging with services
- Enables analysis of treatment cascades through indicator data
- Makes it possible to assess the mobility of KPs through outreach services and health facilities
- Can help reorient services to meet the changing needs and attendance patterns of KPs

Issues to consider when developing a UIC system include:

- Components of the code itself (ideally made up of data about the individual that are nonchanging and can be easily recalled, so they can give their UIC each time they receive services without having to memorize a long, random code)
- Who assigns the UIC and when
- How to check that UICs are not duplicated among individuals
- How to verify UICs when offering services
- How the UIC system is integrated across service providers

For further information on UICs, see the LINKAGES guidelines on UICs with key populations.

3. Programmatic Mapping and Population Size Estimation

Programmatic mapping and population size estimation are implemented as part of initial program planning to:

- Estimate the number, typology, and distribution of KPs in a clearly defined geographic area
- Determine human resource needs for a comprehensive intervention
- Determine infrastructure needs
- Identify the best locations for interventions and service infrastructure
- Set targets for service coverage
- Establish baseline data (e.g., the denominator)[5] against which coverage can be measured

Programmatic mapping and size estimation means the systematic identification of the physical locations of hot spots—places where KPs gather and can be reached with services, e.g., bars or surrounding neighborhoods, streets or spots for solicitation, cruising areas, drug-shooting houses. (This approach is best suited to FSWs but can also be used with other KPs.) Mapping provides detailed data on KPs showing where they can be found, type, number of individuals, and times present. To deliver services effectively, the program should focus interventions on areas with the greatest number of hot spots and develop intervention sites (clusters of hot spots) where a clinical facility or drop-in center is accessible.

As well as identifying where to place services, programmatic mapping also helps identify and map existing 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.

Mapping and Size Estimation of KPs Online

In some countries, increasing numbers of KP individuals use the Internet to socialize and to connect with sexual partners, whether exclusively or in addition to meeting people in public places. Methodologies for estimating the size of KP members who use online (virtual) spaces are still being developed, as are approaches to engage with them and connect them with needed services. This guide focuses on population size estimation and outreach for physical locations (and PEPFAR indicators currently do not count people reached online). However, LINKAGES and other organizations are developing guidance on conducting a stocktaking of the use of information and communications technology (ICT) by KPs as a first step in designing effective virtual outreach.

Programmatic mapping should be done with the close involvement of KP individuals. As a program develops, peer outreach workers will become the natural leaders of mapping because of their knowledge of the hot spots they serve. (See Section 3.4 for more information). Programmatic mapping is implemented in two phases: hot spot identification and hot spot validation.

[5]"Denominator" refers to the total number of KP individuals who are to be reached with program services.

3.1 Hot spot identification

The goal of the first phase of programmatic mapping is to develop a list of hot spots and a rough sense of the numerical range of KP individuals who frequent them so that these spots can be examined in more detail in the second validation phase.

In some instances lists of hot spots may already exist: they may have been compiled by the national AIDS program during previous mapping exercises or a PLACE study (Priorities for Local AIDS Control Efforts). Local organizations may already be implementing programs with KPs (or have done so in the past) and have a record of hot spots. Where lists do not exist for a given area, they can be compiled through a process of talking to key informants—KP individuals (primary informants), but also secondary informants such as brothel keepers, bar owners, hotel managers, taxi drivers, and others with knowledge of where KP individuals gather.

Interviews with secondary key informants may begin as a casual conversation to gain information in a discreet way about hot spots and an estimated range (minimum and maximum) of the number of KP individuals there. If interviewing KP individuals, informed consent should be taken before asking any detailed questions (see section on hot spot validation below).

Clearly defining the geographic area where the mapping will be conducted is important so that all stakeholders such as relevant government officials, etc. are informed and agree to the exercise. Maps of the area should be obtained and then divided into smaller, more manageable units that will be visited by teams during the data collection phase. Maps must be stored securely during and after mapping exercises.

3.2 Hot spot validation

TOOLS 1A, 1B

The second phase of programmatic mapping is often referred to as "hot spot validation." The objectives of this phase are to validate or confirm the existence of hot spots listed in the first phase, determine the operational dynamics of the validated hot spots, and adjust for double-counting among hot spots. All hot spots listed in the first phase are visited, and key informants are interviewed using **Tool 1A: Hot Spot Validation Form**. At the end of this phase, an approximate count of KP individuals present at each hot spot, types of KPs represented, and times when they are present is developed and compiled in **Tool 1B: Hot Spot Register.**

Unlike national or state-wide population estimates, hot spot validation produces estimates *at the level of each hot spot*, adjusts numbers for duplication among spots, and only then aggregates them to an estimate across a wider area, such as a district or the program area of a single implementing partner. This feature of hot spot validation is important because it provides a program with actionable, local data with which to plan outreach and maximize coverage.

Sometimes mapping or population size data may already exist for an area or location that is being considered for the program. The data should be reviewed and reliability assessed: How old are the data? How were they gathered? Have there been significant changes at the hot spot? Often, it is good practice to validate the hot spot, i.e., to conduct a further mapping and size estimation, using the previous information as a reference point.

Data cleaning and analysis

During data collection great care should be taken to ensure that only high-quality data are collected and used for developing the final list of hot spots and size estimates. Following these steps:

- All data collectors should be trained to ensure that they understand the protocol and how to solicit the required information.
- Data collection should be supervised by trained supervisors.
- All forms should be checked at the end of each day for completeness, consistency, and meaningfulness of the information collected before it is entered into the Excel database derived from Tool 1B.
- During data analysis, develop the estimates and adjust for mobility among hot spots (see the protocol for hot spot validation in Annex 5 for details).

Programmatic Mapping in Burundi

A PLACE study conducted in 2013 in Burundi generated detailed venue information for FSWs, MSM, and PWID. Using these results as a starting point, a validation exercise was carried out in 2016 to develop a comprehensive, updated list of hot spots. Community consultants interviewed key informants (members of KPs) at each spot, and a fieldworker completed a form to record the information gathered at each interview. Of almost 1,300 hot spots identified by PLACE in 2013, only around 400 were still active; but in the process of validating them, the team identified more than 400 additional hot spots that had emerged in the three years since the PLACE study. This shows the importance of frequent mapping, especially for programs in places where KPs are highly mobile. The results of the validation exercise enabled effective distribution of resources, microplanning by NGOs working with peer outreach workers, and rapid scale-up of programs.

3.3 Refining hot spot lists

All hot spots that have been initially mapped (or validated) should be revalidated on a regular basis (annually or every six months). This will help capture information on newly emerging hot spots, as well as spots that may no longer be operational (e.g., because of police raids, demolition, changes in the laws). It will also ensure that changes in KP numbers are recorded, and targets can be adjusted accordingly. This is important because as the program becomes established and trusted by the KP community, previously unidentified (and therefore uncounted) individuals may come forward for services, increasing the overall denominator. In addition, KP individuals may move to different hot spots, changing the numbers that frequent some spots. Like initial validation, periodic (annual or semiannual) revalidation can be done using **Tool 1A: Hot Spot Validation Form**. Once the data collection for revalidation is complete, Tool 1B should be updated to reflect the changes.

3.4 Considerations for programmatic mapping

Before beginning programmatic mapping or validation, program planners should be aware of the following considerations:

- Mapping is 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 hot spots.
- Data may underestimate the size of the population, especially where large numbers of KP individuals do not visit hot spots, or if they use virtual (online) sites instead.

Data are necessary to establish and improve programming, but the lack of comprehensive data should not stand in the way of providing services. The goal of the HIV program must be to build immediate access to services for KPs based on known hot spots, and mapping can enhance these efforts, at a later time if necessary. Once programs are established, local teams must diligently pursue information on other hot spots or networks of KP individuals in their vicinities. Mapping cannot uncover all KPs, but an iterative process of program implementation and mapping is needed over time to identify and reach populations.

The role of KP individuals

KP individuals should be involved integrally in programmatic mapping and population size estimation, for several reasons:

- As the intended beneficiaries of services, they have the right to shape program planning from the beginning, rather than having services "imposed" upon them, even in a well-intended manner.
- KP individuals who frequent hot spots are more likely than other people to know where other key population individuals can be found, and they are more likely to establish a rapport with their peers that will enable them to ask the questions necessary for a successful mapping activity.
- Their participation will help increase their support for the program, as well as increasing support among the wider KP community.
- Gives program planners the opportunity to identify those who may have the skills and interest to continue in the program as peer outreach workers or peer navigators.
- The process of mapping and size estimation can be an important step in the empowerment of KP communities, which may itself be a specific output or goal of the program.

Ethical considerations

As with all activities and data involving KPs, the process and outputs of mapping must be handled ethically and with sensitivity to issues of safety and confidentiality. In addition to the confidentiality and data security issues outlined in Section 2.3, the following issues should be kept in mind for any data collection exercise with KPs and should be augmented by any additional issues that KP community members identify as important:

- A mapping readiness assessment should be conducted before any mapping begins, to ensure the process will not cause harm to KPs. In addition to consulting KP communities, an assessment of the risks and benefits of programmatic mapping should be conducted in consultation with KP communities. If the decision is made to move forward, a written strategy describing reasonable and appropriate safeguards for KPs, data collection, and data storage and use should be developed in collaboration with KPs and national agencies or others who will use the data. Please consult the LINKAGES Programmatic Mapping Readiness Assessment for Use with Key Populations.
- A protocol 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. For a sample protocol, see Annex 5.
- A procedure for obtaining informed consent for participation should be designed into all data collection protocols.

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 the 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 KPs further underground, increasing their vulnerability to HIV. These estimates should instead be shared in anonymized format at appropriate forums for policy and advocacy purposes.

4. Using Data to Plan Program Coverage and Infrastructure

4.1 Planning for programs

At the national planning level, reliable information about the location and size of KPs, obtained from initial programmatic mapping, forms the basis for allocating resources for scaling up programs, setting performance targets, assessing coverage, and determining local funding requirements. National programs can use mapping data to prioritize geographic areas where scaling up interventions will ensure coverage of the highest possible number of KP individuals with the available resources, taking into account criteria such as level of HIV risk, prevalence of HIV, and rate of HIV testing. This generally means first scaling up the program in counties/states with the highest concentrations of KPs to ensure the broadest coverage. Saturating coverage in high-concentration areas is preferable to spreading services thinly across a wider area where they are harder to deliver without increased infrastructure, and harder to manage without expanding the number of staff.

At the subnational level (e.g., for a large IP working in a number of districts), important infrastructure decisions include:

- Number of drop-in centers
- Number and type of clinical services delivered by which health facilities (clinics, hospitals, health posts, mobile clinic services, outreach clinics, technical support to government and private health facilities, etc.)
- Number and type of outreach staff

Table 3 provides an example of how resource needs can be calculated at a subnational level.

Table 3. Planning an Intervention Based on the Mapped Numbers in a District

Area	Estimated key population size, and number of intervention sites needed (<1,000 KPs per site)								Total number of intervention sites needed in the district
	FSW		MSM		TG		PWID		
	KPs	Sites	KPs	Sites	KPs	Sites	KPs	Sites	
District 1	1,500	2	1,800	2	1,000	1	500	1	6
District 2	1,800	2	1,000	1	500	1	250	1	5
District 3	2,500	3	1,200	2	500	1	1,000	1	7
District 4	500	1	250	1	500	1	250	1	4
District 5	3,500	4	1,500	2	250	1	1,000	1	8
District 6	1,000	1	1,800	2	750	1	1,000	1	5
District 7	1,200	2	500	1	500	1	1,500	2	6
District 8	1,000	1	3,500	4	1,000	1	1,500	2	8
Total	**13,000**	**16**	**11,550**	**15**	**5,000**	**8**	**7,000**	**10**	**49**

The table shows that the program will need 49 intervention sites across eight districts to saturate the coverage of 36,550 KP individuals across the program. The calculation is based on the assumption that for management to be effective and efficient, a site could cover up to 1,000 individuals from a particular KP. However, the geographical spread of these populations across hot spots and the availability of facilities must be considered when defining the unit for management. If the spots are widely scattered, requiring substantial travel and coordination with facilities to do

outreach, the coverage could be set at less than 1,000 KP individuals per site. Similarly, in densely populated urban areas, if hot spots are clustered close together, communities are already mobilized, and facilities are experienced in serving KPs, the management burden may allow for an intervention site to include more than 1,000 individuals. In some programs it may also be appropriate to combine services, e.g., FSWs and MSM, or MSM and transgender individuals.

4.2 Planning at the local level

TOOL 1B

At the local level, mapping and size estimation generates a list of all hot spots, assigns a range of estimates for KP individuals at each spot by type and by subtypology (such as street-based or brothel-based sex workers), and describes optimal timing for program delivery. This information can then be used to plan services and interventions. For planning purposes, data on hot spots for each KP type is aggregated by each IP using **Tool 1B: Hot Spot Register**. Again, it will be most effective to focus services where the greatest concentration of KP individuals is found, rather than evenly across the whole program area, if this is acceptable to the KP community.

Mapping also feeds into microplanning, which is the foundation of effective outreach by peer outreach workers. In microplanning, peer outreach workers draw maps of their outreach area showing the location, estimated number and type of KP individuals, the days and times when the hot spot is active, and the location of available services. The map helps them plan their outreach, but it can also be used as a basis for validating hot spots. (For more information, see Section 5.1.)

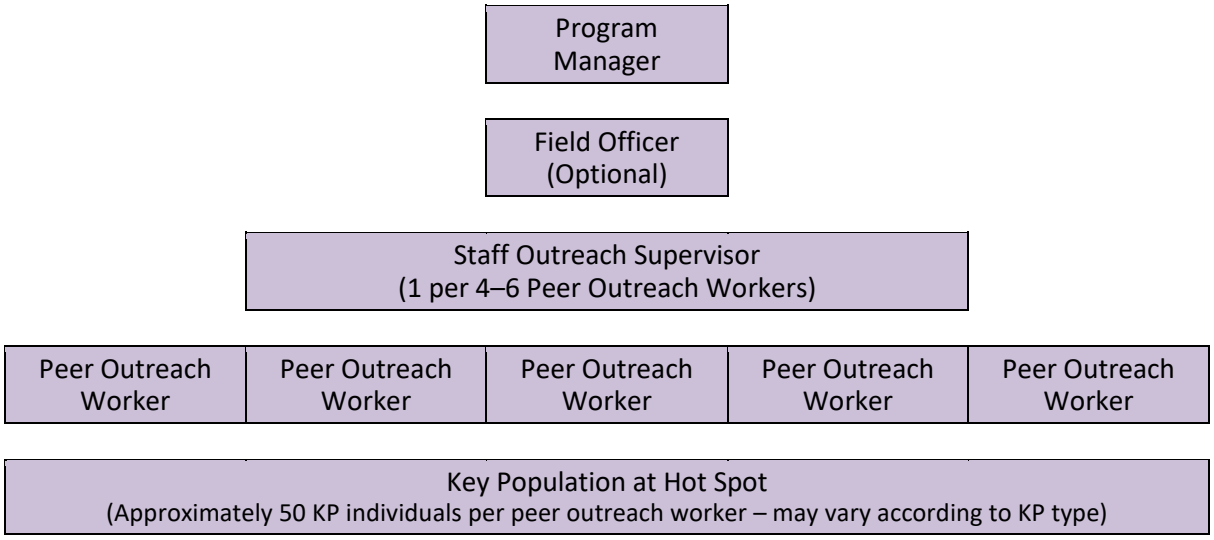
4.3 Organizational structure and staffing

TOOLS 2, 3

The program must also decide on an organizational structure. This may be prescribed by the national program, but there may be some leeway for local variation according to available resources and local needs. Figure 5 suggests how human resources could be deployed to ensure that all operational areas receive the highest levels of coverage. Note that the ratios of staff outreach supervisors to peer outreach workers, and peer outreach workers to KP individuals, are illustrative and may vary according to country guidelines and resources.

It is important to design staffing to manage down to the individual peer outreach worker at the hot spot level, with a focus on monthly tracking of targets and the empowerment of peer outreach workers delivering the program at the front line. The management team should determine the number of staff required and available to work in the different parts of the program. As staff are hired, relevant information on individuals can be recorded in a staff register, including their roles, hours, work location, and remuneration. Information on peer outreach workers and peer navigators is recorded in **Tool 2: Peer Outreach Worker/Peer Navigator Register.**

Figure 5. Sample Organizational Chart



Source: Microplanning in Peer-Led Outreach Programs: A Handbook Based on the Experience of the Avahan India AIDS Initiative. New Delhi (India): Bill & Melinda Gates Foundation; 2013.

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, peer outreach workers, and peer navigators should be aware of the issues of gender, sexual diversity, stigma and discrimination faced by KPs, and the challenges individuals may face in accessing services and gaining acceptance in the wider community. It is also important that the program collect data to reflect the level of training for personnel needed to provide quality outreach and services. **Tool 3: Capacity-Building Register** documents the training that personnel receive. The register can be used for both external and internal trainings.

5. Peer Outreach

5.1 How key populations drive the HIV response

Targeted HIV outreach and services for KPs are driven by peer outreach workers and the individuals they mobilize and empower, through initiatives that build community networks and reduce vulnerability to HIV, violence, and stigma, and promote other important priorities in the KP community.

For programs to be effective and accountable, targets for the number of KP individuals to be reached through peer outreach, and for referring or accompanying individuals to various program services must be clear. Peer outreach workers are assigned geographic areas and a cohort of KP individuals whom they know and provide with outreach information and referrals for services. They are assigned to hot spots where they work or congregate. Other criteria for selecting peer outreach workers may include their interest in volunteering, the size of their social network, leadership and communication skills, and level of literacy.

Peer outreach workers have a defined number of peers to visit each week, a set number of hot 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 them at the hot spot and convenes them in groups (at least once every two weeks) at the program office or drop in-center to review data, discuss bottlenecks and solutions to problems, and solicit their insights about how the program can be improved.

Microplanning

Microplanning is a crucial approach to planning, implementing, monitoring, and strategizing outreach and services for KP individuals. A microplan is a live (continually updated) tool that helps a peer outreach worker plan, prioritize, and follow up on prevention services, based on the risk and vulnerability of each individual. The microplanning process decentralizes outreach management and planning: the outreach team is empowered to make decisions on how to best reach the maximum number of KP individuals at each hot spot.

Microplanning tools typically include the following:

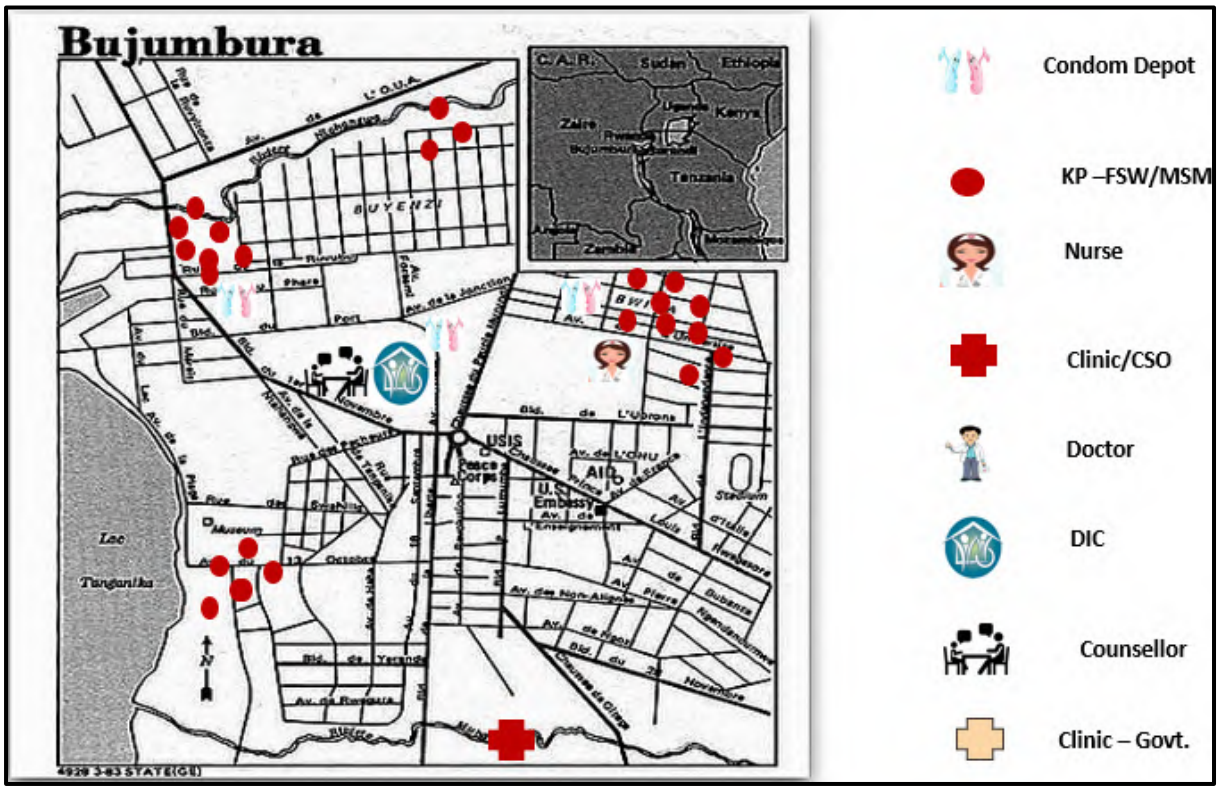
- **Spot mapping** (drawing a simple map of each hot spot, showing amenities and number and location of KP individuals) helps outreach teams assess and prioritize the hot spots the peer is responsible for and plan outreach accordingly (Figure 6).
- **Spot analysis** helps the outreach team analyze each of their hot spots and plan outreach accordingly, clearly defining timing, age range to be reached, etc.
- **Contact/line listing** helps the outreach team map their contacts within the KP community whom they aim to reach. On the basis of this understanding, the team then selects the most appropriate peer outreach workers and plans outreach activities in all the different hot spots, as well as within their networks. Contact listing can also help the team identify gaps in their coverage of the community.
- **Enrollment** (see Section 5.2) of KP individuals into the program is done using a form that records essential basic information about them. This includes a **risk assessment**, which helps peer outreach workers identify their peers on the basis of risk and vulnerability to contracting HIV and therefore prioritize high-risk contacts to provide services. In the absence

of behavioral studies, this assessment can also provide some idea of levels of condom use and need.

- **Peer plan** helps outreach teams build an understanding of the profile of the KP individuals for whom each peer outreach worker is responsible, and develop an outreach plan.
- **Peer calendar** enables the peer outreach worker to plan outreach on the basis of services offered by the program, tracking each KP member individually.
- **Opportunity gap analysis** helps outreach teams understand gaps in availability of services at each hot spot/network, reasons for the gaps, and opportunities to overcome them.

With the exception of the KP Prevention Tracking Sheet (Peer Calendar), these implementation tools are not included in this guide, but individual countries may develop their own toolkits for microplanning. The KP Prevention Tracking Sheet (Peer Calendar) is not only used for outreach but also provides data to monitor the progress of outreach at the local level and improve the effectiveness of outreach and prevention activities (see Tool 5A).

Figure 6. Hot Spot Map



Source: LINKAGES Burundi

5.2 Enrolling key population individuals

TOOLS 4A, 4B

Intensive peer-led outreach is the cornerstone of effective KP programs. It is the main way in which the program establishes contact, trust, and ongoing communication with individuals and provides them with services. Peer outreach workers generally meet individuals on a regular basis (at least once a month) at the hot spots where they are active.

The peer outreach worker should enroll each KP individual in the program as soon as possible after making contact, bearing in mind that it may take time and several contacts before an individual fully trusts the program and is willing to enroll. **Tool 4A: Outreach Enrollment Form** is used to record basic information on the individual's demographic profile and their HIV risk behaviors. One form is completed for each individual. **Tool 4B: Key Population Register** is compiled by the M&E officer to summarize details of all the individuals served by the program, including their name, age, KP type, hot spot, and name of peer outreach worker assigned to them. The categories of information captured in the register can be adapted to suit individual program needs. The register enables the program to track the number of KP individuals registered each month.

Asking about gender identity

It is important that service providers correctly identify transgender (trans) people to ensure they receive the services they need and are treated with respect and dignity. From a program monitoring perspective, it is also important to have a reliable estimate of the number of trans people in a service area and the number who receive services so that program funders and planners can allocate resources, design programs, and offer training where needed to ensure programs are appropriate.

Some trans people may not express their gender when they come into contact with the program (e.g., a trans woman may not feel safe wearing dresses or makeup outside of the privacy of her own home). From a practical point of view, therefore, service providers, including peer outreach workers, should not assume they know the gender identity of any individual. Such an assumption may leave a trans person feeling unsure of their safety and their ability to ask for the services they need, and it is likely to lead to undercounting of trans populations (as well as overcounting of other KPs such as MSM).

A simple two-step question should be used by peer outreach workers, clinical staff, and others when enrolling KP individuals in services. The method appears in the relevant tools, e.g., Tool 4A: Outreach Enrollment Form. The first part of the question asks the individual to state their gender identity (man, woman, transgender man, transgender woman, or another relevant term), and the second part asks the individual what sex they were assigned at birth (male, female, or other). This ensures that if someone does not use the term "transgender" to describe themselves, it is still possible to determine whether they should be counted as a trans person for monitoring purposes because their gender identity and their sex assigned at birth are different. Further instructions are given in Tool 4A.

Use of the two-step question is important with all individuals, not just those whom the service provider considers to be trans or possibly trans. This procedure ensures no one's gender is misidentified by the service provider, and no individual feels they are being singled out. Regardless of their level of experience or expertise, the service provider should never assume a person's gender identity. All relevant staff, including peer outreach workers, should be trained in how to use the two-step question.

Some trans people do not describe themselves as transgender, as this term may not be widely used in their context. This makes it important to rely on the individual's choice of self-identification and to avoid asking only, "Are you male, female, or transgender?", which does not provide for all gender identity options. Country programs should pilot the language and terminology used in the two-step question with trans representatives to ensure that any local terms for gender identities are taken into account and the way the question is asked is appropriate in that context. Programs can ask their strategic information (SI) advisors for support where needed.

5.3 Providing and monitoring outreach services

TOOLS 5A, 5B

Key peer outreach activities include:

- Providing information on STIs and HIV—transmission, risks, symptoms, prevention methods
- Condom and lubricant promotion—demonstrating how to use them, explaining why they should be used, where they are available, and strategies for negotiating condom use (especially for SWs with their clients)
- Provision of commodities—condoms, lubricant, and needle and syringes
- Information about the HIV program as a whole, including other outreach services (e.g., mobile clinics) and referrals to testing, care, treatment, and VL testing services
- What health/STI/HIV services, including pre-exposure prophylaxis (PrEP), are available to KPs, where to find these services, and referrals to them on a regular basis according to program guidelines
- HIV testing in programs where peer outreach workers are trained to do this and/or distribution of self-testing kits where these are available
- Community mobilization and empowerment, including support groups, advocacy activities, and crisis response

Once a KP individual is enrolled, it is important to track all outreach activities to ensure the individual is receiving the services they need and to monitor whether the program is effectively reaching the target population. Peer outreach workers should also strive to reach peers who are not in their known network who are at risk for HIV.

Tool 5A: KP Outreach Tracking Sheet (Peer Calendar) is completed by the peer outreach worker to record all interactions with the KP individuals assigned to them. Since the form is quite large, peer outreach workers in many programs carry a notebook or "daily diary" to record their interactions with each individual. On a daily basis (or at the end of each week), the peer outreach worker transfers the information from their diary to the Outreach Tracking Sheet. The peer outreach worker must understand the importance of keeping the tracking sheet confidential and secure, along with any other documents containing information that might identify KP individuals. Protecting information must be a prominent feature of peer outreach worker training. The use of aliases, rather than individuals' actual names, can help ensure confidentiality.

Tool 5A contains questions on risk behaviors for HIV, making it possible to deliver tailored services. An alternative way of recording this information is to use a separate, simple risk categorization tool that calculates a numerical score. For an example, see Tool A in Part 3. If such a tool is used, the risk

assessment columns in Tool 5A could be replaced by a single column recording the score. This can help identify those at highest risk, to prioritize them for outreach.

On a monthly basis, the peer outreach worker gives the Tracking Sheet to their staff outreach supervisor, who combines the data from all of the peer outreach workers they supervise in **Tool 5B: KP Outreach Compilation Sheet**. This summary sheet enables the program to track the number of individuals being reached, the number of contacts each peer outreach worker has with their cohort of individuals, and the volume of services provided.

Monitoring the Enhanced Peer Outreach Approach

The Enhanced Peer Outreach Approach (EPOA) developed by LINKAGES complements peer outreach by engaging previously unidentified KP individuals for HIV prevention and testing—particularly those who are hard to reach and may be at high risk of HIV, or HIV positive. The goal is to increase HIV testing yield, link HIV-positive individuals with treatment and care, and connect HIV-negative individuals with services that will help them remain HIV negative. The EPOA is led by peer outreach workers, who engage KP individuals to persuade peers in their own social and sexual networks to be tested for HIV. It focuses on those who are not found at traditional hot spots, which is particularly important because technology changes the ways that some individuals contact and meet sexual partners.

Sample enrollment and referral forms for the EPOA are provided in the *LINKAGES Enhanced Peer Outreach Approach Implementation Guide* (2017), along with forms to track the referral coupons that are an essential part of the network referral approach. The NetDraw open source software can be used to show the various referral chains.

Monitoring coverage at the program level

Once peer outreach workers have been trained and outreach has begun, the program should closely monitor the coverage levels, i.e., the number of KP individuals at each hot spot who have been enrolled in the program compared to the population size estimate for that hot spot. The data for this are drawn from Tool 5B: KP Outreach Compilation Sheet for the numbers enrolled, and Tool 1B:Hot Spot Register for the population size estimate. Table 4 shows how the data can be used to summarize coverage level at each hot spot.

Table 4. Coverage Calculation by Hot Spot
Date (Month/Year) _____

County	Hot Spot Name	Type of Hot Spot	No. of KP Individuals	Number of KP Individuals Enrolled in the Program	% Estimated Population Enrolled
District A	1	Bar	200	148	74%
District A	2	Bar	200	125	63%
District A	3	Park	100	90	90%
District A	4	Park	100	95	95%
District A	5	Bar	100	80	80%
District A	6	Massage Parlor	60	75	125%
District A	7	Cafe	50	25	50%
District A	8	Street	50	30	60%
District A	9	Street	50	60	120%
District A	10	Bar with Lodging	50	50	100%
		TOTAL	**960**	**778**	**81%**

The table shows that of the 10 hot spots, three have achieved saturation, defined as registration of 100 percent or more of estimated individuals. The table also shows that while three of the hot spots are close to saturation (80 percent or higher coverage), four are struggling, and the program manager can investigate to determine why those hot spots are far from the target. An important part of the analysis is understanding why two hot spots have reached more than the estimated number of FSWs (greater than 100 percent). Reviewing this coverage calculation will also allow intervention staff to understand the turnover rate of individuals within the program.

The program manager should conduct this exercise every month and adjust resources accordingly, e.g., add peer outreach workers to a hot spot, assign peer outreach workers to new hot spots, or take on additional hot spots and KP individuals, until saturation, as defined by the program target, is achieved. Ideally, the program target should be 100 percent coverage of the estimated population.

Monitoring coverage at the hot spot level

Monitoring outreach at the hot spot level is important for peer outreach workers, their supervisors, and the program manager. Regular analysis helps outreach workers understand and fix problems in the field. It also provides an opportunity to identify intervention sites where serious problems with implementation exist, especially if a continuous pattern is observed over a long period of time. This monitoring helps ensure targets are met, and the program objectives achieved. Tool 5B: KP Outreach Compilation Sheet can give the outreach supervisor information on the raw numbers of individuals reached and services delivered. Figure 7 uses an excerpt of Tool 5B, with data on HIV testing status and referrals.

Figure 7. Example of KP Prevention Compilation Sheet

MONTH	TOTAL KPs RESPONSIBLE	TOTALS REACHED DURING REPORTING PERIOD														
		TYPE OF KP*							REACH TYPE		HIV STATUS**			REFERRAL STATUS***		
		1	2	3	4	5	6	7	FIRST TIME	REPEAT	1	2	3	1	2	3
	D	E							F		G			H		
M1	35	35							30	5	3	5	27	4	2	21
M2	35	35							0	35	5	11	19	1	8	10
M3	40	35							5	35	3	19	18	2	15	1

* **Type of KP:** 1=FSW, 2=MSM sex worker, 3=MSM not sex worker, 4=Transgender sex worker, 5=Transgender not sex worker, 6=PWID male, 7=PWID female

** **HIV status:** 1=known HIV positive, 2=HIV negative and tested within past 3-6 months, 3=tested more than 3-6 months ago/don't know/never tested/refuse to say

*** **Referral status:** 1=Tested for HIV on the spot, 2=Accepted referral for HTC, 3=Declined referral for HTC

It can be difficult to analyze performance from data like these, because the size of peer outreach workers' cohorts may vary (Column D). Instead, it may be more effective to translate the figures into percentages (this can be programmed in if the tool is created as an Excel spreadsheet). Figure 8 uses the same data as Figure 7, presented as percentages to show the proportion of enrolled individuals who have been contacted and have received services. This makes it easy to see that in months 1 and 2, for example, comparatively few individuals eligible for HIV testing and counseling (HTC) have successfully completed referrals for it—just 22 percent of those eligible in month 1, and 47 percent in month 2 (see red shading in Column H). The peer outreach worker's performance improved in month 3, however, with 94 percent of eligible individuals completing a referral (blue shading in Column H).

Figure 8. Example of KP Prevention Compilation Sheet, Showing Percentages

MONTH	TOTAL KPs RESPONSIBLE	TOTALS REACHED DURING REPORTING PERIOD														
		TYPE OF KP*							REACH TYPE		HIV STATUS**			REFERRAL STATUS***		
		1	2	3	4	5	6	7	FIRST TIME	REPEAT	1	2	3	1	2	3
	D	E							F		G			H		
M1	35	35							30	5	9%	14%	77%	15%	7%	78%
M2	35	35							0	35	14%	31%	54%	5%	42%	53%
M3	40	35							5	35	8%	48%	45%	11%	83%	6%

5.4 Referrals to health services

TOOL 6

Once a KP individual has been enrolled in the program and begins receiving outreach services, the peer outreach worker may need to provide referrals to a variety of clinical services, such as:

- HIV counseling and testing
- STI screening and treatment
- PrEP
- ART
- Care following gender-based violence (GBV), including PEP
- Family planning (FP)
- Prevention of mother-to-child transmission
- Tuberculosis (TB) screening and treatment

The program should develop clear guidelines for making referrals and train all staff on how to refer individuals for these services. Proactive, accompanied referrals are more likely to be successful than passive referrals and should be the norm. **Tool 6: Referral Slip (Clinical Services)** can be used to record referrals. While the referral slip can be adapted to suit specific program needs and procedures, the individual **must not** be identified by name on the slip to preserve their anonymity (especially if the slip is lost). Instead, a UIC is used (see Section 2.4). See text box for an example of how referrals are made and tracked.

Processing and Tracking Referrals in the Democratic Republic of the Congo (DRC) and Côte d'Ivoire

The LINKAGES program in DRC uses a referral slip designed especially for the program, whereas LINKAGES Côte d'Ivoire is required to use the pre-existing slip designed by the government. While there are differences in the layout and details that the two slips record, both are aligned with the sample referral slip in this toolkit (Tool 6), and both collect the same basic information, including details of the referring IP and name of the person making the referral; the UIC, age, and sex of the person being referred; the name and address of the place to which the person is being referred; and the reason for the referral. The person making the referral signs and dates the slip.

The slips have different formats, reflecting the slightly differing procedures used to track referrals:

In DRC, the referral slip is completed with a single carbon copy. The carbon copy is kept by the LINKAGES program staff. The original slip is taken by the KP individual, who gives it to the person providing the service (at the clinic, drop-in center, etc.). The service provider retains the copy and completes a separate section at the bottom of the slip to show that the service was provided. This is collected by the peer outreach worker later in the month and kept in the individual's file at the program office to show that the referral was successful.

In Côte d'Ivoire, instead of using a carbon copy, the referral slip has two identical sections to record the referral. The top part of the slip is torn off and kept by LINKAGES program staff. The KP individual takes the second part to the service provider, who retains it. As in DRC, below this part of the slip there is a section for the service provider to complete, documenting the outcome of the referral. This section is returned to the program and attached to the top part of the referral slip to show that the referral has been completed successfully.

HIV self-testing

HIV self-testing refers to a process in which a person collects his or her own specimen (oral fluid or blood), performs an HIV test using a supplied kit, and then interprets the results. HIV self-testing approaches range from unassisted self-testing (with limited or no involvement of anyone else) in a private setting to directly assisted self-testing (where a testing provider or trusted person demonstrates how to use the self-test kit). HIV self-testing is a screening test, and it requires that self-testers with a reactive result receive further testing from a trained provider using a validated national testing algorithm.

Self-test kits can be distributed by outreach workers providing services in the community, at facilities operated by community-based organizations, by health facility staff, or in collaboration with pharmacies and other private-sector partners. While kits may be collected for individual use, it is likely that individuals may also collect kits for use by others, such as by regular partners of sex workers.

Programs are currently required to report the number of self-test kits distributed through the various distribution points. They are also encouraged to disaggregate these data based on the manner in which the testing was done (assisted versus unassisted). Further disaggregation based on sociodemographic characteristics, such as the age/gender of the users of the test kits, is also encouraged. Data to monitor the distribution of self-testing kits can be collected using stand-alone tools (reporting sheets) and integrated into existing data collection tools, as shown in Tool 9.

5.5 Monitoring referrals for nonmedical services, including entitlements

TOOL 7

Links to essential nonmedical services are important components of any intervention with KPs, to ensure they have access to all services they are eligible to receive. Entitlements may include government ID cards, food ration cards, social insurance cards, and bank accounts.

The program should maintain **Tool 7: Referral Register for Social-Protection Services** to document these referrals. The register records the KP individual's UIC and date of referral, the place referred to, and for what service, as well as the outcome, where known.

5.6 Managing inventories and distribution of prevention commodities

TOOLS 8A, 8B, 8C

Prevention commodities—male and female condoms and lubricant for those whose sexual behavior puts them at risk of HIV, and sterile needles and syringes for people who inject drugs—are an essential frontline component of a comprehensive HIV prevention package. They may be distributed directly by peer outreach workers, or from other outlets supplied by the program, such as a drop-in center or clinic. Distribution should take place according to the quantity required by peer outreach workers to supply the needs of their KP individuals, and the quantities regularly distributed by each outlet. Peer outreach workers can calculate this through a condom gap analysis for each individual, using the risk assessment information on their Peer Calendar (Tool 5A), while Tools 8B and 8C are used to record data on distribution from outlets. Careful and regular tracking of distribution and use is important to ensure supplies are procured in good time and sufficient inventory is always on hand.

Tool 8A: Condom and Lubricant/Needle and Syringe Outlet Register records basic information on outlets or distribution points for these commodities. It is used each time a new outlet is added or an old one is discontinued. **Tool 8B: Condom and Lubricant Inventory Register** is used to track the source and quantity of condoms and lubricant across the program, and to show whether they have been distributed to outlets or given to peer outreach workers for direct distribution to KP individuals. **Tool 8C: Condom and Lubricant Outlet Inventory/Distribution Register** records the distribution of commodities to individual outlets, and how many have been distributed by those outlets in a given period (typically monthly). This helps to monitor and plan commodity promotion activities in each area where an outlet is located. For programs working with people who inject drugs, corresponding tools are provided in Part 3 (Tools B and C).

6. Clinical Services

6.1 Enrolling and serving key population individuals at clinics

TOOL 9

The comprehensive package of clinical services for KPs is described in the *LINKAGES Program Implementation Guide* (Element 5.1). Monitoring clinical services received by KP individuals is important in order to track their progress along the cascade of HIV prevention, diagnosis, care, treatment, and VL testing. This is true whether the individual is HIV negative and being supported with prevention commodities and regular HTC, or whether they are HIV positive, in which case early initiation of ART is important, along with other treatment and support as needed. Monitoring the cascade therefore requires close collaboration between the program and providers of clinical services, which may be nonprogram facilities, i.e., government-run or private health care providers.

Each KP individual who enters the clinic should be enrolled for services and given a health and risk assessment using indicators relevant to their KP status, so that s/he receives appropriate services based on any diagnosis (see the sample Clinic Enrollment Form in Part 3, Tool D). Each time the enrolled client returns, the clinician should use a separate form to record the reason for the visit, symptoms, tests and treatment performed, and other services given, such as FP, HTC, as well as any referrals made. If an individual is provided with PrEP, a dedicated tracking form may be used to record the treatment given and ensure the individual has been prescribed a sufficient supply.

Many national programs have their own forms for patient enrollment, clinic visits, and PrEP tracking mandated by the Ministry of Health (MOH), and where this is the case, government clinics will use these forms. If the MOH forms do not capture information that programs feel is important, it may be possible to arrange with the clinic to use an amended version, e.g., to attach a sheet with additional questions. Part 3 of this toolkit provides sample forms that can be adapted or used, especially in countries where no government-mandated forms exist.

Coverage of clinical services can be monitored over time at the program level, using key indicators such as the number of KP individuals contacted through outreach, and the number accessing clinical services. **Tool 9: Clinical Services Compilation Sheet** brings together data from the clinic enrollment, clinic visit, and PrEP tracking forms for use in tracking these indicators.

Partner notification

Also referred to as index partner testing, family testing, or voluntary partner referral (VPR), this approach delivers HTC to persons potentially exposed to HIV through a person diagnosed with HIV (the index partner). These persons may include the individual's

- Sexual partners
- Drug injection partners
- Children

VPR, derived from the WHO partner notification guidance, includes partner elicitation, violence screening, counseling, and four options for referral: patient-led, provider-led, dual (provider and patient), and contract (first patient and then provider, if necessary). Beyond being a person-centered

approach, VPR ensures the confidentiality of both people living with HIV and their partners; voluntary, informed engagement; and safety (including support for safe, voluntary disclosure). For an example of a form for recording and tracking VPR, see Part 3, Tool G.

6.2 Monitoring services for key population individuals living with HIV

TOOLS 10A, 10B, 11

If a KP individual tests HIV positive (or already knows they are HIV positive), it is important to refer them for ART if they are not already enrolled. Likewise, an individual who was previously on ART but has stopped taking it can be encouraged to re-enroll.

Programs may use peer navigators to help KP individuals address the practical, medical, and emotional aspects of an HIV diagnosis. A peer navigator is a KP individual, usually living with HIV themselves, who is trained to provide this assistance to a cohort of KP individuals living with HIV, similar to the way peer outreach workers work with HIV-negative KP individuals.

Tool 10A: HIV Care and Support Tracking Sheet (Peer Navigator Calendar) is used by the peer navigator to record details of each individual for whom they are responsible, including whether they are enrolled on ART, and the services provided by the peer navigator or program staff (as opposed to services provided at health facilities). These may include practical or informational support for adherence, psychosocial support and referrals, referrals for care, and provision of prevention commodities. **Tool 10B: HIV Care and Support Compilation Sheet** is completed monthly by the peer navigator's supervisor to compile information on all KP individuals living with HIV who have been reached, and to report on the relevant indicators.

Once a KP individual begins receiving treatment services, it is important to record and track the progress of the individual through the cascade of HIV services. **Tool 11: HIV Treatment Compilation Sheet** is used to record details for each individual and their progress through treatment and care, including when and where they are registered for ART, CD4 and viral load levels, as well as whether they are receiving support from groups or a peer navigator. The program should coordinate with the clinic to obtain the information for this sheet by regularly reviewing clinic records in order to monitor whether the individuals are being retained in care and treatment, and a number of related indicators required by PEPFAR and LINKAGES. (Where clinical services are offered directly at drop-in centers, it may be possible for drop-in center staff to update the compilation sheet themselves.)

7. Structural Interventions

7.1 Violence prevention and response

TOOL 12

KPs face harassment, violence, and abuse that directly affect their ability to access services and to practice health-seeking behaviors, including negotiating condom use. Stigma and discrimination are additional factors that affect their ability to seek help. The prevention of physical, sexual, emotional, or economic violence, and of any other human rights violation, is therefore essential to help build a supportive and safer environment, reducing vulnerability and increasing safer sex practices among KPs. It is equally important to establish systems to respond to violence and provide crisis support within the shortest possible time. These systems, including crisis response teams, should be formed with the participation of KP individuals, who may already have developed informal systems for responding to violence.

An approach to programming for KPs that takes seriously the actual and threatened violence they experience and finds ways to reduce it and mitigate its effects will build their confidence and trust and lead to improved outcomes. From both a practical and a human rights perspective, addressing violence is a precondition of successful programming, and should be considered from the beginning.

Tool 12: Violence Disclosure and Service Provision Form can be used by program staff (including peer outreach workers or peer navigators), health care workers, or others to record details of any incident of violence reported by a KP individual. These data can help program managers plan advocacy and sensitization activities with stakeholders (such as police, community leaders, religious leaders, etc.) to reduce violence and track trends in the community.

7.2 Advocacy with power structures

TOOL 13

Programs should work with gatekeepers and stakeholders in the community to sensitize them about the needs and vulnerabilities of KPs, as well as issues such as sexual identity and orientation, sex work, and injecting drug use. Such groups include law enforcement, religious organizations, community elders, and providers of services such as clinical staff or the staff of government agencies. Workshops and training sessions can be led by program staff and trained KP individuals.

In the short term, sensitization helps ensure opportunities for continuous access of services by KPs. Long-term benefits include the creation of an enabling environment in which KPs can easily access services without outside support, helping them to practice healthy behaviors, use health services, and enjoy their fundamental rights. Use **Tool 13: Advocacy/Sensitization Activity Register** to monitor and document a program's advocacy activities.

8. Using a Dashboard to Make Program Decisions

A dashboard gives the management team a macrolevel (district-level) analysis of the program and enables it to track progress toward objectives. A set of key indicators reported on frequently are displayed. With data shown in an easily understood format, program managers can use the dashboard to answer key questions on performance, strategize, and modify program activities if needed.

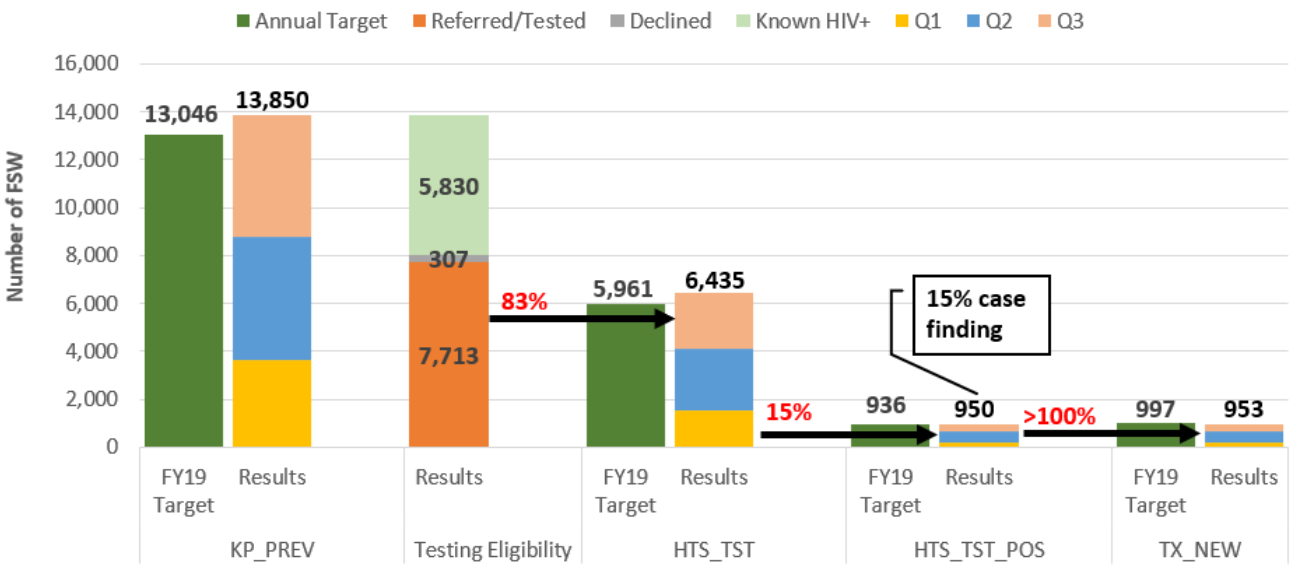
A simple table can be used for monitoring infrastructure and staffing:

Indicator	Numerator	Denominator	Expected Level
Ratio of staff outreach supervisors to peer outreach workers	Total staff outreach supervisors	Total peer outreach workers	1:5
Ratio of peer outreach workers to KP individuals	Number of active peer outreach workers	Number of enrolled KP individuals	1:50
Proportion of staff posts filled	Number of staff	Total number of planned-for staff	100%
Proportion of staff trained in prescribed training curriculum	Number of trained staff	Total number of staff	100%
Number of planned drop-in centers established compared to plan	Number of drop-in centers established	Planned number of drop-in centers	*Target: 100%*
Number of project-owned health facilities opened compared to plan	Number of health facilities opened	Planned number of health facilities	*Target: 100%*

For ongoing monitoring of progress, dashboard graphs such as Figures 9–11 can be used. These can be created from the data recorded by peer outreach workers and peer navigators, and gathered from clinics. They can depict progress in a given time period, typically a quarter, or over a series of quarters.

Dashboards can be created at the hot spot level, but it is more usual for the IP to use them across its program and to report these indicators up to the subnational or national level, where similar dashboards can be created. The following are examples of national-level dashboards aggregating data from multiple IPs.

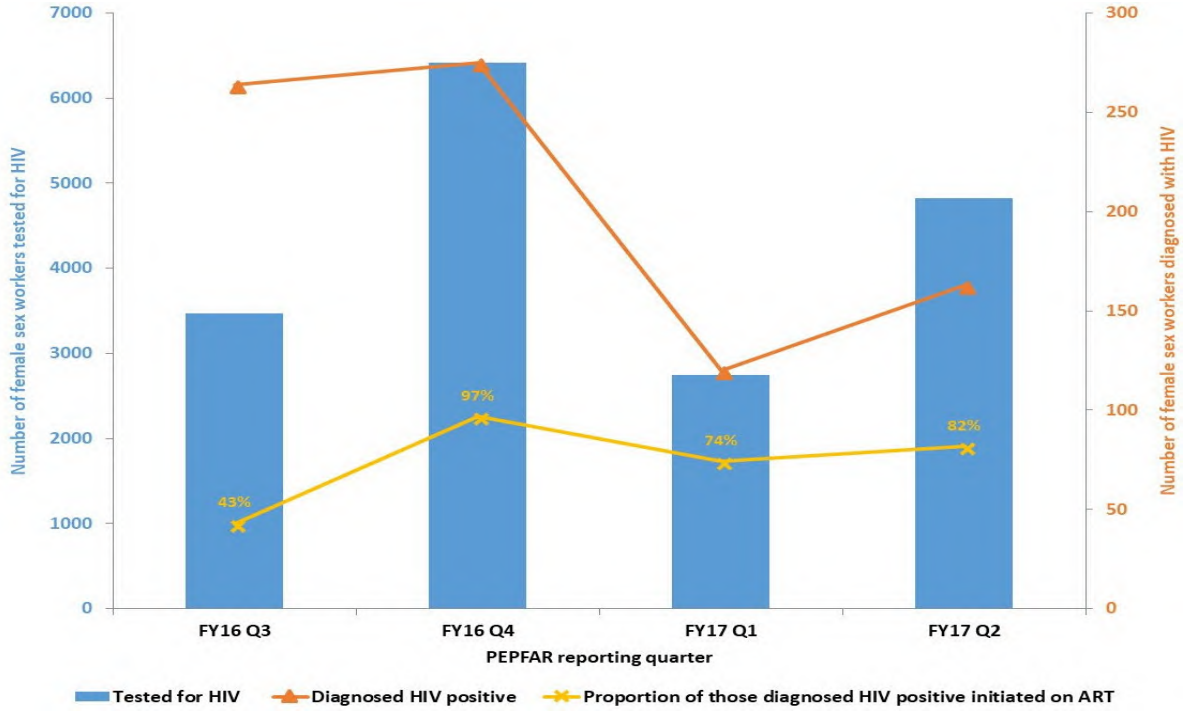
Figure 9. Dashboard of Performance across the LINKAGES Cascade



Source: LINKAGES Malawi

In this example, the high HIV-positive rate among those tested (15 percent) shows those being reached are at high risk of infection. At the same time, almost 300 of those FSWs reached were already known to be HIV positive, suggesting that efforts could be increased to reach others who have not been recently tested. The graph shows the progress against key indicators such as KP_PREV, HTS_TST, and TX_NEW. The bar farthest to the left shows that more than 100 percent of the target number of KP individuals has been reached. The right-hand side of the graph shows the great majority of individuals who tested positive have been enrolled in clinical care and initiated on ART.

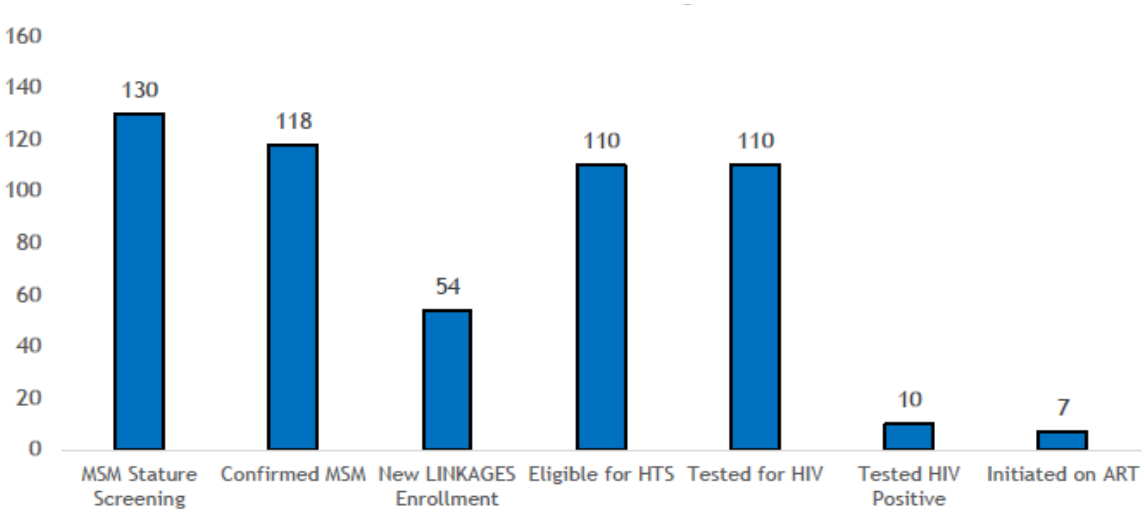
Figure 10. Tracking HIV Testing, Diagnosis, and ART Enrollment over Time



Source: LINKAGES DRC

Figure 10 shows the fluctuating numbers of FSWs tested for HIV over the course of 12 months. In this case, the drop in numbers in Q1 FY17 was due to an outbreak of civil conflict that severely disrupted outreach. However, the yellow line shows that the proportion of those diagnosed HIV positive who were initiated on ART was less affected by these challenges.

Figure 11. Tracking Performance of Enhanced Peer Outreach Approach



Source: LINKAGES Malawi

In Figure 11, nearly all the MSM who were contacted and identified were tested for HIV, and nearly half became enrolled in the LINKAGES program. The graph shows a testing yield (HIV positive rate) of 9 percent (10 out of 110 tested).

PART 2.
TOOLKIT

Tool 1A: Hot Spot Validation Form

Implementing Partner		**Peer Outreach Worker**
Hot spot name		**Revised name (if applicable)**
Address/location		**District**
Hot spot type* ☐	**Hot spot code** ☐☐☐	

***Hot spot type:** **1**=Bar with lodging, **2**=Bar without lodging, **3**=Brothel, **4**=Strip club**, 5**=Street/Highway, **6**=Home, **7**=Casino**, 8**=Beach, **9**=Guest house/rest house/hotel/lodging, **10**=Massage parlor**, 11**=Park, **12**=Beer tavern, **13**=Public toilet, **14**=Injecting den, **15**=Uninhabited building, **16**=Other (specify)

Type of KP found 1=FSW 2=MSM 3=Transgender people 4=PWID ☐	**Respondent** 1=KP 2=Other (specify) 3=None ☐	**Status of hot spot** 1=Active 2=Inactive 3=Duplicate 4=Closed 5=Not found ☐

Name of interviewer	**Signature**
Date of visit 1 (DD/MM/YY) ____/_____/_____	**Date of visit 2** (DD/MM/YY) ____/_____/_____

INFORMED CONSENT

"My name is _____. I work for _____ CSO. We are visiting sites today to understand more about the people who visit this site. It is OK if I ask you some questions?"

Informed consent was requested from respondent.	*YES* ☐	*NO* ☐
Respondent gave their informed consent to participate.	*YES* ☐	*NO* ☐

HOT SPOT PROFILE

1	On a typical (normal) day, how many key population individuals work at/visit this hot spot?	*MIN* ☐☐☐ *MAX* ☐☐☐
2	What time of day are the greatest number of key population individuals to be found at this hot spot (what is the peak time)? **CIRCLE AS APPLICABLE**	*MORNING*.....*A* *AFTERNOON*.....*B* *EVENING*.....*C* *NIGHT*.....*D* *ALL 24 hrs*.....*E*
3	On which day/s of the week, if any, is the maximum number of key population individuals found at this hot spot (what is the peak day)? **CIRCLE AS APPLICABLE**	*MONDAY*.....*A* *TUESDAY*.....*B* *WEDNESDAY*.....*C* *THURSDAY*.....*D* *FRIDAY*.....*E* *SATURDAY*.....*F* *SUNDAY*.....*G*
4	On a peak day, how many key population individuals work at/visit this hot spot?	*MIN* ☐☐☐ *MAX* ☐☐☐
5	Name any special day (or period) when the number of key population individuals is higher than on a peak day.	_____
6	On that special day or period, how many key population individuals work at/visit this hot spot?	*MIN* ☐☐☐ *MAX* ☐☐☐
7	On average, how many sex acts do key population individuals have per week at this hot spot?	*MIN* ☐☐☐ *MAX* ☐☐☐

8	How many individual (unique) key population individuals work at/visit this hot spot? *Regularly = at least once a week* *Occasionally = less than once a week*	REGULARLY ☐☐☐ OCCASIONALLY ☐☐☐
9	How many key population individuals who come to this hot spot also work at/visit other hot spots?	☐☐☐
10	How many hot spots (including this one) does a key population individual usually go to in a day to meet other key population individuals or clients?	☐☐
11	How many key population individuals who come to this hot spot also use a mobile phone to arrange meetings with other key population individuals or clients?	*MIN* ☐☐☐ *MAX* ☐☐☐
12	How many key population individuals who come to this hot spot also use the Internet/social media to arrange meetings with other key population individuals or clients?	*MIN* ☐☐☐ *MAX* ☐☐☐
13	Were any of the following available at this hot spot during the last 12 months?	*Free condoms* — *YES* ☐ *NO* ☐ *Condoms for sale* — *YES* ☐ *NO* ☐ *Safer sex education provided by NGO/CSO* — *YES* ☐ *NO* ☐
14	Are there condoms available now?	*YES* ☐ *NO* ☐
15	In the past three months, have you observed cases of violence against key population individuals at this hot spot?	*YES* ☐ *NO* ☐
16	If yes, who was/were the perpetrator(s)?	1. _____ 2. _____ 3. _____

SERVICE DELIVERY POINTS

17	Do you know any places at this hot spot where services are available? *If yes, enter the information below.*		
	Name of service delivery point	**Type of service delivery point**	**Location**
A			
B			

INFORMATION ON OTHER HOT SPOTS

18	Do you know any other place like this in this city/town/village where key population individuals work/visit? *If yes, enter the information below.*	
	HOT SPOT NAME AND ADDRESS/LOCATION	**CONTACT**
A		
B		

Tool 1A: Instructions for Completing Hot Spot Validation Form	
This tool is used to validate hot spots identified through programmatic mapping or other available information. One form is completed for each listed hot spot, either by interviewing a PRIMARY KEY INFORMANT (key population individual) or a SECONDARY KEY INFORMANT (someone at the hot spot who is familiar with it). If a listed spot is not active or is a duplicate of one of the hot spots already listed, only the first part of the form is completed, providing the reason as INACTIVE or DUPLICATE, as appropriate. Once the form is completed, the program manager or M&E officer should check the name/location of any hot spots reported by the respondent against the Hot Spot Register (Tool 1B). If the newly reported hot spot is not already listed, its name should be added to the Hot Spot Register, and the spot should be visited to validate it using a new hot spot validation form.	
Who should complete	Peer Outreach Worker
When to complete	When mapping a newly identified hot spot, or validating an existing hot spot. Repeat periodically (once a year).
INSTRUCTIONS	
The first part of the form is used to identify the hot spot by its geographic location and type.	
Implementing partner	Write the name of the implementing partner.
Peer outreach worker	If the hot spot already has a peer outreach worker assigned, write their name here. If the spot is being mapped for the first time and has no peer outreach worker assigned, leave this field empty.
Hot spot name	Write the name of the hot spot. If a new hot spot, use a name that identifies it appropriately. If validating a previously mapped hot spot, write the name of the spot as listed on the Hot Spot Register (Tool 1B).
Revised name	If validating a previously mapped hot spot and the name does not seem to identify it appropriately – or the location has shifted slightly – write an appropriate revised name here. If the hot spot is being mapped for the first time, leave this field empty.
Address/ Location	Write the address or other information that clearly identifies the location of the hot spot.
District	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 administrative divisions other than district are used, write the relevant type of administrative unit.
Hot spot type	Write the number corresponding to the type of hot spot in the box.
Hot spot code	The hot spot code is a unique number assigned by the program manager or M&E officer of the implementing partner when a new hot spot is identified. If an already identified hot spot is being validated, the code can be taken from the Hot Spot Register (Tool 1B). If the hot spot is being mapped for the first time, the interviewer should leave this field empty (it will be completed by the M&E officer or program manager).
Type of KP found	Write the type of key population individual to be found at the hot spot, using one of the code numbers provided. If different types of key population individuals are engaging in risk behaviors at the spot, use an additional hot spot validation form for each key population type.

Respondent	Write the code number that describes the respondent(s) interviewed.
Status of hot spot	If the respondent reports that key population individuals are engaging in risk behaviors at the hot spot, use code 1 (active). If the respondent reports that no key population individuals engage in risk behaviors at the hot spot, use code 2 (inactive). If the hot spot turns out to have already been validated, use code 3 (duplicate). If the hot spot is an establishment such as a bar or lodging that is not open when visited, use code 4 (closed). If it cannot be located, use code 5 (not found).
Name and signature of interviewer	The person conducting the interview should write their name and their signature on this line. If the interviewer is the peer outreach worker assigned to the hot spot, they should write their name here as well as at the top of the form.
Date of visit 1 **Date of visit 2**	Write the date of the visit as visit 1. If the hot spot cannot be validated on the first visit, for example, because it is not possible to identify a respondent and a second visit is necessary, record the date of the second visit under visit 2. If more than two visits are made, record the date of the final visit date.
Informed consent	The interviewer should use the question written in italics, or a similar question, to request informed consent from the respondent (the person being interviewed). It is the responsibility of the interviewer to answer any questions the respondent may have, before asking the respondent the detailed questions about the hot spot. The respondent may wish to understand more about the overall purpose of the project, the reason for mapping, how the information they provide will be used, and whether it will be kept confidential. The interviewer should check the appropriate boxes to show they have asked for and received the informed consent of the respondent.

Row	HOT SPOT PROFILE
1	Ask the respondent for their best estimate of the lowest and highest number of key population individuals who work at or visit the hot spot on a typical (normal) day.
2	Ask the respondent for their best estimate of the peak time of day, and circle the appropriate code letter. If there is more than one peak time, circle all relevant letters.
3	Ask the respondent for their best estimate of the peak day, i.e., a day when a higher number of key population individuals visit than on other days, and circle the appropriate code letter. If there is more than one peak day, circle all relevant letters.
4	Ask the respondent for their best estimate of the lowest and highest number of key population individuals who work at or visit the hot spot on a peak day.
5	Sometimes a particular day of the month is even busier than the peak days of a normal week. Examples may include the end of each month (when people are paid and have money to spend), a festival day, or holiday period. Ask the respondent if there is a particular day that is busier than any other, and record their answer here (e.g., "last day," "15th," etc.).
6	Ask the respondent for their best estimate of the lowest and highest number of key population individuals who work at or visit the hot spot on a special day or period.
7	Ask the respondent for their best estimate of how many sex acts take place at the hot spot each week.
8	Ask the respondent for their best estimate of how many individual key population members work at or visit the hot spot regularly (at least once a week), and occasionally (less than once a week). This means unique key population individuals, i.e., if the same key population individual comes to the hot spot three times a week, they should be counted only once.

	So, for example, if 30 key population individuals come every day of the week, and 10 more key population individuals come on just two days of the week, the total number of unique key population individuals coming regularly will be 40 (30+10). If in addition, 5 key population individuals come only once a month, the total number of key population individuals coming occasionally will be 5.
9	Ask the respondent for their best estimate of the number of key population individuals who work at or visit this hot spot who also work at or visit any other hot spot. If the respondent is unable to give an estimate, leave this field empty. The purpose of this question and question 10 is to adjust hot spot numbers to take account of the mobility of key population individuals.
10	Sometimes key population individuals move from one hot spot to another during the course of the day. Ask the respondent for their best estimate of how many different hot spots (including this one) a typical key population individual also visits during a normal day. If the respondent is unable to give an estimate, leave this field empty.
11	Ask the respondent how many key population individuals use a mobile/cell phone to contact other key population individuals or clients in order to arrange meeting for sex. This refers to making phone calls, not using a smartphone for emails, etc.
12	Ask the respondent how many key population individuals use the Internet or social media to contact other key population individuals or clients in order to arrange meeting for sex. This refers to social messaging apps, websites, etc., that may be accessed from a smartphone.
13	This question is to find out about availability of HIV prevention services at the hot spot.
14	This question refers to the availability of condoms, whether free or for sale, at the hot spot.
15-16	These questions are used to give an indication of the risk of violence at the hot spot, which is important for assessing related HIV risk, and for assessing the safety or risk of doing outreach. In Question 16, it is not necessary to record names of individuals, but the type of individual, e.g., client of sex worker, police, gang member.
	SERVICE DELIVERY POINTS This section of the form is used to identify any points with relevant social or clinical services that are available to key population individuals.
17	List here any service delivery points that the respondent knows of that are close to the hot spot. These might include clinical services (whether at a public or private clinic, or available through a community-based outreach point or a drop-in center) and social services. The list can also be added to through the observations of the interviewer and anyone else involved in mapping or validating the hot spot.
	INFORMATION ON OTHER HOT SPOTS This section of the form is used to identify any new hot spots that have emerged or any that have been missed in the mapping data.
18	Ask the respondent if they know any other hot spots than the one where you are interviewing them. If they do, check the box “Yes;” otherwise check “No” and thank the respondent. If the respondent does know any other hot spots, ask them for the name and address/location of each one. Ask if they know any contact person in the hot spots who might be willing to help validate information about that spot, and enter that name under “Contact.”

Tool 1B: Hot Spot Register

Implementing Partner								Month/Year		
Type of KP										
Row No.	**Hot spot code**	**Name of hot spot**	**Address/ Location**	**District**	**Hot spot type***	**Estimated Number (Average)**		**Peak day(s)**	**Peak time(s)**	**Peer outreach worker responsible**
						Male	**Female**			
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

* **Codes** for type of hot spot: **1**=Bar with lodging, **2**=Bar without lodging, **3**=Brothel, **4**=Strip club**, 5**=Street/highway, **6**=Home, **7**=Casino**, 8**=Beach, **9**=Guest house/rest house/hotel/lodging, **10**=Massage parlor**, 11**=Park, **12**=Beer tavern, **13**=Public toilet, **14**= Injecting den, **15**=Uninhabited building, **16**=Other (specify)

Tool 1B: Hot Spot Register		
This tool is a compilation of validated hot spots frequented by a specific key population type and where interventions can be established by a single implementing partner. It is compiled from the information in Tool 1A: Hot Spot Validation Form. A separate form should be completed for each type of key population. If the implementing partner is implementing programs in multiple cities/towns/districts, any subunit list can be extracted from this comprehensive list.		
Contributes to indicator(s)	**1.1**	Estimated number of key population individuals in the country program geographic area
	1.2	Number of key population individuals to be covered annually, as per contract (target set for financial year)
	2.1	Number of mapped spots in country program geographic area where key population individuals can be reached
	3.1	Number of peer outreach workers needed (calculated from recommended ratio of key population individuals to peer outreach workers)
	3.2	Number of staff outreach supervisors needed (calculated from recommended ratio of peer outreach workers to staff outreach supervisors)
Who should complete	Program manager/M&E officer	
When to complete	Upon completion of hot spot mapping, before starting the intervention. Revise annually, following revalidation of hot spots.	

COLUMN	INSTRUCTIONS
	Month/Year: Write the month and year when mapping or validation of the hot spots is carried out. This is a reference point for deciding when revalidation of hot spots should be carried out and a new list developed.
	Type of KP: Write the type of key population (FSWs, MSM, TG, PWID) here. Do not mix different types of key populations in a single list.
A	**Hot spot code:** The hot spot code is a unique number assigned by the program manager or M&E officer of the implementing partner when a new hot spot is identified. It should correspond to the code used to identify the hot spot on Tool 1A.
B	**Name of hot spot:** Write the name of the hot spot.
C	**Address/Location:** Write the location of the hot spot, including its address or other information that clearly identifies its location.
D	**District:** 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 administrative divisions other than district are used, write the relevant type of administrative unit.
E	**Hotspot type:** Write the number corresponding to the type of hot spot.
F-G	**Estimated number (average):** This refers to the estimated number of key population individuals at the hot spot and is used for microplanning and M&E. Use the average of the minimum and maximum peak-day estimate from the hot spot mapping/validation form (Tool 1A, Row 4).
H	**Peak day(s):** Write the peak day or days here, from Tool 1A, Row 3 using the same codes given in that response, i.e., "A" for Monday, "B" for Tuesday, etc.
I	**Peak time(s):** Write the peak time or times of day for hot spot activity, from Tool 1A, Row 2 using the same codes given in that response, i.e., "A" for morning, "B" for Afternoon, etc.
J	**Peer outreach worker responsible:** Write the name of the peer outreach worker who is assigned to provide program services at the hot spot. If more than one peer outreach worker is assigned because of the size of the hot spot, list the names of all peer outreach workers responsible for that spot.

Tool 2: Peer Outreach Worker/Peer Navigator Register

Implementing Partner						**District/Sublocation**			
Row No.	**Name**	**Phone**	**Age**	**Gender**	**Type of KP**	**Role** (POW/PN)	**Date begun** (DD/MM/YY)	**Date ended** (DD/MM/YY)	**Reason for ending**
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Tool 2: Peer Outreach Worker/Peer Navigator Register		
This tool records the number of peer outreach workers and peer navigators in the program.		
Contributes to indicator(s)	**10.3**	Number of outreach personnel who discontinued working in the last month
	11.1	Number of peer outreach workers currently doing outreach work
Who should complete	Program manager/staff outreach supervisor	
When to complete	At the start of the program, when peer outreach workers/peer navigators are recruited, and then whenever a peer outreach worker/peer navigator joins or leaves the program.	

COLUMN	INSTRUCTIONS
A	**Name:** Write the name of the peer outreach worker or peer navigator – given (first) name followed by any second name, followed by family name.
B	**Phone**: Write the mobile (or landline) number where they can most easily be contacted.
C	**Age:** Write the age in completed years, e.g., if the individual is 24 years and 5 months, write 24. (Similarly, if he/she is 24 years and 11 months, again write 24 years.)
D	**Gender:** Write the gender of the individual. Male = M, female = F, transgender person = TG
E	**Type of KP:** Write the key population type to which the peer outreach worker/peer navigator belongs. Sex worker = SW, men who have sex with men = MSM, transgender = TG, people who inject drugs = PWID If the peer outreach worker/peer navigator belongs to more than one category, e.g., an MSM who is also a sex worker, write in all the codes that apply.
F	**Role (POW/PN):** Write whether the individual is a peer outreach worker (POW) or peer navigator (PN).
G	**Date begun**: Write the date on which the individual began working as a peer outreach worker or peer navigator. Use DD/MM/YY format.
H	**Date ended**: If the peer outreach worker/navigator stops working in the program (even if they continue using program services), write the date they stop work here, using DD/MM/YY format.
I	**Reason for leaving:** Write the main reason for ending their work as a peer outreach worker or peer navigator, e.g., “moved from area,” “wishes to stop,” “removed from position.”

Tool 3: Capacity-Building Register

Implementing Partner:					
Date		**Training Name**	**Number of Participants**		
From	**To**		**Peer Outreach Workers/ Peer Navigators**	**LINKAGES Staff**	**Others**

1	**Objectives of the training**
2	**Training format**
3	**Training curriculum and material used**
4	**Training process (summary of each day of the training)**
5	**Participants' feedback**

List of Participants

Row No.	Name	Role in Project	Age	Gender
1				
2				
3				
4				
5				
6				

Tool 3: Capacity-Building Register		
The capacity-building register records details of each training conducted, the topics covered, methodology adopted (training material used), and number of staff trained by their type. This form should also be completed if the implementing partner did not organize the training itself but its staff attended training organized by another organization.		
Contributes to indicator(s)	**10.2**	Number of staff/peer outreach workers/peer supervisors who received training
Who should complete	Program manager	
When to complete	At the end of each training session	
INSTRUCTIONS		
Date	Write the beginning and ending dates of the training in DD/MM/YY format.	
Training name	Write the type of training, e.g., induction training, skills-building session, peer navigator training, refresher training	
Number of participants	Write the number of individuals who attended in each of the three categories. Note that "LINKAGES Staff" means program staff directly funded by LINKAGES (therefore, for example, staff of a clinic not supported by LINKAGES would be counted under "Others").	
ROW	**INSTRUCTIONS**	
1	**Objectives of the training:** Write a brief description of the training objectives. Trainings generally fall into three broad categories: program management (outreach, TI component, MIS, etc.), financial management (audit, preparation of statement of expenditures, etc.), and clinical management (doctor training, counseling, STI symptoms, etc.).	
2	**Training format:** This may be classroom training, participatory training, or a field visit/exposure visit, etc.	
3	**Training curriculum and material used:** Briefly describe the topics covered and materials used.	
4	**Training process (summary of each day of the training):** Briefly describe the agenda for each day, and the knowledge/skills gained.	
5	**Participants' feedback:** Summarize the feedback provided by the participants on the training objectives, format, curriculum and materials, and outcomes.	
List of participants	Record the details of the participants who attended the training, including their name, role within the program, age, and gender. This part of the form can be collected as an attendance sheet (if clearly filled in by the participants), or it can be compiled from attendance sheets after the training is over.	

Tool 4A: Outreach Enrollment Form

1	Implementing partner	**2**	Date of enrollment (DD/MM/YY)
3	District	**4**	Hot spot code *(to be completed by outreach supervisor)*
5	Staff outreach supervisor	**6**	Peer outreach worker
7	Name/alias of key population individual	**8**	Date of birth (DD/MM/YYYY)
9	Gender identity ☐ Man ☐ Woman ☐ Transgender man (female to male) ☐ Transgender woman (male to female) ☐ Other ☐ Refuse to answer	**10**	Sex assigned at birth ☐ Male ☐ Female ☐ Other ☐ Refuse to answer
11	Type of KP (CHECK ALL BOXES THAT APPLY)	☐ Sex worker ☐ MSM ☐ PWID ☐ Transgender	
12	Nationality	**13**	UIC
14	Contact address *(optional)*	**15**	Phone number
16	What is the best place to meet you for outreach?		
17	Have you been been contacted by a peer outreach worker from any HIV prevention, testing, treatment, and care program in the last 6 months?	Yes ☐ No ☐	
18	Have you visited any DIC/clinic/wellness center for any STI or HIV services in the last 6 months?	Yes ☐ No ☐	
19	If yes, which facility did you visit?		

FOR SEX WORKERS			**FOR MSM/TRANSGENDER WOMEN**		
20	At what age did you start sex work?		**25**	At what age did you first have anal sex?	
21	How many times have you had vaginal or anal sex in the last week?		**26**	How many times have you had receptive anal sex in the last week?	
22	Did you use a condom **every time** you had sex with your boyfriend/ intimate partner in the last week?	Yes ☐ No ☐	**27**	Did you use a condom every time you had receptive or penetrative anal sex in the last week?	Yes ☐ No ☐
23	Did you use drugs or alcohol on any occasion when you had sex in the last week?	Yes ☐ No ☐	**28**	Did you use drugs or alcohol on any occasion when you had sex in the last week?	Yes ☐ No ☐
24	Have you experienced physical or sexual violence in the last month?	Yes ☐ No ☐	**29**	Have you experienced physical or sexual violence in the last month?	Yes ☐ No ☐

FOR PWID	
30	At what age did you first inject drugs?
31	How many times have you injected in the LAST 24 HOURS? _____ LAST WEEK? _____
32	How many times have you shared nonsterile injecting equipment (syringe or needle) in the LAST 24 HOURS? _____ LAST WEEK? _____
33	How many times have you had penetrative sex (vaginal or anal) in the LAST 24 HOURS? _____ LAST WEEK? _____
34	How many times have you had receptive vaginal or anal sex in the LAST 24 HOURS? _____ LAST WEEK? _____
35	Have you experienced physical or sexual violence in the last month? Yes ☐ No ☐

Signature _____
Staff outreach supervisor

Signature _____
Peer outreach worker

Tool 4A: Outreach Enrollment Form	
The outreach enrollment form is used to enroll the new key population individual into the program. The form contains information about the basic profile of the key population individual and their risk assessment. It serves as the authenticated document of the key population individual having enrolled in the program to access services. Once this form has been completed, the staff outreach supervisor or peer outreach worker should forward it to the M&E officer to record the information in Tool 4B: Key Population Register.	
Who should complete	Staff outreach supervisor/Peer outreach worker
When to complete	One form should be completed for each key population individual when they enroll in the program.
ROW	**INSTRUCTIONS**
1	**Implementing partner:** Write the name of the implementing partner.
2	**Date of enrollment:** Enter the date the key population individual was enrolled in the program, using DD/MM/YY format.
3	**District:** 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 administrative divisions other than district are used, write the relevant type of administrative unit.
4	**Hot spot code:** The hot spot code is a unique number assigned by the program manager or M&E officer of the implementing partner when a new hot spot is identified. The code is taken from the Hot Spot Register (Tool 1B).
5	**Staff outreach supervisor:** Write the name of the staff outreach supervisor who oversees the peer outreach worker. Assign a two-digit numeric code to uniquely identify the staff outreach supervisor.
6	**Peer outreach worker:** This is the name of the peer outreach worker who will regularly contact the key population individual during outreach. Normally this is the peer outreach worker who enrolls the key population individual.
7	**Name/alias of the key population individual:** Write the full name of the key population individual in BLOCK LETTERS. The name should appear in the same way on all other forms. If the key population individual does not wish to give their name, they can provide an alias (other name), but they should be asked to remember this name and to use it whenever they receive program services.
8	**Date of birth:** Enter using DD/MM/YY format. If possible, verify the reported date of birth through any supporting documents or proofs of identify that the key population individual has. If the key population individual does not know or remember their date of birth, write "NA" (not available).
	Gender identity and sex assigned at birth: *It is important to ask both parts of the two-step question on gender identity (Rows 9 and 10). Ask the questions clearly and respectfully, and record the answer that the individual gives. If the individual refuses to answer, check the "refuse to answer" box. For further information on recording gender identity, see* *Section 5.2*.
9	**Gender identity:** Preface the question by saying, "I'd like to ask you two short questions about your gender and sex. In this program we ask everyone these questions when they enroll for services, to help ensure high-quality care for all, and that's why I am asking them today." "Do you consider yourself a man, a woman, a transgender man, transgender woman, or something else?" Check the appropriate box according to their response.

10	**Sex assigned at birth:** Ask the key population individual, "What sex were you assigned at birth – that is, did your birth certificate record that you were male, female, or something else, or do you not know?" Check the appropriate box according to their response.
11	**Type of KP:** Check all the boxes that apply (e.g., if a key population individual is a female sex worker who also injects drugs, check sex worker and PWID)
12	**Nationality:** Ask the key population individual their nationality and write it here. If possible, verify the information through any supporting documents or proofs of identify that the key population individual has. If the key population individual does not know or remember their nationality, write "NA" (not available).
13	**Program ID/UIC:** Enter the program ID or UIC (unique identifier code) according to the program protocol for generating and assigning the code (see Section 2.4).
14	**Contact address:** Write address where the key population individual currently lives. Include any landmark or other information relevant to the contact address. This information is optional; if the key population individual prefers not to give it, that is OK.
15	**Phone number:** Write the mobile (or landline) number where they can most easily be contacted.
16	**What is the best place to meet you for outreach?** Ask the key population individual where it is easiest and safest for them to meet in future.
17	**Have you been been contacted by a peer outreach worker from the HIV prevention program in the last 6 months?** If the key population individual says they have been contacted by a peer outreach worker from an HIV prevention program in the past 6 months, check "Yes," otherwise check "No."
18	**Have you ever visited any DIC/clinic/wellness center for any services in the last 6 months?** If the key population individual has visited a DIC/clinic/wellness center to obtain any STI or HIV services in the last 6 months through any HIV prevention program, check "Yes," otherwise check "No."
19	**If yes, which facility did you visit?** Write the name and address (where known) of the facility.
For the following sections, ask all the questions that apply. *For example, if a female sex worker also injects drugs, ask the questions in the Sex Workers and PWID sections. If a man who has sex with men also sells sex, ask the questions in the Sex Workers and MSM sections.*	
	FOR SEX WORKERS
20	**At what age did you start sex work?** Write the age in years. If the FSW does not know or remember the age, ask them to estimate (e.g., "15-18").
21	**How many times have you had vaginal or anal sex in the last week?** Write down the number of sex acts (vaginal or anal) that the sex worker says they have had in the past week. If there were no sex acts during either time period, write "0." (Do not leave the line blank unless the key population individual refuses to answer the question.)
22	**Did you use a condom every time you had sex with your boyfriend/intimate partner in the last week?** Check the box "yes" or "no" to record whether the sex worker says they used a condom each time they had sex with their boyfriend/intimate partner (not clients) in the last week.
23	**Did you use drugs or alcohol on any occasion when you had sex in the past week?** Check the box "yes" or "no" to record whether the sex worker says they used drugs or alcohol (i.e., were under the influence of drugs or alcohol) on any occasion when they had sex in the past week).
24	**Have you experienced physical or sexual violence in the last month?** Check the box "yes" or "no" to record whether the sex worker says they experienced physical or sexual violence in the past month.

	FOR MSM/TRANSGENDER WOMEN
25	**At what age did you first have anal sex?** Write the age in years. If the MSM or transgender individual does not know or remember the age, write "98."
26	**How many times have you had receptive anal sex in the last week?** Write down the number of receptive anal sex acts that the MSM or transgender person says they have had in the past week. If there were no sex acts during either time period, write "0." (Do not leave the line blank unless the key population individual refuses to answer the question.)
27	**Did you use a condom every time you had receptive or penetrative anal sex in the last week?** Check the box "yes" or "no" to record whether the key population individual says they used a condom each time they had sex in the last week.
28	**Did you use drugs or alcohol on any occasion when you had sex in the past week?** Check the box "yes" or "no" to record whether the key population individual says they used drugs or alcohol (i.e., were under the influence of drugs or alcohol) on any occasion when they had sex in the past week.
29	**Have you experienced physical or sexual violence in the last month?** Check the box "yes" or "no" to record whether the key population individual says they experienced physical or sexual violence in the past month.
	FOR PWID
30	**At what age did you first inject drugs?** Write the age in years. If the PWID does not know or remember the age, write "98."
31	**How many times have you injected in the last 24 hours/last week?** Write down the number of times the PWID reports having injected drugs during the past 24 hours, and in the past week. If the PWID did not inject during either time period, write "0." (Do not leave the line blank unless the key population individual refuses to answer the question.)
32	**How many times have you shared nonsterile injecting equipment (syringe or needle) in the last 24 hours/last week?** Write down the number of times the PWID reports having shared injecting equipment (needles, syringes, etc.) during the past 24 hours, and in the past week. If the PWID did not report having shared equipment, write "0." (Do not leave the line blank unless the key population individual refuses to answer the question.)
33	**How many times have you had penetrative sex (anal or vaginal) in the last 24 hours/last week?** Write down the number of penetrative sex acts that the PWID reports having in the past 24 hours, and in the past week. If there were no sex acts during either time period, write "0." (Do not leave the line blank unless the key population individual refuses to answer the question.)
34	**How many times have you had receptive vaginal or anal sex in the last 24 hours/last week?** Write down the number of receptive sex acts (vaginal or anal) that the PWID reports having in the past 24 hours, and in the past week. If there were no sex acts during either time period, write "0." (Do not leave the line blank unless the key population individual refuses to answer the question.)
35	**Have you experienced physical or sexual violence in the last month?** Check the box "yes" or "no" to record whether the key population individual says they experienced physical or sexual violence in the past month.

Tool 4B: Key Population Register

Row No.	District	Hot spot code	Staff outreach supervisor	Peer outreach worker	Date of enrollment	Name of KP	Date of birth	KP type*	Program ID/UIC	Phone number
	A	B	C	D	E	F	G	H	I	J
1										
2										
3										
4										
5										
6										
7										
8										

* **Codes: 1**=Female sex worker, **2**=MSM sex worker, **3**=MSM not sex worker, **4**=Transgender sex worker, **5**=Transgender not sex worker, **6**=PWID male, **7**=PWID female

Tool 4B: Key Population Register		
This tool is a master register compiling information about all key population individuals enrolled in the program. It provides easy access to information about the key population individuals, e.g., the number and type registered at each hot spot, their ages, and the peer outreach worker assigned to them. The information for the Master Register comes directly from Tool 4A: Outreach Enrollment Form. Each line of the Key Population Register represents the data from a single Outreach Enrollment Form.		
Contributes to indicator(s)	**4.1**	Number of key population individuals registered (enrolled) by the project during the reporting period
Who should complete	Monitoring and Evaluation Officer	
When to complete	The register should be filled in when the implementing partner has a list of key population individuals registered with the program. It should be updated regularly, mostly on a weekly basis, or as new registrations happen.	

COLUMN	INSTRUCTIONS
A-J	These columns are completed with information from the corresponding parts of Tool 4A.
A	Tool 4A, No. 3
B	Tool 4A, No. 4
C	Tool 4A, No. 5
D	Tool 4A, No. 6
E	Tool 4A, No. 2
F	Tool 4A, No. 7
G	Tool 4A, No. 8
H	Tool 4A, No. 11
I	Tool 4A, No. 13
J	Tool 4A, No. 15

Tool 5A: KP Outreach Tracking Sheet (Peer Calendar)

IMPLEMENTING PARTNER					STAFF OUTREACH SUPERVISOR									PEER OUTREACH WORKER													MONTH/ YEAR		
ROW NO.	HOT SPOT	HOT SPOT CODE	NAME/ ALIAS	PRO-GRAM ID/ UIC	GENDER	AGE	TYPE OF KP*	NEW TO OUTREACH? (Y/N)	DATE OF CONTACT	RISK ASSESSMENT				VIOLENCE		HTC		IEC	REFERRAL FOR HEALTH SERVICES (Y/N for all columns)							COMMOD-ITIES (QUANTITY)		
										NO. SEX ACTS IN LAST WEEK	CONDOM USE WITH SEX PARTNERS**	DRUG/ALCOHOL USE DURING SEX**	SHARING DRUG-INJECTING EQUIPMENT***	REPORTED	ADDRESSED	HIV STATUS****	REFERRAL STATUS*****		STI		TB	HBV/HCV	FP	ART		OTHER (SPECIFY)	CONDOM (M/F)	LUBE	NEEDLE/SYRINGE
																			REFERRED	REFERRAL COMPLETED				REFERRED	REFERRAL COMPLETED				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	BB	CC
1																													
2																													
3																													
4																													
5																													
6																													
7																													

* **Type of KP: 1**=Female sex worker, **2**=MSM sex worker, **3**=MSM not sex worker, **4**=Transgender sex worker, **5**=Transgender not sex worker, **6**=PWID male, **7**=PWID female

** **Condom use with sex partners; Drug and/or alcohol use during sex: E**=Every time, **M**=Most times, **O**=Occasionally, **N**=Never

*** **Sharing drug-injecting equipment: D**=Daily, **F**=Frequently (1-6 times a week), **O**=Occasionally (1-3 times a month), **N**=Never

**** **HIV status: 1**=known HIV positive, **2**=HIV negative and tested within past 3-6 months, **3**=tested more than 3-6 months ago/don't know/never tested/refuse to say

***** **Referral status: 1**=Tested for HIV on the spot, **2**=Accepted referral for HTC, **3**=Declined referral for HTC

Tool 5A: KP Outreach Tracking Sheet (Peer Calendar)	
This is an essential tool for outreach activities. The peer outreach worker uses it to record all the services that he/she provides to key population individuals at the hot spot. Each service delivered in the course of a month is recorded including information, education, and communication; screening for violence; referrals for health services; and distribution of commodities. This information is then compiled at the site level to aggregate to the project level.	
Who should complete	Peer outreach worker, with the help of staff outreach supervisor
When to complete	Whenever the peer outreach worker provides services to key population individuals. A new line should be completed for each contact, i.e., if the same key population individual is contacted twice during the reporting period, their name will appear on two lines of the form.

COLUMN	INSTRUCTIONS
A	**Hot spot:** Write the name of the hot spot.
B	**Hot spot code:** The hot spot code is a unique number assigned by the program manager or M&E officer of the implementing partner when a new hot spot is identified. The code is taken from the Hot Spot Register (Tool 1B).
C	**Name/Alias:** Write the name of the key population individual, or an alias (other name) chosen by them. Using an alias is a good idea in environments where key population individuals would be at risk of harassment if their name was seen on this form by unauthorized people, e.g., law enforcement officers.
D	**Program ID/UIC:** Enter the program ID or UIC (unique identifier code) as it appears on Tool 4A (Outreach Enrollment Form), Row 13.
E	**Gender:** Write the gender of the key population individual as it appears on Tool 4A (Outreach Enrollment Form), Row 9.
F	**Age:** Write the age in completed years, e.g., if the individual is 24 years and 5 months, write 24. (Similarly, if he/she is 24 years and 11 months, again write 24 years.)
G	**Type of KP:** Write the numerical code for the key population individual type according to the key at the bottom of the form.
H	**New to outreach?** If this is the first time that the key population individual is receiving outreach services, write "Y," otherwise write "N."
I	**Date of contact:** Write the day of the month (the month and year are recorded at the top of the form).
	RISK ASSESSMENT – *to be completed every six months or annually, according to country program guidelines. Note that the risk assessment factors are examples, and the criteria used can be enlarged (e.g., age), adapted to the national context or to specific key populations (e.g., receptive anal intercourse for men who have sex with men). For another risk assessment tool, see Part 3, Tool A.*
J	**No. sex acts in last week:** Write the number of sex acts (penetrative or receptive vaginal sex, or penetrative or receptive anal sex) that the key population individual reports having had in the past week.
K	**Condom use with sex partners:** Record whether the key population individual reports using condoms every time they had sex in the past week.

L	**Drug/alcohol use during sex:** Record how often key population individual reports using alcohol or drugs when having sex in the past week, using the codes at the bottom of the page.
M	**Sharing drug-injecting equipment:** Record how often the key population individual reports sharing drug-injecting equipment (needles and syringes) in the past week, using the codes at the bottom of the page.
N	**Violence reported:** Check this box if the key population individual reports having experienced violence (whether this was since your last meeting, or at some earlier time). Use Tool 12 (Violence Disclosure and Service Provision Form) for more complete screening.
O	**Violence addressed:** Check this box if you or other program staff refer the key population individual for supportive post-violence services at a program clinic or from another provider. Use Tool 12: Violence Disclosure and Service Provision Form to see the range of appropriate services and record those to which the individual is referred.
	HIV PREVENTION
P-Q	**HIV status:** *HIV status should be asked about every three months, or at a different interval if required by national policy.* Ask the key population individual if they know whether they are HIV positive or HIV negative, and whether they are willing to tell you. (If using the phrase "HIV status," make it clear that this refers to being HIV negative or being HIV positive.) Record their answer using the numerical code at the bottom of the form. ***Note that the key population individual is not required to answer this question, but it should be asked because this information is needed for PEPFAR disaggregations.*** **Referral status:** If the key population individual is HIV negative and was last tested more than 3 to 6 months ago (according to the timeline set by national policy), or does not know their HIV status, has never been tested, or refuses to say what their status is, offer them an HIV referral (or peer-assisted testing on the spot, if available). • If a referral for an HIV test is accepted, column Q can be completed once the outcome is known, using codes 1, 2, or 3. (If the peer outreach worker does not accompany the key population individual for the test, this information can be added when the program receives notification from the testing facility, i.e., a copy of the referral slip showing that the referral was completed – see Tool 6 for more information.) • If the key population individual refuses a referral, column Q can be completed immediately, using code 4 from the bottom of the page.
R	**IEC:** Check the box if an information, education, and communication (IEC) session was delivered to the key population individual, whether one-on-one or in a group. IEC sessions may cover topics such as STIs, HIV, hepatitis, sexual and gender-based violence, stigma and discrimination.
S-Z	**REFERRAL FOR HEALTH SERVICES:** Check the appropriate box to indicate services to which you have referred the key population individual (STI screening, TB screening, hepatitis B or C screening, FP, ART, or other service. A key population individual may be referred for more than one service. For STIs and ART, note also whether the referral was successfully completed.
AA-CC	**COMMODITIES:** List the quantity of commodities provided to the key population individual – the number of male or female condoms, lubricant packs, and sterile needles/syringes.

Tool 5B: KP Outreach Compilation Sheet

STAFF OUTREACH SUPERVISOR						MONTH/YEAR																														
ROW NO.	HOT SPOT CODE	TYPE OF KP AT HOT SPOT*	PEER OUTREACH WORKER'S NAME	MONTH	TOTAL KPs RESPONSIBLE FOR	TOTALS REACHED DURING REPORTING PERIOD																																
						TYPE OF KP*							REACH TYPE		HIV STATUS**			REFERRAL STATUS***			VIO-LENCE		IEC	REFERRAL FOR HEALTH SERVICES							COMMOD-ITIES		
						1	2	3	4	5	6	7	FIRST TIME	REPEAT	1	2	3	1	2	3	REPORTED	ADDRESSED		STI	TB	HBV/HCV	FP	ART	OTHER (SPECIFY)	CONDOM (M/F)	LUBE	NEEDLE/SYRINGE			
	A	B	C		D	E							F		G			H			I		J	K	L	M	N	O	P	Q	R	S			
1				M1																																
				M2																																
				M3																																
2				M1																																
				M2																																
				M3																																
3				M1																																
				M2																																
				M3																																

* **Type of KP: 1**=Female sex worker, **2**=MSM sex worker, **3**=MSM not sex worker, **4**=Transgender sex worker, **5**=Transgender not sex worker, **6**=PWID male, **7**=PWID female

** **HIV status: 1**=known HIV positive, **2**=HIV negative and tested within past 3-6 months, **3**=tested more than 3-6 months ago/don't know/never tested/refuse to say

*** **Referral status: 1**=Tested for HIV on the spot, **2**=Accepted referral for HTC, **3**=Declined referral for HTC

Tool 5B: KP Outreach Compilation Sheet		
This is a compilation tool for all the peer outreach workers being supervised by a single staff outreach supervisor. It indicates the performance by intervention site in each staff outreach supervisor's area. A separate line should be completed for each hot spot. If a hot spot is served by more than one peer outreach worker, a separate line should be completed for each peer outreach worker at the hot spot. The form is designed to cover three months. The information for the Compilation Sheet comes directly from Tool 5A: KP Outreach Tracking Sheet (Peer Calendar)		
Contributes to indicator(s)	**4.2 KP_PREV**	Number of key population individuals reached with individual and/or small-group-level HIV prevention interventions designed for the target population during the reporting period
	4.3	Average number of contacts per key population individual with peer outreach workers during the reporting period
	4.4 PP_PREV	Number of priority population individuals reached with standardized, evidence-based interventions designed to promote the adoption of HIV prevention behaviors and service uptake during the reporting period
	5.1	Number of male/female condoms; lubricant/needles distributed by program to key population individuals during the reporting period
Who should complete	Staff Outreach Supervisor	
When to complete	Preferably update weekly, and should be completed by the end of the month	

COLUMN	INSTRUCTIONS
A-B	These fields are completed from the corresponding fields in Tool 5A (Columns B and G).
C	**Peer outreach worker's name:** Write the name of the individual peer outreach worker.
D	**Total KPs responsible for:** This is the total number of key population individuals that a peer outreach worker is responsible for, regardless of whether they are new to the program, and regardless of whether they have been contacted during the month. For each peer outreach worker, write the total number of unique key population individuals listed on the peer outreach worker's tracking sheet/peer calendar. This number may vary from month to month and so should be entered for each month.
E	**Type of KP:** Write the total number of key population individuals of each type contacted by the peer outreach worker during the month, referring to the code numbers at the bottom of the sheet. For example, if the peer outreach worker contacted 30 female sex workers and 5 transgender sex workers, write 30 in column 1, and 5 in column 4. (See Tool 5A, Column G.)
F	**Reach type:** Write the total number of key population individuals who were reached by outreach for the first time during the month, or who received repeat outreach, in the appropriate column (Tool 5A, Column H).

G	**HIV status:** Write the total number of key population individuals reached during the month who fell into each category (1-3) listed at the bottom of the sheet (Tool 5A, Column P).
H	**Referral successful:** Write the total number of key population individuals reached during the month who fell into each category (1-4) listed at the bottom of the sheet (Tool 5A, Column Q).
I	**Violence:** Write the total number of key population individuals who have reported violence and/or have had this addressed (Tool 5A, Columns N-O).
J-P	**IEC, and referral for health services:** Write the total number of key population individuals who received an IEC session or a referral to other health services (Tool 5A, Columns R-Z).
Q-S	**Commodities:** Write the total number of each kind of commodity distributed (Tool 5A, Columns AA-CC).

Tool 6: Referral Slip (Clinical Services)

TO BE COMPLETED BY THE PERSON MAKING THE REFERRAL		
Implementing partner		
1	Referral slip number	
2	Date of referral	
3	Client program ID/UIC	
4	Referred to (facility name)	
5	Facility address	
6	Facility type	☐ Public clinic ☐ Private clinic ☐ Drop-in center ☐ Hospital
7	Reason for referral:	☐STI ☐HCT ☐ ART ☐FP ☐TB ☐PMTCT ☐ PrEP ☐ Other _____
8	Referred by	Name _____ Position _____
TO BE COMPLETED BY THE SERVICE PROVIDER		
9	Date referral completed	
10	Name of person accompanying client (if any)	
11	Receiving person at facility	Name _____ Position _____
12	Actions taken/services provided	
13	Signature	

Tool 6: Referral Slip (Clinical Services)		
The referral slip is used by a peer outreach worker, peer navigator, or other program staff member when referring a key population individual for clinical services. The form should be written out in duplicate. The person making the referral keeps the first copy; the key population individual takes the other copy to the referral center. The copies are ultimately distributed as follows: **Copy 1:** Retained at the referral center, as a record that the referral was made **Copy 2:** Retained by the referral center, and collected by the program manager/counselor at the end of every reporting month, as a record that the referral was successfully completed.		
Contributes to indicator(s)	**6.1 HTS_LINK**	Number of key population individuals successfully referred to or navigated to an HIV testing site
	6.2 HTS_TST	Number of key population individuals tested for HIV who received their results during the reporting period
Who should complete	Peer outreach worker, peer navigator, or other program staff person making the referral	
When to complete	When a key population individual is referred for any services outside the implementing partner's system	

ROW	INSTRUCTIONS
1	**Referral slip number:** This is a continuous serial number maintained by the implementing partner so that each referral has its own unique number. Serial numbers can be preprinted or prestamped on the referral slips.
2	**Date of referral:** Write the date using DD/MM/YY format.
3	**Client program ID/UIC:** Enter the program ID or UIC (unique identifier code) as it appears on Tool 4A: Outreach Enrollment Form, Row 13.
4-6	**Referred to:** Write the name and address of the facility, and check the box to indicate its type.
7	**Reason for referral:** Check the box indicating the reason or reasons for referral.
8	**Referred by:** The person making the referral should write their name and position.
9	**Date referral completed:** This is the date that the key population individual attends the clinic
10	**Name of person accompanying:** If the key population individual is accompanied by a representative of the program, e.g., a peer outreach worker or peer navigator, they should write their name here.
11	**Receiving person at facility:** The clinical staff person who provides services to the key population individual should write their name and position.
12	**Actions taken:** The service provider should summarize what services have been provided.
13	**Signature:** The service provider should sign the form.

Tool 7: Referral Register for Social-Protection Services

Row No.	Program ID/UIC	KP Type	Age	Gender	Date of referral	Institution referred to	Service(s) referred for	Contact person at the referral service	Outcome of referral
	A	B	C	D	E	F	G	H	I
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
19									
19									

Tool 7: Referral Register for Social-Protection Services		
This register is used to track whether the program is meeting the needs of key population individuals beyond health, in order to support them and create a more enabling environment. Referrals that may be recorded here could include ID cards, voter ID, social-security programs, ration cards, educational services, support groups, etc.		
Contributes to indicator(s)	**4.5**	Number of key population individuals referred to social-protection services during the reporting period
Who should complete	Staff Outreach Supervisor or Program Manager	
When to complete	Weekly, and consolidated monthly	
INSTRUCTIONS		
All the columns in the form are self-explanatory.		

Tool 8A: Condom and Lubricant/Needle and Syringe Outlet Register

Implementing Partner										
Row No.	Hot spot	Location	Hot spot code	Type of outlet/ facility*	Type of commodity	Outlet holder		Date started	Date discontinued	Reason for discontinuation
						Name	Gender			
	A	B	C	D	E	F	G	H	I	J
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

* **Code**: **1**=Individual outlet holder, **2**=Public place, **3**=Private place, **4**=Vending machine, **5**=Health facility, **6**=DIC, **7**=Other

Tool 8A: Condom and Lubricant/Needle and Syringe Outlet Register	
The condom outlet register is updated whenever an outlet for condoms, or for needles and syringes, is inducted into the program. It shows the distribution and type of outlet established by the program.	
Who should complete	Monitoring and Evaluation Officer
When to complete	When outlets are first established. Update every quarter.
COLUMN	**INSTRUCTIONS**
A	**Hot spot:** Write the name of the hot spot where the outlet is located.
B	**Location:** Write the location of the hot spot, including its address or other information that clearly identifies its location.
C	**Hot spot code:** The hot spot code is a unique number assigned by the program manager or M&E officer of the implementing partner when a new hot spot is identified. The code is taken from the Hot Spot Register (Tool 1B).
D	**Type of outlet/facility:** Use the numeric code from the bottom of the list to indicate the type of outlet or facility.
E	**Type of commodity:** If the outlet supplies condoms and/or lubricant, write "C," "L," or "C/L," as appropriate. If it supplies needles and syringes, write "N/S"
F-G	**Outlet holder:** If the outlet holder is a person other than a peer outreach worker (i.e., not a vending machine, health facility, DIC, etc.), write their name and gender here. Otherwise, write "N/A" (not applicable).
H	**Date started:** Write the date that the outlet holder or facility began supplying the commodities, using DD/MM/YY format.
I	**Date discontinued:** If the outlet stops supplying commodities, write the date here using DD/MM/YY format.
J	**Reason for discontinuation:** Note the reason that outlet stopped supplying commodities.

Tool 8B: Condom and Lubricant Inventory Register

Implementing partner																		
Row No.	Date	Opening Balance Condoms and Lubricant			Number Received						Number Distributed to						Closing Balance		
					MOH/Donor			Other Sources			Peer Outreach Workers			Outlets					
		MC	FC	L	MC	FC	L	MC	FC	L	MC	FC	L	MC	FC	L	MC	FC	L
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			

Tool 8B: Condom and Lubricant Inventory Register	
This tool helps the program manager track the inventory (stock levels) of male and female condoms and lubricants across the program. It is used to record the sources of condoms and lubricants, and the numbers distributed to peer outreach workers and to outlets. Based on the available stock, the program manager can place future procurement orders. (Note that this register does not record the number of condoms and lubricants distributed by peer outreach workers and outlets to key population individuals. Tool 8C is used to record distribution by outlets.)	
Who should complete	Program Manager
When to complete	Update monthly
COLUMN	**INSTRUCTIONS**
A	**Date:** Write the date that the inventory is recorded, using DD/MM/YY format.
B-D	**Opening balance condoms and lubricant:** Record the number of male and female condoms and lubricants in stock at the beginning of the accounting period.
E-J	**Number received:** Record the quantity of condoms and lubricants received from the MOH/donor or from other sources.
K-P	**Number distributed:** Record the total quantity of condoms or lubricants distributed to peer outreach workers or to outlets. (Note: this is not the same as the quantity distributed by peer outreach workers or outlets.)
Q-S	**Closing balance:** This is calculated by adding the opening balance to the number received, and subtracting the number distributed: • For male condoms, this is columns (B+E+H)-(K+N), with the result written in column Q. • For female condoms, this is columns (C+F+I)-(L+O), with the result written in column R. • For lubricants, this is columns (D+G+J)-(M+P), with the result written in column S. The results should be checked against the quantities of condoms and lubricants remaining in stock once the distributions have been made. Write the closing balances in columns Q-S, **and** in columns B-D of the next row. These numbers form the opening balance for the next accounting period.

Tool 8C: Condom and Lubricant Outlet Inventory/Distribution Register

Implementing partner																		
Row No.	Hot spot	Hot spot code	Name of outlet/ facility	Type of outlet/ facility*	Date	Opening Balance			Supplied to Outlet			Date	Distributed			Closing Balance		
						MC	FC	L	MC	FC	L		MC	FC	L	MC	FC	L
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		

* **Code**: **1**=Individual outlet holder, **2**=Public place, **3**=Private place, **4**=Vending machine, **5**=Health facility, **6**=DIC, **7**=Other

Tool 8C: Condom and Lubricant Outlet Inventory/Distribution Register		
This tool guides the program on the distribution pattern of condoms/lubricants to and from various outlets.		
Contributes to indicator(s)	**5.1**	Number of male/female condoms; lubricant/needles distributed by program to key population individuals during the reporting period
Who should complete	Program Manager	
When to complete	Each time outlet is supplied with commodities	

COLUMN	INSTRUCTIONS
A	**Hot spot:** Write the name of the hot spot where the outlet is located.
B	**Hot spot code:** The hot spot code is a unique number assigned by the program manager or M&E officer of the implementing partner when a new hot spot is identified. The code is taken from the Hot Spot Register (Tool 1B).
C	**Name of outlet/facility:** Write the name of the outlet/facility here.
D	**Type of outlet/facility:** Use the numeric code from the bottom of the list to indicate the type of outlet or facility.
E	**Date:** Write the date that condoms/lubricant are distributed to the outlet, using DD/MM/YY format.
F-H	**Opening balance:** Record the numbers of male condoms (MC), female condoms (FC), and lubricants (L) currently at the facility before new stock is supplied.
I-K	**Supplied to outlet:** Record the numbers of new stock of condoms and lubricants supplied to the facility.
L	**Date:** Write the date on which the remaining columns (M-R) are recorded, using DD/MM/YY format. This will typically be the day on which a new supply is received, or the day before this.
M-O	**Distributed:** Record the numbers of male condoms (MC), female condoms (FC), and lubricants (L) distributed since the stock was supplied on the date shown in column E.
P-R	**Closing Balance:** Record the total numbers of condoms and lubricants in stock at the facility on the date shown in Column L. For male condoms, the total is F+I-M. For female condoms, the total G+J-N. For lubricants, the total is H+K-O.

Tool 9: Clinical Services Compilation Sheet

Clinic																	Reporting period (MM/YY–MM/YY)										
ROW NO.	PROGRAM ID/UIC	DATE OF BIRTH	GENDER	HOT SPOT CODE	TYPE OF KP	MONTH	RISK ASSESSMENT?	HTC					STIs			ABSCESS TREATMENT	FAMILY PLANNING SERVICES	RISK REDUCTION				PEP		PREP	VIOL-ENCE	PARTNER REFERRAL		COMMENTS
								TESTED	RECEIVED RESULTS	SELF-TEST KIT GIVEN	TESTED HIV POSITIVE	REFERRED FOR ART	SCREENED	DIAGNOSED	TREATED			MALE CONDOMS	FEMALE CONDOMS	LUBRICANT	NEEDLES/SYRINGES	SCREENED	TREATED	NEWLY ENROLLED	RECEIVED POST-GBV CLINICAL CARE	PARTNER CONTACTED	OUTCOME*	
	A	B	C	D	E		F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1						M1																						
						M2																						
						M3																						
2						M1																						
						M2																						
						M3																						
3						M1																						
						M2																						
						M3																						

***Partner referral outcome:** 1=refused an HIV test, 2=known to be HIV positive, 3=received an HIV test, **tested HIV negative**, 4=received an HIV test, **tested HIV positive**

Tool 9: Clinical Services Compilation Sheet		
This sheet compiles data on individual key population members from the forms for clinic enrollment, clinic visits, PrEP and violence reporting. It is completed monthly by clinical staff and enables program staff to track the services that key population individuals have received, in order to report on the indicators listed below. The tracking sheet collects data over three months and thus can be used to see the individual's progress over this period.		
Contributes to indicator(s)	**6.2 HTS_TST**	Number of key population individuals tested for HIV who received their results during the reporting period
	6.3 HTS_TST_POS	Number of key population individuals testing positive for HIV during the reporting period among those tested and received results
	6.4	Number of individual HIV self-test kits distributed
	8.1 STI_SCREEN	Number of key population individuals screened for STIs using a national algorithm during the reporting period
	8.2 STI_DIAG	Number of key population individuals diagnosed with an STI during the reporting period
	8.3 STI_TREAT	Number of key population individuals treated for an STI during the reporting period
	9.1 PREP_NEW	Number of individuals who have been newly enrolled on PrEP to prevent HIV infection during the reporting period
	9.2	Number of key population individuals screened for TB during the reporting period
	9.3	Number of key population individuals referred to TB centers during the reporting period
	9.4	Number of female key population individuals of reproductive age (15–49) provided with family planning services during the reporting period
	9.5	Number of people who inject drugs treated for abscesses during the reporting period
Who should complete	Clinic Staff – preferably Clinician	
When to complete	Monthly	
COLUMN	**INSTRUCTIONS**	
A-E	These fields are completed with information from the clinic visit form.	
F	Write "Y" or "N" to show whether a risk assessment was conducted during the reporting period.	
G-K	Write "Y" or "N" to show whether any of the listed components of HTC were delivered.	
L-N	Write "Y" or "N" to show whether any of the listed components of STI screening and treatment were delivered.	

O	Write “Y” or “N” to show whether abscess treatment was given to person who injects drugs.
P	Write “Y” or “N” to show whether FP services were given to a female key population individual.
Q-T	Write the quantity of any risk reduction commodities that were given.
U-V	Write “Y” or “N” to show whether the key population individual was screened for PEP or given PEP.
W	Write “Y” or “N” to show whether the key population individual was newly enrolled for PrEP during the reporting period.
X	Write “Y” or “N” to show whether the key population individual received any post-violence clinical care services.
Y-Z	In Column Y, Write “Y” or “N” to show whether the sexual partner of a key population individual was contacted to offer HIV testing services. In Column Z, indicate the outcome using the numerical code below the table.

Tool 10A: HIV Care and Support Tracking Sheet (Peer Navigator Calendar)

Implementing Partner											Location							
Peer navigator											Signature							
Row No.	Program ID/UIC	Date of Birth	Gender	Hot spot code	KP type	Month	Date	HIV/ART status*	Successfully navigated for ART enrollment during reporting period? (Y/N)	Successfully navigated for ART re-enrollment during reporting period? (Y/N)	On ART? (Y/N)	Care and support services to HIV-positive KP outside health facilities							
												Support for adherence on ART (Yes/No)	ART adherence counseling (Yes/No)	Psycho-social support and referrals (Yes/No)	Referral made to comprehen-sive HIV care (Yes/No)	Commodity provision (specify quantity)			
																Male Condoms	Female Condoms	Lubricant	Needles/ syringes
	A	B	C	D	E		F	G	H	I	J	K	L	M	N	O	P	Q	R
1						M1													
						M2													
						M3													
2						M1													
						M2													
						M3													

*__Code__: **N** = newly diagnosed (whether or not on ART); **K** = known HIV positive and not previously initiated on ART; **L** = lost to follow-up

Tool 10A: Hiv Care and Support Tracking Sheet (Peer Navigator Calendar)	
This form collects information on key population individuals living with HIV who are receiving care and support services through peer navigators outside of the health facility. Each peer navigator completes this form for all the key population individuals living with HIV whom they are overseeing. The tracking sheet collects data over three months and thus can be used to see the individual's progress over this period.	
Who should complete	Peer Navigator
When to complete	Each time the peer navigator provides services in the field
COLUMN	**INSTRUCTIONS**
A-E	The key population individual's UIC or program ID number, their date of birth, gender, hot spot codes, and key population type can be taken from Tool 4A (Outreach Enrollment Form), 4B (Key Population Register) or 5A (KP Outreach Tracking Sheet [Peer Calendar]); or from Tool 11 (HIV Treatment Compilation Sheet)
F	**Date:** Write the date of the meeting using DD/MM/YY format
G	**HIV/ART status:** Use the code at the bottom of the form to indicate whether the key population individual is newly diagnosed with HIV (whether or not they are on ART), previously knew that they were HIV positive but has never been initiated on ART, or is lost to follow-up (did not attend an appointment for ART for more than three months). If the key population individual began ART **before** the reporting period and is currently on ART, leave this column blank (the fact that they are on ART will be recorded in column J instead).
H	**Successfully navigated for ART enrollment during reporting period?:** Record whether you or another program member (e.g., a peer outreach worker) successfully enrolled the key population individual in ART for the first time during the reporting period.
I	**Successfully navigated for ART re-enrollment during reporting period?:** Record whether you or another program member (e.g., a peer outreach worker) successfully re-enrolled the key population individual in ART during the reporting period, after they had been lost to follow-up.
J	**On ART?:** If the key population individual is currently on ART (whether they began it before or during the reporting period), write "Y," otherwise write "N."
K-N	**Care and support services:** Indicate whether any of the listed care and support services have been provided by the peer navigator (not by the health facility). ("Referral made to comprehensive HIV care" indicates that the peer navigator made a referral to a health facility, not that care was provided at the facility.)
O-R	**Commodity provision:** If male or female condoms, lubricants, or needles and syringes have been provided, list the quantity of each.

Tool 10B: HIV Care and Support Compilation Sheet

Peer Navigator				Peer Outreach Supervisor				Reporting Period (MM/YY-MM/YY)	
Row No.	Program ID/UIC	Date of Birth	Gender	Hot spot code	KP type	Month	Successfully navigated for ART enrollment? (Y/N)	Successfully navigated for ART re-enrollment? (Y/N)	Received care and support services outside health facilities? (Y/N)
	A	B	C	D	E		F	G	H
1						M1			
						M2			
						M3			
2						M1			
						M2			
						M3			
3						M1			
						M2			
						M3			

Tool 10B: HIV Care and Support Compilation Sheet		
This sheet compiles data from Tool 10A. It is completed monthly by the supervisor of peer navigators. It enables program staff to track whether key population individuals living with HIV have been navigated to enroll (or re-enroll) in ART, and whether they have received support for retention on ART in order to report on the indicators listed below. The tracking sheet collects data over three months and thus can be used to gauge progress on the indicators within each quarter.		
Contributes to indicator(s)	**7.2 TX_LINK_NEW**	Number of HIV-positive key population individuals navigated by LINKAGES to a service delivery point not operated by LINKAGES and newly initiated on ART during the reporting period
	7.3 TX_LINK_RETURN	Number of HIV-positive key population individuals previously lost to follow-up (or who stopped treatment) who are navigated by LINKAGES to a service delivery point not operated by LINKAGES and re-enrolled in ART during the reporting period
	7.6 COMM_SUPP_RET	Number of key population individuals receiving care and support services outside the health facility (e.g., ART adherence counseling, psychosocial support, assistance accessing services, etc.) during the reporting period
Who should complete	Peer outreach supervisor	
When to complete	Monthly	

COLUMN	INSTRUCTIONS
A-E	Complete these fields with information from Tool 10A, Columns A-E.
F	Complete this field with information from Tool 10A, Column H.
G	Complete this field with information from Tool 10A, Column I.
H	Complete this field with information from Tool 10A, Columns K–N (if one or more services were offered, write “Y;” if no services were offered, write “N”).

Tool 11: HIV Treatment Compilation Sheet

Row No.	Program ID/UIC	Date of birth	Gender	KP type	Date of HIV diagnosis (month/year)	Previously lost to follow-up? (Y/N)	Date of ART registration (month/year)	Place of ART registration	Date started on ART (month/year)	Month	HIV care status/outcome*	ART status/outcome**	CD4 test		Viral load test		Care in the community		Peer outreach worker/ Peer navigator
													Date	Level	Date	Level	Participated in support group (Y/N)	Reached by peer navigator (Y/N)	
	A	B	C	D	E	F	G	H	I		J	K	L	M	N	O	P	Q	R
1										M1									
										M2									
										M3									
2										M1									
										M2									
										M3									

Codes:

* **New:** key population individual has been newly enrolled during the reporting period in HIV care and received clinical assessment or CD4 count, but has not yet started ART; **Active:** either key population individual was enrolled in a previous reporting period and is currently accessing HIV care (received clinical assessment or CD4 count or viral load test) but has not yet started ART; or key population individual is currently receiving HIV care while on ART.

** **Active:** key population individual is actively accessing ART; **Stopped:** key population individual has missed the appointment date by more than four days but less than three months: **LTFU:** key population individual has missed the appointment by more than three months; **D:** key population individual died within the reporting period; **TI:** key population individual officially transferred in from another HIV care and treatment center during the reporting period; **TO:** key population individual officially transferred out to another HIV care and treatment center during the reporting period.

Tool 11: HIV Treatment Compilation Sheet		
This register captures information on each of the key population individuals living with HIV in the program. It provides data for a number of indicators in the HIV cascade. The information is collected from various sources, including government ART centers, testing centers, and other clinic records where key population individuals living with HIV seek services.		
Contributes to indicator(s)	**7.1 TX_NEW**	Number of key population individuals newly initiated on ART during the reporting period
	7.4 TX_CURR	Number of key population individuals currently receiving ART during the reporting period
	7.5 TX_PVLS	Percentage of key population individuals with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months whose viral load is suppressed (<1000 copies/ml)
	7.7 TX_RET	Percentage of key population individuals still on treatment 12 months after initiation of ART
Who should complete	Peer outreach supervisor, in coordination with clinic staff; or drop-in center clinical staff, where services are offered at a drop-in center	
When to complete	As data are received/gathered from sources, and at least quarterly.	

COLUMN	INSTRUCTIONS
A-D	**Program ID/UIC/KP Type/Age/Gender:** This information should be taken from the clinic enrollment form.
E	**Date of HIV diagnosis:** The date (MM/YY) when the key population individual was diagnosed as HIV positive
F	**Previously lost to follow-up?:** If a key population individual was previously diagnosed HIV positive, registered for ART or began ART, but missed an appointment by more than three months, they are lost to follow-up. In this case, write “Y”; otherwise write “N”
G-I	**Date of ART registration/started on ART:** Write the dates as they apply to the key population individual, using MM/YY format.
J	**HIV care status/outcome:** If the key population individual **has not** started ART at this facility at the end of the quarter, use the code at the bottom of the form to indicate whether the key population individual is enrolled in care in the current reporting period but is not yet accessing ART (“New”); or enrolled in care in a previous reporting period but is not yet accessing ART (“Active”); or is receiving both care and ART (“Active”).
K	**ART status/outcome:** If the key population individual **has** started ART at this facility at the end of the quarter, use the code at the bottom of the form to indicate whether the key population individual is currently accessing HIV care, has stopped, is lost to follow-up, has died, or has transferred into or out of ART at this facility.
L-M	**CD4 test:** Write the date of the CD4 test and the level recorded.
N-O	**Viral load test:** Write the date of the viral load test and the level recorded. The source must be the patient’s medical record and/or laboratory information systems (LIS)
P-R	**Care in the community:** These columns record whether the key population individual has received care and support services outside the health facility (e.g., ART adherence counseling, psychosocial support, assistance accessing services, etc.) during the quarter, and whether they were reached by a peer navigator during the quarter.
T	**Peer outreach worker/peer navigator:** Write name of peer outreach worker/navigator.

Tool 12: Violence Disclosure and Service Provision Form

VERBAL CONSENT STATEMENT *(To be read by peer outreach worker or person to whom victim discloses)*

Before beginning to complete this form, please read the following verbal consent statement to the victim in his/her first language.

"I understand that (***Name of person filling this form or LINKAGES project***) is documenting the details of the violence I experienced. I give (***Name of person filling this form or LINKAGES project)*** permission to share the information collected with service provider(s) that I choose to visit. This information will help service providers meet my safety, health, psychosocial, and/or legal needs. I understand that my information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request. I also understand that I can choose whether or not to answer any question."

□ *Agree; proceed to complete all parts of the form.*

□ *Disagree; information on the experience of violence should not be recorded (Q11–17). However, services can still be offered and documented.*

Note: Unless otherwise specified, mark only one response field for each question.

PART 1 – Administrative Information
(*To be completed by peer outreach worker or person to whom victim disclosed, with help from outreach supervisor as needed)*

1. Date of disclosure (Day/Month/Year):	2. Name of person to whom victim disclosed:
3. Location of disclosure: □Hotline/WhatsApp □ Clinic □ Community □ DIC □ Virtual □ Other (specify): _____	4. Job title of person to whom victim disclosed: □ Outreach worker □ Peer outreach worker □ Outreach supervisor □ Health worker □ Other (specify): _____

5. How did the person disclose?

□ Spontaneous disclosure *(client begins to talk about violence without being asked whether they have experienced violence)*

□ Disclosure after screening *(client shares an incident(s) of violence after being asked whether they have experienced violence)*

6. UIC or program ID:	7. Age of the victim in years:

PART 2 – Information about the disclosure, the victim, and the incident of violence
(*To be completed by service provider or person to whom victim disclosed, with help from outreach supervisor as needed)*

8. Gender identity: □ Man □ Woman □ Transgender man (female to male) □ Transgender woman (male to female) □ Other □ Refuse to answer

9. Sex assigned at birth: □ Male □ Female □ Other □ Refuse to answer	10. KP type (can select multiple): □ SW □ MSM □ PWID □ Transgender
11. Date of violence (Day/Month/Year):	12. Time of day of violence: □ Morning □ Afternoon □ Night
13. Location of violence (e.g., hot spot name):	14. When was the incident disclosed? □ Within 24 hours of violence □ >24 and ≤72 hours after □ >72 and ≤120 hours □ >5 days and ≤1 month □ >1 month and ≤3 months □ >3 months after violence

15. Type of violence (can select multiple):

□ **Physical** (includes hitting, slapping, kicking, shoving, choking, use of a weapon to physically harm someone)
□ **Sexual** (includes rape; sexual abuse that includes physical contact, regardless of penetration; forced sex without a condom)
□ **Emotional** (includes humiliation, verbal harassment, psychological torture, and threats)
□ **Economic** (includes denial of resources, blackmail, theft)
□ Other **human rights violation** (condom and/or lubricant confiscation, arbitrary arrest): _____

16. A brief description of the incident (not more than 200 words):

17. Who committed the violent incident? (Check as applicable)

☐ Local leader(s)	☐ General community
☐ Police	☐ Family member(s)
☐ Military	☐ Regular partner or past partner
☐ Security guard(s)	☐ Sex work client(s)
☐ Madam(s)/pimp(s)/bar manager(s) or owner(s)	☐ Health care facility staff
☐ Local gang(s)	☐ Other(specify): _____

18. Services provided at initial disclosure: □ Provided key messages (thank victim, explain it was not their fault, validate their feelings, offer support) □ Provided information on available services □ Discussed safety plan □ Explored next steps □ Referred □ Accompanied

PART 3 – Information about service eligibility and services received following initial disclosure
(To be completed by case manager, and/or health worker providing services)

19. Job title of person who is completing Part 3: □ Outreach supervisor □ Case manager □ HCW □ Other (specify): _____

20. Name of person filling out Part 3:

21. For sexual violence victims only: At disclosure, was individual eligible for post-exposure prophylaxis (PEP)?
□ Yes □ No □ Did not determine

22. For sexual violence victims only: At disclosure, was individual eligible for emergency contraception (EC)?
□ Yes □ No □ Did not determine

23. Note the services or referrals provided to the victim following the disclosure of violence (mark all that apply). These can be services provided directly or via referral.	Check boxes to indicate whether the service was provided at a PEPFAR-supported (LINKAGES) clinic or through referral; then show whether referral was completed			
	Provided at LINKAGES-supported clinic	Provided at other LINKAGES-affiliated non-clinic (e.g., DIC)	Referral made to non-LINKAGES provider	Referral completed to non-LINKAGES provider
Initial assessment to determine services victims should be offered (i.e., the information collected above)				
Treatment of injuries				
Forensic examination for victims of sexual assault ("rape kit")				
Rapid HIV testing				
PEP				
STI screening/treatment				
Emergency contraception (EC)				
Immediate psychosocial counseling				
Mental health evaluation				
Tetanus vaccine				
Initiation of ART				
Longer-term psychosocial support (e.g., support group)				
Legal counsel				
Police				
Child protection services for minor children of victims				
Economic empowerment				
Temporary shelter				
Crisis response team				
Other (specify): _____				

24. Follow-up action planned (describe in 200 words):

25. Completion of PEP? □ Yes □ No □ Not applicable/person did not receive PEP □ Unknown

26. HIV test 3 months post sexual violence? □ Person not tested □ Tested negative □ Tested positive
□ Not applicable/person did not experience sexual violence

27. Follow-up actions taken (can include completion of referrals noted under Q23). If victim reported any issues related to treatment at referral facilities, note here. If the victim pursues legal action, please document any legal outcomes, including the date of those outcomes.

Tool 12: Violence Disclosure and Service Provision Form		
This form is completed whenever an incident of violence is disclosed by a key population individual to a program staff member (including peer outreach workers, peer navigators and any other program staff), a health care provider at a clinic, or staff of another program-related facility.		
Contributes to indicator(s)	**7.8 GEND_GBV**	Number of individual key population individuals provided with post-exposure prophylaxis (PEP) during the reporting period
	12.1 GBV_REPORT_COMM	Number of key population individuals who report to program staff or outreach workers, outside of clinical facilities, that they have experienced violence during the reporting period
	12.2	Number of incidents of violence reported during the reporting period
	12.3 GEND_GBV	Number of key population individuals receiving post-gender-based-violence clinical care based on the minimum package
Who should complete	This form should be completed by the person to whom the victim of violence initially disclosed (with support as needed), and by those who provide services to the victim. If a victim would prefer to share details of the violence experienced with an outreach supervisor or health worker instead of a peer outreach worker, this preference should be honored, and Parts 1 and 2 can be completed by someone other than the peer outreach worker. The victim should be referred to an outreach supervisor or health worker as needed.	
When to complete	When an incident of violence is reported by a key population individual. If a key population individual reports multiple incidents of violence at one time, use this form to capture information on the most recent incident of violence only.	
INSTRUCTIONS		
The form contains instructions for who is to complete each of the sections, and how to do so.		

Tool 13: Advocacy/Sensitization Activity Register

1	Implementing partner	**2**	Date ___/___/_____
3	Activity name or type		
4	Was activity… □ Face to face (meeting, etc.)? □ Virtual (e.g., webinar, phone conference)?		
4a	If face to face: Hot spot (if applicable)		
	Location	District	
5	Number of participants: _____		
6	What issue was discussed?		
7	Whom did you advocate with?		

Community pressure groups	☐	Government officials	☐
Local leaders	☐	General community	☐
Police	☐	Family members	☐
Military	☐	Religious groups	☐
Madams/pimps	☐	Regular partners of sex workers	☐
Bar managers and owners	☐	Clients of sex workers	☐
Local gangs	☐	Health care provider	☐
Fellow employee	☐	Employer	☐
Magistrate/judiciary	☐	Other (specify) _____	☐

8	What follow-up activities were planned?		
	Action point	**Person responsible**	**Timeline**
	1.		
	2.		
	3.		
9	Name of person who led the activity _____ Signature _____		

Tool 13: Advocacy/Sensitization Activity Register		
This form is completed when an advocacy activity is held in the area where key population individuals operate. It is important to have a definite objective for the meeting and methods used for sensitizing stakeholders. The activity should end with specific action items with timelines and responsibility.		
Contributes to indicator(s)	**13.1**	Number of individuals reached by sensitization/advocacy workshops during the reporting period
Who should complete	Staff Outreach Supervisor or Program Manager	
When to complete	Each time an advocacy or sensitization session is conducted with stakeholders.	
INSTRUCTIONS		
All the columns in the form are self-explanatory.		

PART 3.
SUPPLEMENTARY TOOLS

Tool A: Risk Categorization Tool

Sex Worker		
Risk Category	**Score**	**KP Score**
What is your age?	<25 yrs = 1 ≥25 yrs = 0	
How many years have you been a sex worker?	<2 yrs = 1 ≥2 yrs = 0	
How many sex acts (receptive vaginal or anal sex) have you had in the last week?	<8 = 0 ≥8 = 1	
Did you use a condom every time you had sex with your boyfriend/intimate partner in the last week?	Yes = 0 No = 1	
Did you use drugs or alcohol on any occasion when you had sex in the last week?	Yes = 1 No = 0	
Have you experienced any physical or sexual violence in the last month?	Yes = 1 No = 0	
	TOTAL SCORE	
	Risk Level: 0 = Low, 1-2 = Medium, 3+ = High	

Men Who Have Sex with Men/Transgender People		
Risk Category	**Score**	**KP Score**
What is your age?	<25 yrs = 1 ≥25 yrs = 0	
How many years ago did you first have anal sex?	<2 yrs = 1 ≥2 yrs = 0	
How many times have you had receptive anal sex in the last week?	<8 = 0 ≥8 = 1	
Did you use a condom every time you had anal sex (receptive or penetrative) in the last week?	Yes = 0 No = 1	
Did you use drugs or alcohol on any occasion when you had sex in the last week?	Yes = 1 No = 0	
Have you experienced any physical or sexual violence in the last month?	Yes = 1 No = 0	
	TOTAL SCORE	
	Risk Level: 0 = Low, 1-2 = Medium, 3+ = High	

Tool A: Risk Categorization Tool	
This tool helps the peer outreach worker prioritize outreach to individuals based on factors associated with a higher risk for acquiring HIV. These include simple demographic information and information on their sexual behaviors and experience of violence. The factors (and the wording of the questions) can be adjusted to suit local circumstances, but they should be used uniformly across a program by an implementing partner so that the program has standard criteria by which to assess how many key population individuals are at low, medium, or high risk.	
Who should complete	Peer outreach worker
When to complete	Every six months or annually, depending on program criteria
INSTRUCTIONS	
Ask the key population individual each of the questions in turn. Depending on their answer, score the question with 0 or 1. Add the scores to get the total, which will indicate the relative risk level of the individual (low, medium, or high) according to the scale at the bottom of the tool.	

Tool B: Needle and Syringe Inventory Register

Implementing Partner																	
Row No.	Date	Opening Balance Needles/Syringes		Number Received				Number Distributed to								Closing Balance	
				MOH/ Donor		Other Sources		Peer Outreach Worker		DIC		Health facility		Others			
		N	S	N	S	N	S	N	S	N	S	N	S	N	S	N	S
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	

Tool B: Needle and Syringe Inventory Register	
The inventory register helps the program manager track the stock levels of needles and syringes across the program. Based on the available stock, the program manager can place future procurement orders.	
Who should complete	Program Manager
When to complete	Update monthly
COLUMN	**INSTRUCTIONS**
A	**Date:** Write the date that the inventory is recorded, using DD/MM/YY format.
B-C	**Opening balance needles/syringes:** Record the number of needles and syringes in stock at the beginning of the accounting period.
D-G	**Number received:** Record the quantity of needles and syringes received from the MOH/donor or from other sources.
H-O	**Number distributed:** Record the total quantity of needles and syringes distributed to peer outreach workers, DICs, health facilities, or other outlets.
P-Q	**Closing balance:** This is calculated by adding the opening balance to the number received, then subtracting the number distributed. For needles, this is columns (B+D+F)-(H+J+L+N), with the result written in column P. For syringes, this is columns (C+E+G)-(I+K+M+O), with the result written in column Q. The results should be checked against the quantities of each remaining in stock once the distributions have been made.

Tool C: Needle and Syringe Outlet Inventory/Distribution Register

Implementing Partner										
Row No.	**Hot spot**	**Hot spot code**	**Name of outlet/facility**	**Type of outlet/ facility***	**Date**	**Opening Balance**	**Supplied to Outlet**	**Date**	**Distributed**	**Closing Balance**
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

* **Codes**: **1**=Individual outlet holder, **2**=Public place, **3**=Private place, **4**=Vending machine, **5**=Health facility, **6**=DIC, **7**=Other

Tool C: Needle and Syringe Outlet Inventory/Distribution Register		
This tool guides the program on the distribution pattern of needles/syringes to and from various outlets.		
Contributes to indicator(s)	**5.1**	Number of male/female condoms/lubricant/needles distributed by program to key population individuals during the reporting period
Who should complete	Program Manager	
When to complete	Each time outlet is supplied with commodities	

COLUMN	INSTRUCTIONS
A	**Hot spot:** Write the name of the hot spot where the outlet is located.
B	**Hot spot code:** The hot spot code is a unique number assigned by the program manager or M&E officer of the implementing partner when a new hot spot is identified. The code is taken from the Hot Spot Register (Tool 1B).
C	**Name of outlet/facility:** Write the name of the outlet.
D	**Type of outlet/facility:** Use the numeric code from the bottom of the list to indicate the type of outlet or facility.
E	**Date:** Write the date that needles/syringes are distributed to the outlet, using DD/MM/YY format.
F	**Opening balance:** Record the number of needles/syringes currently at the facility before new stock is supplied.
G	**Supplied to outlet:** Record the number of new stock of needles/syringes supplied to the facility.
H	**Date:** Write the date on which the remaining columns (I-J) are recorded, using DD/MM/YY format. This will typically be the day on which a new supply is received, or the day before this.
I	**Distributed:** Record the number of needles/syringes distributed since the stock was supplied on the date shown in column E.
J	**Closing balance:** Record the total number of needles/syringes in stock at the facility on the date shown in column H, i.e., F+G-I.

Tool D: Clinic Enrollment Form

Facility name		Date (DD/MM/YYYY) ___ /___ /_____	
District		Location	
Name of hot spot		Hot spot code	
Staff outreach supervisor		Peer outreach worker	
1	Name of KP	**2**	Date of birth (DD/MM/YYYY): ___ /___ /_____
3	Gender identity ☐ Man ☐ Woman ☐ Transgender man (female to male) ☐ Transgender woman (male to female) ☐ Other ☐ Refuse to answer	**4**	Sex assigned at birth ☐ Male ☐ Female ☐ Other ☐ Refuse to answer
5	Type of KP (CHECK ALL BOXES THAT APPLY) ☐ Sex worker ☐ MSM ☐ PWID ☐ Transgender		
6	Program ID/UIC	7	Phone Number
8	Contact address		
9	Have you visited any DIC/clinic/wellness center for any services in the last six months?		☐ Yes ☐ No
10	If Yes, which center did you visit?		
11	Have you been contacted by a peer outreach worker from the HIV prevention program?		☐ Yes ☐ No

SEXUAL HISTORY AND RISK ASSESSMENT		
12	At what age did you first have sexual intercourse?	_____
13	In the past three months, have you had sex?	☐ Yes ☐ No
14	In the past ONE WEEK, how many sexual partners did you have?	_____
15	**For MSM only:** What type of sex do you have in most sexual encounters?	Anal Penetrative ☐ Anal Receptive ☐ Oral ☐ Other ☐
16	Have you ever had sex in exchange for cash or goods? *(If Yes, ask Questions 16a-16c. If No, skip to Question 17.)*	☐ Yes ☐ No
16a	If Yes, at what age did you start having sex in exchange for cash or goods (sex work)?	_____
16b	In the past ONE WEEK, how many men/women did you have sex with in exchange for cash or goods?	_____
16c	In the past ONE WEEK, how many men/women did you have sex with <u>not</u> in exchange for cash or goods?	_____
17	Did you use a condom every time you had sex in the…	Last 24 hours? ☐ Yes ☐ No Last one month? ☐ Yes ☐ No
18	Did you use lubricant every time you had sex in the last one month?	☐ Yes ☐ No

19	During the past one month how often have you consumed drinks containing alcohol?	☐ Never ☐ Sometimes ☐ Most days ☐ Every day		
20	Have you ever used/consumed a drug for nonmedical purpose?	EVER ☐ Yes ☐ No	LAST MONTH ☐ Yes ☐ No	LAST WEEK ☐ Yes ☐ No
21	Have you injected drugs for nonmedical purposes in the past three months?	☐ Yes ☐ No		
21a	If Yes, how many times have you injected in the…	Last 24 hours? _____ Last week? _____		
21b	If Yes, how many times have you shared nonsterile injecting equipment (syringe or needle) in the…	Last 24 hours? _____ Last week? _____		

SEXUALLY TRANSMITTED INFECTIONS		
22	In the past six months, have you ever had any of these symptoms? **PLEASE READ ALL**	Genital/anal ulcer disease ☐ Foul-smelling vaginal/anal/penile discharge ☐ Painless growth in vaginal/anal/penile area ☐ Itch in genital/anal area ☐ Rash in genital/anal area ☐ Bubo ☐ Dysuria ☐ LAP ☐ Others ☐
23	Where did you receive treatment for the above mentioned symptoms you had in the past six months?	Pharmacy ☐ Private doctor ☐ Government clinic ☐ Herbalist ☐ NGO/program clinic ☐ DIC ☐ Other _____ ☐ Not received treatment ☐

REPRODUCTIVE HEALTH (WOMEN ONLY)		
24	How many pregnancies have you had in your lifetime, including abortions?	☐☐
25	Are you currently pregnant? *(If No, skip to Question 26)*	☐ Yes ☐ No
25a	If pregnant, are you visiting a health facility for antenatal care?	☐ Yes ☐ No
26	How many children do you have now?	_____
27	Are you currently using any method to prevent pregnancy?	Pill ☐ Injection ☐ Implant ☐ IUD ☐ Condom ☐ BTL ☐ Other ☐ None ☐

SEXUAL AND GENDER-BASED VIOLENCE			
28	In the last three months have you ever experienced violence?	Yes ☐ No ☐	
29	If yes which type? **CHECK ALL THAT APPLY**	Physical ☐ Sexual ☐ Emotional ☐ Economic ☐ Other human-rights violation _____ Other (specify) _____	
30	Who perpetrated the violence?	Local leader(s) ☐ Police ☐ Military ☐ Security guard(s) ☐ Madam(s)/pimp(s)/bar manager(s) or owner(s) ☐ Local gangs ☐ General community ☐	Family member(s) ☐ Regular partner or past partner ☐ Sex work client(s) ☐ Health care facility staff ☐ Other (Specify) ☐ _____
31	Did you seek help?	Yes ☐ No ☐	
32	If yes, where did you seek the help? **CHECK ALL THAT APPLY**	Medical/hospital ☐ Legal/police ☐ Family ☐ Peers ☐ Friends ☐ Religious leader ☐ Chief/village elder ☐ HIV program (e.g., peer outreach worker, drop-in center ☐ Other (specify)_____ ☐	
HIV TESTING AND COUNSELING			
33	Have you ever tested for HIV?	Yes ☐ No ☐ (Skip to Question 40)	
34	If yes, how long ago?	Within the last 3 months ☐ Within the last 6 months ☐ Within the last 1 year ☐ More than 1 year ago ☐	
35	If yes, would you like to share your test result with me?	Tested positive ☐ Tested negative ☐ Results unknown ☐ I do not want to share ☐	
36	If positive, have you disclosed your HIV status to anyone?	Yes ☐ No ☐	
37	If yes, to whom?	Intimate/regular partner ☐ Regular client ☐ Friend/relative ☐ Other _____ ☐	
38	If positive, are you receiving HIV treatment?	Yes ☐ No ☐ If Yes, duration _____	
39	If receiving treatment, which facility is providing it (address of the facility)?		
CONTACT PERMISSIONS			
40	Could we contact you by phone (including SMS) for services related to STI/FP/HIV testing/HIV care/GBV, or other services?	Yes ☐ No ☐	
41	Could we contact you through your peer outreach worker/peer navigator for services related to STI//HIV testing/HIV care/GBV, or other services?	Yes ☐ No ☐	
	Signature/Thumbprint of the KP _____	**Service provider** Name _____ Signature_____	

TOOL D: CLINIC ENROLLMENT FORM	
This tool is used for each key population individual when they visit the clinic for the first time for program clinical services. It captures all the basic history of the individual so the clinician can plan their future clinical management. Except where indicated, all questions are asked of all key population individuals. Key population individuals are not required to answer any questions and are still entitled to receive services.	
Who should complete	Clinic Staff
When to complete	When a new key population individual comes to the clinic for the first time for services

ROW	INSTRUCTIONS
	BASIC INFORMATION
	Information on the name of the implementing partner, hot spot, hot spot code, staff outreach supervisor, and peer outreach worker can be provided by the peer outreach worker or peer navigator who accompanies the key population individual to the clinic, or it can be obtained from the program manager or peer outreach supervisor at the implementing partner's program office.
	Gender identity and sex assigned at birth: *It is important to ask both parts of the two-step question on gender identity (Rows 3 and 4). Ask the questions clearly and respectfully, and record the answer that the individual gives. If the individual refuses to answer, check the "refuse to answer" box. For more information on recording gender identity, see Section 5.2.*
3	**Gender identity:** Preface the question by saying, "I'd like to ask you two short questions about your gender and sex. In this program we ask everyone these questions when they enroll for services, to help ensure high-quality care for all, and that's why I am asking them today." "Do you consider yourself a man, a woman, a transgender man, transgender woman, or something else?" Check the appropriate box according to their response.
4	**Sex assigned at birth:** Ask the key population individual, "What sex were you assigned at birth – that is, did your birth certificate record that you were male, female, or something else, or do you not know?" Check the appropriate box according to their response.
6	**Program ID/UIC:** This can be provided by the peer outreach worker or peer navigator who accompanies the key population individual to the clinic, or it can be obtained from the program manager or peer outreach supervisor at the implementing partner's office.
12-21b	**SEXUAL HISTORY AND RISK ASSESSMENT:** These questions are asked of all key population individuals, with the exception of questions 16a-16c, which are only for key population individuals who sell sex.
22-23	**SEXUALLY TRANSMITTED INFECTIONS:** These questions record the key population individual's STI history.
24-27	**REPRODUCTIVE HEALTH:** These questions are asked only of female sex workers.
28-32	**SEXUAL AND GENDER-BASED VIOLENCE:** These questions screen for recent experience of violence.
33-39	**HIV TESTING AND COUNSELING:** These questions record whether the key population individual has ever been tested for HIV and the results, if they are willing to share these. For key population individuals who report that they are HIV positive, the questions also cover care they are currently receiving. Note that for question 37, "Intimate/regular partner" refers to a husband, wife, boyfriend or girlfriend, not to the client of a sex worker.
40-41	**CONTACT PERMISSIONS:** The service provider should ask for permission to contact the key population individual by phone or via their peer outreach worker or peer navigator.

Tool E: Clinic Visit Form

This form is completed by the clinical staff for each key population individual each time the individual visits the clinic. The information is collected to understand the key population individual's clinical history and any current conditions; to help the doctor diagnose and treat illnesses, especially STIs, HIV, TB, etc.; or to provide services such as FP, HIV testing, etc. Many countries have a national (MOH) form for recording clinic visits, and service providers will use those.

GENERAL PATIENT INFORMATION			
Name		**Date of Birth (DD/MM/YYYY)**	__/__/____
Gender identity	☐ Man ☐ Woman ☐ Transgender man (female to male) ☐ Transgender woman (male to female) ☐ Other ☐ Refuse to answer	**Sex assigned at birth**	☐ Male ☐ Female ☐ Other ☐ Refuse to answer
Type of KP (CHECK ALL BOXES THAT APPLY)	☐ Sex worker ☐ MSM ☐ Transgender ☐ PWID		
UIC/Program ID		**Phone No.**	
District	**Name of hot spot**		
Date of visit (DD/MM/YY)	___/___/_____	**New client?**	☐ Yes ☐ No
Reason for visit (*check all boxes that apply*)	☐ Quarterly check-up ☐ Positive HIV self-test ☐ ART check-up ☐ Reproductive health ☐ Other services _____ ☐ Follow up	☐ PrEP ☐ STI	
Presenting complaints			
Referred by	☐ Peer ORW/Staff ORW ☐ Partner	☐ Self ☐ Other	
Any clinical exam performed?	☐ Yes ☐ No		
If yes, state findings			

STI SYNDROME AND TREATMENT		
Syndrome	**X**	**Treatment**
1. GUD		
2. Cervicitis		
3. PPT		
4. ARD		
5. UD (male)		
6. Vaginitis		
7. Vaginitis + Candida		
8. PID		

FAMILY PLANNING AND RISK REDUCTION SERVICES			
Services	**X**	**Services**	**X**
Family planning counseling		Post-abortion care	
Risk reduction counseling		PEP	
Condom demonstration/education		Lubricant given (quantity)	
Male condoms given (quantity)		Female condoms given (quantity)	
Needles/syringes given (quantity)		PrEP	

HIV TESTING AND COUNSELING SERVICES					
HIV status reported status	**Counseled**	**Tested**	**Received results**	**Testing results**	**ART**
Positive [ ]	Yes [ ]	Yes [ ]	Yes [ ]	Positive [ ]	Provided here [ ]
Negative [ ]	No [ ]	No [ ]	No [ ]	Negative [ ]	Gets elsewhere [ ]
Unknown [ ]				Indeterminate [ ]	Referred [ ]

OTHER SERVICES						
Conditions	**Screened**		**Treated**		**Referred**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Sexual and gender-based violence						
Psychosocial support						
TB						
Hepatitis B						
Hepatitis C						
Alcohol use						
Opioid substitution therapy						
Cervical cancer						
Abscess						
Other (specify) _____						

REFERRAL SERVICES	
Client referred for laboratory tests? Yes [ ] No [ ]	If Yes, which test? ☐ STI ☐ HIV ☐ CD4 ☐ VL ☐ Other Location _____
Client referred to other health facilities? Yes [ ] No[ ]	If Yes, which facility? _____
CLINICIAN'S COMMENTS	
Next appointment date ___ /___ /_____	Reason:
Clinician's Name _____	Signature_____ Date ___ /___ /_____

Tool F: PrEP Tracking Form

Name						UIC/Program ID						Reason for taking medication	
KP Type						Phone							
Visit	Appoint-ment date	Anti-HIV	TPHA	Cr	HBsAg	STIs	Side effects	Medication received	Lot No.	No. of medication left (tablet/ bottle)	No. of medication received this time (tablet/ bottle)	Name of Physician	Physician Comments
	A	B	C	D	E	F	G	H	I	J	K	L	M
M.0													
M.1													
M.3													
M.6													
M.9													
M.12													
M.15													
M.18													
M.21													
M.24													
M.27													
M.30													
M.33													
M.36													

Has client ever received PrEP/nPEP before? ☐ No ☐ Yes, received nPEP/PrEP at _____

TOOL F: Prep Tracking Form	
This sheet is used by the clinician to track a key population individual who is starting or continuing on PrEP.	
Who should complete	Clinic Staff
When to complete	Each time the client comes to receive a PrEP prescription
COLUMN	**INSTRUCTIONS**
Reason for taking medication	Write the primary reason for prescribing PrEP, e.g., being in a serodiscordant relationship, inability to negotiate condom use, etc.
B	**Anti-HIV:** Indicate whether an HIV test was conducted during the visit
C	**TPHA:** Syphilis test result
D	**Cr:** Creatinine clearance/serum creatinine test result
E	**HBsAg:** Heptitis B test result
F	**STIs:** Any reported STI? In countries using a syndromic approach, record the type of syndrome the client presents with.
G	**Side effects:** Report any side effects of current medication
H	**Medication received:** List medications other than PrEP that are prescribed during visit
I	**Lot No.:** List lot number of PrEP
J	**No. of medication left (tablet/bottle)**: List the amount of PrEP medication that the client still has
K	**No. of medication received (tablet/bottle)**: List the amount of medication given to the client on this visit
L	**Name of Physician:** Physician's name
M	**Comments:** Any other relevant comments

Tool G: Voluntary Partner Referral Tracking Form

This is a sample form developed by PEFAR. It should be adapted to suit the local context. Refer to the guidance in the Index and Partner Notification Testing Toolkit.

Index Client Information Form

***Complete one form per index client**

Instructions: Complete this form while interviewing the HIV-positive index client who has verbally agreed to receive index testing services.

Date form completed (dd/mm/yyyy): _____/_____/_____

Name of Person Completing Form:_____

Name of Health Facility or HIV Testing Site:_____

INFORMATION ABOUT THE INDEX CLIENT

Index Client's Name (Last, First, Middle): _____

DOB (dd/mm/yyyy):_____ **Age**:_____yrs.

Gender: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male)

Marital Status: ☐ Single ☐ Engaged to be married ☐ Married/cohabitating-monogamous

☐ Divorced ☐ Widow/er ☐ Married-polygamous: # wives ____

Client's Personal Cell Phone Number: _____

Alternative contact number (if available):_____

Address (including any landmarks, e.g. next to the church):

_____

_____

Date of HIV Diagnosis: (dd/mm/yyyy):_____

Is the index client currently enrolled in an HIV treatment program? ☐ Yes ☐ No

If yes, name of health facility_____

If yes, list the index client's ART enrollment number:_____

For women: How many biological children < 15 does the index client have?_____

How many of these children have an "unknown status" and need an HIV test?_____

Partner Elicitation Form

***Complete one form for each index client**

Instructions: Ask the index client to tell you the names of all the people they have had sex with in the past 12 months, including both main/married partners and casual/unmarried partners. If the client injects drugs, ask them to also tell you the names of their injecting drug use partners. You may wish to start with the main sex partner and then ask about other partners, or you may wish to start by asking about the most recent partner and working backwards in time.

List names(s) of partners (Tick ☐ if name is unknown)	**Phone Number**	**Alternative Phone Number**
1) ☐	☐ Unknown	☐ Unknown
2) ☐	☐ Unknown	☐ Unknown
3) ☐	☐ Unknown	☐ Unknown
4) ☐	☐ Unknown	☐ Unknown
5) ☐	☐ Unknown	☐ Unknown
6) ☐	☐ Unknown	☐ Unknown
7) ☐	☐ Unknown	☐ Unknown
8) ☐	☐ Unknown	☐ Unknown
9) ☐	☐ Unknown	☐ Unknown
10)☐	☐ Unknown	☐ Unknown

Partner Information Form

***Complete one form for each partner named by the index client.**

Instructions: Ask the client to give you as much information as they can about each of the partners they named on the partner elicitation form.

Write "N/A" for any information not available.

After completing a separate form for each contact, file all completed forms in the client's folder or medical chart.

Partner's Name (Last, First, Middle):_____

Partner's Nickname:_____

Partner's DOB (dd/mm/yyyy):_____ **Partner's Age:**_____yrs.

Partner's Gender: ☐ Male ☐ Female ☐ Transgender

Partner physical description:

_____

Partner's Address (including any landmarks, e.g. next to the church):

_____

_____

How would you describe your relationship to this partner?

☐ My wife/husband/fiancée ☐ We live together but are not married
☐ My girlfriend/boyfriend ☐ Someone I had sex with for fun
☐ Someone who pays me or gives me things to have sex with her/him
☐ Someone I paid to have sex with

Do you currently live with this partner? ☐ Yes ☐ No ☐ Declines to answer

As far as you know, has this partner ever tested positive for HIV?

☐ Yes ☐ No ☐ Don't know ☐ Declines to answer

<u>If yes,</u> is this partner currently taking medications for HIV?

☐ Yes ☐ No ☐ Don't know ☐ Declines to answer

SCREEN FOR INTIMATE PARTNER VIOLENCE (IPV)

Because your safety is very important to us, we ask all clients the following questions:

1. Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you?
   ☐ Yes ☐ No
2. Has [partner's name] ever threatened to hurt you?
   ☐ Yes ☐ No
3. Has [partner's name] ever forced you to do something sexually that made you feel uncomfortable?
   ☐ Yes ☐ No

DETERMINE INDEX TESTING PLAN

Instructions: Show the "Options for Getting Your Partner Tested" and "Options for HIV Testing for Biological Children" cards to the index client and review the options. Ask the client, which option they would prefer and record their chosen options below. If the client choses "contract referral", record the date (30 days from today's date) by which the partner/child(ren) should come for HIV testing services. If the client choses "dual referral" for partner notification, record the date when the joint disclosure session will occur.

Index Client's Plan for Notifying This Partner:

☐ **Client Referral:** Index client will notify partner

☐ **Provider Referral:** Health care providers will notify the partner

☐ **Contract Referral:** Both the index client and health care provider will notify the partner. The index client will first try notifying the partner no later than __ __ / __ __ / __ __ __ __. After which the provider will contact the partner (with permission from the index client).

☐ **Dual Referral:** The index client and health care provider will jointly notify the partner. This joint session will occur on __ __ / __ __ / __ __ __ __.

☐ Partner Testing not recommended at this time due to safety concerns.

☐ No Partner Testing needed, partner is known positive.

Index Client's Plan for Testing Child(ren):

☐ **Contract Referral:** The index client will bring the child(ren) to the facility within 30 days: __ __ / __ __ / __ __ __ __. After which a provider will visit the index client's home (with permission from the index client).

☐ **Community Based:** Health care providers will visit the index client's home and test the child(ren).

☐ **Facility Based:** Index client brings child(ren) to the facility for testing.

☐ Family Testing not recommended at this time due to safety concerns.

☐ No Family Testing needed, complete family tree. All children know their status, and any children living with HIV are on HIV treatment.

Outcome of Partner Testing Services Form

INDEX CLIENT INFORMATION

Name:_____

HTS/ART Clinic Number:_____

Gender: □ Male □ Female □ Transgender **Date of Birth:**_____/_____/_____

PARTNER 1	PARTNER 2	PARTNER 3
Gender: □ Male □ Female □ Transgender	**Gender:** □ Male □ Female □ Transgender	**Gender:** □ Male □ Female □ Transgender
Date of Birth:_____/_____/_____	**Date of Birth:**_____/_____/_____	**Date of Birth:**_____/_____/_____
Type of Partner Testing:	**Type of Partner Testing:**	**Type of Partner Testing:**
□ Client □ Provider □ Contract □ Dual	□ Client □ Provider □ Contract □ Dual	□ Client □ Provider □ Contract □ Dual
Date/Method of 1st Contact Attempt:	**Date/Method of 1st Contact Attempt:**	**Date/Method of 1st Contact Attempt:**
_____/_____/_____ Phone Home	_____/_____/_____ Phone Home	_____/_____/_____ Phone Home
Date/Method of 2nd Contact Attempt:	**Date/Method of 2nd Contact Attempt:**	**Date/Method of 2nd Contact Attempt:**
_____/_____/_____ Phone Home	_____/_____/_____ Phone Home	_____/_____/_____ Phone Home
Date/Method of 3rd Contact Attempt:	**Date/Method of 3rd Contact Attempt:**	**Date/Method of 3rd Contact Attempt:**
_____/_____/_____ Phone Home	_____/_____/_____ Phone Home	_____/_____/_____ Phone Home
Was partner contacted? □ Yes □ No	**Was partner contacted?** □ Yes □ No	**Was partner contacted?** □ Yes □ No
If yes, who contacted partner?	**If yes, who contacted partner?**	**If yes, who contacted partner?**
□ Client □ Provider □ Client + Provider	□ Client □ Provider □ Client + Provider	□ Client □ Provider □ Client + Provider
Outcome of Partner Testing Services:	**Outcome of Partner Testing Services:**	**Outcome of Partner Testing Services:**
□ Partner received an HIV test	□ Partner received an HIV test	□ Partner received an HIV test
□ Partner refused an HIV test	□ Partner refused an HIV test	□ Partner refused an HIV test
□ Partner known to be HIV-positive	□ Partner known to be HIV-positive	□ Partner known to be HIV-positive
□ Other:_____	□ Other:_____	□ Other:_____
Partner's HIV status (if tested):,	**Partner's HIV status (if tested):**,	**Partner's HIV status (if tested):**,
□ HIV-positive □ HIV-negative	□ HIV-positive □ HIV-negative	□ HIV-positive □ HIV-negative
Is the partner on ART (if HIV-positive)?	**Is the partner on ART (if HIV-positive)?**	**Is the partner on ART (if HIV-positive)?**
□ Yes □ No	□ Yes □ No	□ Yes □ No

***Complete additional forms if index client has more than 3 partners.**

Outcome of Family Testing for Biological Children

INDEX CLIENT INFORMATION

Name:_____

HTS/ART Clinic Number:_____

Gender: □ Male □ Female □ Transgender **Date of Birth:**_____/_____/_____

No. of Children:_____

Date *form completed* (dd/mm/yyyy): _____/_____/_____

Date for *community home visit* (dd/mm/yyyy): ____/_____/_____ OR Date to *return to facility* (dd/mm/yyyy): _____/_____/_____

Child 1	Child 2	Child 3	Child 4
Name:_____	**Name:**_____	**Name:**_____	**Name:**_____
Gender: □ Male □ Female	**Gender:** □ Male □ Female	**Gender:** □ Male □ Female	**Gender:** □ Male □ Female
Date of Birth: ____/____/____	**Date of Birth:** ____/____/____	**Date of Birth:** ____/____/____	**Date of Birth:** ____/____/____
Type of Family Testing: □ Facility □ Community □ Contract	**Type of Family Testing:** □ Facility □ Community □ Contract	**Type of Family Testing:** □ Facility □ Community □ Contract	**Type of Family Testing:** □ Facility □ Community □ Contract
Child's HIV Status: □ HIV-positive □ HIV-negative □ Unknown	**Child's HIV Status:** □ HIV-positive □ HIV-negative □ Unknown	**Child's HIV Status:** □ HIV-positive □ HIV-negative □ Unknown	**Child's HIV Status:** □ HIV-positive □ HIV-negative □ Unknown
If tested HIV-positive, ART Start Date_____/____/____ ART Client Number_____	**If tested HIV-positive,** ART Start Date_____/____/____ ART Client Number_____	**If tested HIV-positive,** ART Start Date_____/____/____ ART Client Number_____	**If tested HIV-positive,** ART Start Date_____/____/____ ART Client Number_____

Instructions

- Complete this testing form for all biologic children of the index client. If the index patient has more than 4 children, complete additional forms as needed so that all children are recorded.
- If the index HIV patient is a child, complete the form for all the child's siblings and biological parents
- Children of male index clients do not need HIV testing unless their biological mother is HIV-positive, deceased, or her HIV status is unknown/not documented.
- This form should be reviewed and updated at least annually. Children with a "known HIV status" should not be re-tested unless they have a new exposure.

Tool H: Tool for Assessing Communication by Peer Outreach Workers

Implementing partner		Hot spot	
Peer outreach worker		Date	
Peer outreach supervisor conducting assessment		Signature	
No.	Quality Indicators	Score	Observations/ Remarks
		0=not done **1**=needs improvement **2**=average **3**=good **4**=very good **5**=excellent	
A.	**Greeting, Rapport, and Ground-Building**		
1	Peer outreach worker greets the key population individual(s) with a smile and displays a pleasant and friendly attitude through appropriate body language.		
2	Peer outreach worker builds rapport with the key population individual(s) and prepares the ground appropriately before beginning the session.		
3	Peer outreach worker finds an appropriate space to carry out the session.		
4	Peer outreach worker asks key population individual(s) if the time is convenient 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 key population individual(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 key population individual/s to establish a dialogue and gain their involvement.		
2	Peer outreach worker encourages key population individual(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 key population individual(s) and allows appropriate silence for the key population individual to speak.		
4	Peer outreach worker is able to facilitate the session in a manner and tone of voice that sustains the interest of key population individual(s).		
C.	**Nonjudgmental Attitude**		
1	Peer outreach worker is nonjudgmental toward key population individual(s)' lifestyle and sexual practices.		
2	Peer outreach worker shows empathy with key population individual(s)' situation/expression of feelings.		

No.	Quality Indicators	Score	Observations/ Remarks
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, and place for the next session and thanks the key population individual(s) before leaving.		
E.	**Record Keeping**		
1	Peer outreach worker records the session and method used in accordance with the prescribed management information system forms.		

Tool H: Tool for Assessing Communication by Peer Outreach Workers	
This form can be used to record an assessment of the quality of communication of a peer outreach worker with key population individuals. 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 key population individual, for example at a hot spot. The staff outreach supervisor ranks the peer outreach worker on a 0–5 scale (0-Not Done, 1-Needs Improvement, 2-Average, 3-Good, 4-Very Good, 5-Excellent). Feedback should be given to the peer outreach worker as soon as possible, in the context of supportive supervision.	
SECTION	**INSTRUCTIONS**
A	**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 to find an appropriate place and time to conduct the session, and to use appropriate language to ensure retention and proper understanding.
B	**Two-way communication/ensuring understanding:** In a high-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.
C	**Nonjudgmental attitude:** For a good communication session, the peer outreach worker must show empathy and be nonjudgmental toward the individual's lifestyle and sexual practices.
D	**Conclusion/thanks/next visit:** To ensure understanding, 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, time, and place for the next session.
E	**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 I: Key Population Group Register

SECTION 1: GROUP DETAILS		
Support group name		
Date of first meeting		
Executive committee (if applicable)		
Date committee effective from: ____ /____ /_____		
Position	**Name**	**Date of election**
President		
Secretary		
Treasurer		
Member		
Member		
Member		
Member		

SECTION 2: GROUP MEMBERS						
Row No.	**Name**	**Program ID/UIC**	**KP type**	**Age**	**Month/year of joining**	**Month/year of leaving**
	A	**B**	**C**	**D**	**F**	**G**
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

SECTION 3: MEETING SUMMARY			
Date	**Venue**	**Start time**	**Facilitator**

ATTENDEES			
Row No.	**Name**	**Program ID/UIC**	**Signature**
1			
2			
3			
4			
5			
6			
7			
8			

TOPICS DISCUSSED

OUTCOMES/DECISIONS

Tool I: Key Population Group Register	
This register is used to track the development and meetings of groups formed by key populations. These may be support groups, advocacy groups, savings and income groups, etc. Groups may have an executive committee (or leadership team) to manage them. Members of the executive committee should be elected by the group members themselves, and the committee members should rotate so that all group members have the opportunity to serve.	
Who should complete	Staff Outreach Supervisor
When to complete	Section 1: Whenever a group is formed and starts functioning regularly. Sections 2 and 3: At each meeting
SECTION	**INSTRUCTIONS**
1: Group details	Record the name of the group and the date of its first meeting. If the group has an executive committee, record the date that the committee took office, the names of the committee members, and the dates they were elected.
2: Group members	Record the names and other details of the members of the group as they join. If a group member leaves, the date they do so is recorded here also.
3: Meeting summary	This part of the tool can be a separate attendance sheet that is passed around at meetings, or it can form part of an overall support group register. Group members fill in their name, the date, and their signature. The staff outreach supervisor completes the Program ID/UIC, unless the group members know this themselves. The meeting facilitator fills in the date, venue, start time, and their own name. After the meeting, the facilitator notes the topics discussed and any outcomes or decisions. Note that for a general support group meeting, it may be appropriate to leave the sections on topics discussed and outcomes empty since the meeting may have confidentiality rules that require this information not be recorded.

ANNEXES

Annex 1. Comparison of Tools between 2016 and 2020 Program Monitoring Guides

2016 TOOLS (OLD TOOLKIT)		2019 TOOLS (THIS TOOLKIT)	
1	Hot Spot Validation Form	**1A**	Hot Spot Validation Form
1A	Hot Spot List	**1B**	Hot Spot Register
1B	Hot Spot List (PWID)		
2	Infrastructure Status	*Not included*	
3	Staff Register	*Not included*	
4	Peer Outreach Worker Register	**2**	Peer Outreach Worker/Peer Navigator Register
5	Capacity-Building Register	**3**	Capacity-Building Register
6A	Outreach Enrollment Form (FSW/MSM)	**4A**	Outreach Enrollment Form
6B	Outreach Enrollment Form (PWID)		
6C	Master Register (FSW/MSM)	**4B**	Key Population Register
6D	Master Register (PWID)		
7A	Individual Tracking Sheet/Peer Calender (Outreach)	**5A**	KP Outreach Tracking Sheet (Peer Calendar)
7B	ORW Compilation Sheet by Peer Outreach Worker Sites	**5B**	KP Outreach Compilation Sheet
8A	Condom Outlet Register	**8A**	Condom and Lubricant/Needle and Syringe Outlet Register
8B	Condom and Lubricant Inventory Register	**8B**	Condom and Lubricant Inventory Register
8C	Needle and Syringe Inventory Register	**Part 3, Tool B**	Needle and Syringe Inventory Register
8D	Condom/Lubricant Outlet Inventory/Distribution Register	**8C**	Condom/Lubricant Outlet Inventory/Distribution Register
8E	Needle and Syringe Outlet Inventory/Distribution Register	**Part 3, Tool C**	Needle and Syringe Outlet Inventory/Distribution Register
9A	MSM/Transgender Person Clinic Enrollment Form	**Part 3, Tool D**	Clinic Enrollment Form
9B	FSW Clinic Enrollment Form	**Part 3, Tool D**	Clinic Enrollment Form
9C	Referral Slips	**6**	Referral Slip (Clinical Services)
10	FSW/MSM Clinic Visit Form	**Part 3, Tool E**	Clinic Visit Form
10A	KP Individual Tracking Sheet for Clinical Services	**9**	Clinical Services Compilation Sheet
11	KP PLHIV Tracking Sheet	**11**	HIV Treatment Compilaton Sheet
11A	Case Manager/Peer Navigator – Individual Form	**10A**	HIV Care and Support Tracking Sheet (Peer Navigator Calendar)
		10B	HIV Care and Support Compilation Sheet
12	Crisis Management Register	**12**	Violence Disclosure and Service Provision Form
13	Advocacy/Sensitization Register	**13**	Advocacy/Sensitization Activity Register
14	Referral Register (for Nonmedical Services)	**7**	Referral Register for Social-Protection Services
15	Support Group Register	**Part 3, Tool I**	Key Population Group Register
15A	Gender_Norm – Individual Form	*Not included*	
16	Tool for Assessment of Communication by Peer Outreach Workers	**Part 3, Tool H**	Tool for Assessing Communication by Peer Outreach Workers
17	Assessment of Referral Service Point	*Not included*	

Annex 2. Definitions of 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, sex workers (SWs), and people who inject drugs (PWID).[6] The following key populations groups are considered in this *Monitoring Guide and Toolkit for HIV Prevention, Diagnosis, Treatment, and Care Programs with Key Populations*.

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 among 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 are not defined as SWs.

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 nonmedical 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 (therapeutic injection) are not included in this definition. The definition also does not include individuals who self-inject nonpsychotropic substances, such as steroids or other hormones, for body shaping or improving athletic performance. While these guidelines focus on people who inject drugs due to the specific risk for HIV transmission posed by sharing 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 nonconforming. Transgender people may self-identify as transgender, female, male, trans woman or trans man, 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.

[6]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).

Annex 3. Phases of an HIV Program with Key Populations

The lifecycle of an HIV prevention, diagnosis, treatment, and care program for key populations can be divided into four phases that may overlap. These are illustrated below, along with the relevant program monitoring tools.

PHASE	MONITORING INDICATORS	MONITORING TOOLS
Phase I: Preparatory		
Programmatic mapping and size estimation, or validation of existing mapping data • List of hot spots for implementing the program, including number of key population individuals at each hot spot	1.1, 1.2 2.1	1A, 1B 2A, 2
Recruitment of staff according to the coverage need • Basic training of implementing partner staff, including staff outreach supervisors and peer outreach workers	3.1 10.1, 10.2 10.3	3
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 hot spot • Registering key population individuals for services • Prioritizing needed structural interventions for key populations (e.g., advocacy, self-help groups, legal literacy, etc.) **Provide services** • Distribute condoms and lubricants, needles and syringes • Clinical services for key populations, e.g., HIV testing, PEP, STI testing and treatment (referral or through program-run clinics) • ART • Other related health services (TB, hepatitis B, hepatitis C)	4.1, 4.2, 4.3, 4.4, 4.5 5.1, 5.2, 5.3 6.1, 6.2, 6.3, 6.4 7.1, 7.2, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8 8.1, 8.2, 8.3 9.1, 9.2, 9.3, 9.4, 9.5 11.1, 11.2 12.1, 12.2, 12.3 13.1 14.1	2 4A, 4B 5A, 5B 6, 7 8A, 8B, 8C 9 10A, 10B 11 12 13
Phase III: Intensive Service Delivery and Refinement of Services **Provide all the services at program scale** • Key populations receive condoms and lubricants, needles and syringes • Behavior change communication • Health services, including STI, HIV testing services, ART, PrEP • Peer navigation for key population individuals living with HIV • EPOA • 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 individuals (e.g., community organizations and self-help groups) • Key population individuals lead their own initiatives • Key population individuals empowered to take up and operate the program on their own		

Annex 4. Sample Oath of Confidentiality and Code of Conduct

Oath of Confidentiality

I understand that, in the course of my duties in this program, I will come in contact with sensitive, personal information about individuals who would agree to be part of the program. I understand that this information is highly confidential, and I pledge to protect the confidentiality of all individuals receiving services from the program. I will protect their confidentiality by not discussing or disclosing any information about them to an unauthorized person, including the fact that they have received services from the program. 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 if their personal and medical information is disclosed to unauthorized persons.

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

Signature of staff member: _____

Witness: _____

Date: _____ / _____ / _____

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.

Annex 5. Sample Hot Spot Validation Protocol

(Adapted from protocol drafted by LINKAGES Democratic Republic of the Congo, 2017)

I. Objectives

- Develop a validated list of hot spots where key population individuals can be found
- Estimate the number of key population individuals that are found in program areas
- Determine community activities and services at the hot spots
- Use hot spot list and key population size estimates for program planning

II. Methods and Description of Implementation Steps

Steps

Step 1: Preparation: LINKAGES DRC will begin the hot spot validation exercise by developing a list of hot spots to be visited. For the purpose of the current activity a hot spot will be defined as follows: *a physical place or event where people (key population members and their partners) meet for sexual relations or make an appointment for sexual relations.*

Step 2: Hot spot validation: All hot spots on the integrated listed will be visited. An interview with a key population individual or others knowledgeable about the hot spot will be conducted. The interview will include questions about whether or not the hot spot exists and the number of key population individuals and program activities found at the hot spot.

Step 3: Data analysis and use: Data collected during the site visits will be compiled and analyzed to generate a new hot spot list, estimate the number of key population individuals in each hot spot and program area, and document prevention activities currently taking place. These results will be used to set up or improve programming in new and existing hot spots.

Data Collection Procedures

Trained interviewers consisting of peer educators (PEs) from LINKAGES implementing partners (IPs) and community-based organization (CBO) service providers who work with key population individuals (health care workers, social workers) will administer a hot spot validation form to key informants at the hot spots included in the integrated list.

Separate forms will be used for each key population type. Only one interview will be conducted in hot spots frequented only by FSWs or MSM. Two interviews, one with an MSM and another with a FSW or a non-key population member knowledgeable about these groups, will be conducted in hot spots that are frequented by both MSM and FSWs.

The table below describes the criteria used to identify and select key population or non-key population key informants (KIs).

Types of KI	Key Informants	Selection Criteria
Primary	Key population (FSWs, MSM, transgender people, PWID) found at active hot spots	First available key population individual willing to be interviewed
Secondary	Pimps, taxi drivers, tea vendors, petty shop owners, agents, bar owners, etc., found at active hot spots.	First available non-key population individual willing to be interviewed in cases where a key population individual is not found

All hot spots included in the integrated list will be visited, and the hot spot validation form will be completed at each hot spot. The following procedures will be followed by the interviewers:

- Arrive physically at the place (hot spot) listed
- Confirm the name or reference used to describe the hot spot as listed
- Walk around the site/hot spot and get the information by using observation methods
- Interview first available key population individual or non-key population member if key population individual not found after two visits
- Administrate the hot spot validation form
- Complete the form correctly based on the information provided by the interviewed person
- Participate in exchange meeting with other interviewers and supervisors at end of the day

At the end of each the day, all interviewers will meet with their supervisors to review the data collected on the hot spots visited and share the name of any new hot spot identified by the key informants. This information will be used to produce a separate list of new hot spots identified. The list will be cross-checked against the integrated hot spot list produced for this activity to identify hot spots that need to be assigned to interviewers for validation. This exercise will be done at the end of each day of data collection.

Data Management and Analysis

At the end of the exercise, all data collected will be recorded in a password protected MS-Excel sheet designed to store and analyze data. Data will be entered for one respondent interviewed at each hot spot. The data will be cleaned to produce a de-duplicated list of validated hot spots at the M&E/CBO level and M&E/LINKAGES level.

The minimum and maximum number of key population individuals at the national level will be calculated using the formula below, which adjusts for mobility by taking into account the number of key population individuals indicated in each hot spot as well as mobile variability of key population individuals. Given that Ni is the overall estimate, Ni is then a function of the following factors:

- Crude gross estimate for the city (Cr)
- Proportion of key population individuals who visit/socialize in other places (pi)
- Average number of places where key population individuals operate (mi)

$$Ni = C_r (1-pi) + (C_r * pi/mi)$$

Data Use and Dissemination Plan

Upon completion of primary data analysis and prior to finalizing the report, results will be shared with LINKAGES HQ team and USAID mission to confirm and contextualize results. Once the report is final, the IPs will use these lists to confirm correct allocation of the peer outreach workers to existing hot spots and select and train peer outreach workers in new hot spots. At the program level the list of validated hot spots will be used to:

- Plan and allocate the hot spots to the IPs' peer outreach workers
- Make final determination of whether sufficient peer outreach workers exist in the different hot spots to meet outreach targets
- Provide estimates for key population individuals in each of the locations across the health zones to enable effective targeting and maximum coverage for outreach activities
- Inform and engage the IPs and the key population organizations in taking ownership and responsibility regarding the prevention of HIV/AIDS

Annex 6. Further Resources

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

LINKAGES Key Population Program Implementation Guide. 2017, LINKAGES. https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-implementation-guide.pdf

LINKAGES Enhancd Peer Outreach Approach Implementation Guide. 2017, LINKAGES. https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-enhanced-peer-outreach-implementation.pdf

Unique Identifier Codes: Guidelines for Use with Key Populations. 2016, LINKAGES. https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-uic-guidance.pdf

Programmatic Mapping Readiness Assessment for Use with Key Populations. 2017, LINKAGES. https://www.fhi360.org/sites/default/files/media/documents/resource-mapping-readiness-assessment.pdf

Performance Indicator Reference Sheets for Key Populations. 2017, LINKAGES. https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-performance-indicators-reference-sheets.pdf

Fast-Track: Ending the AIDS Epidemic by 2030. 2014, UNAIDS. http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update. 2016, WHO. http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/

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/

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"]. 2015, 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

Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions [the "IDUIT"]. 2017, UNODC.
http://www.unaids.org/sites/default/files/media_asset/2017_HIV-HCV-programmes-people-who-inject-drugs_en.pdf

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

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

Peer-Led Outreach at Scale: A Guide to Implementation. 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

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 Approach: Cyclical Quality Improvement for Prevention Interventions with High Risk Groups. 2011, FHI 360/Aastha.
http://www.fhi360.org/sites/default/files/webpages/India_Aastha_Cont_Quality/foreword.html

Priorities for Local AIDS Control Efforts (PLACE Tool Kit). 2019, MEASURE Evaluation.
https://www.measureevaluation.org/resources/tools/hiv-aids/place